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GOVERNANCE OF HEALTH FINANCING AND STRATEGIC PURCHASING OF SERVICES IN KYRGYZSTAN





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Abstract

This paper takes stock of three cycles of health financing reform in Kyrgyzstan under three national health strategies implemented over the last 20 years. The report reviews and synthesizes lessons learned and recommendations of previous reports produced by national and international research and development partners. It notes that the main goals of health financing reform in the country – financial protection and financial sustainability – can only be achieved in the coming decade through close coordination with the design and implementation of other components of the health strategy, such as pharmaceutical policy and service delivery optimization. Equally, the paper notes where strategic use of financing tools will be needed to support effective implementation of other pillars of the national health sector strategy: *Healthy population – prosperous country*, the State Programme for Health Development 2030.

Keywords

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Table of contents

Acknowledgements	4
Acronyms and abbreviations	5
1. Scope of the report	6
2. Background of the first two successful state health strategies	7
3. Stalling of progress under Den Sooluk	8
4. Causes of the stalling of progress	11
5. Public financial management, norms and incentives: barriers and enablers	18
6. Governance and stewardship weaknesses blunting reform momentum	20
7. Financing issues in the SPHD2030 and action plan	23
8. Recent progress and areas for future action	25
9. Conclusion	36
References	37



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Acronyms and abbreviations

ADP	Additional Drug Package
HCO	Health care organizations
JAR	Joint annual review
KGS	Kyrgyz Som
MHIF	Mandatory Health Insurance Fund
MoF	Ministry of Finance
MoH	Ministry of Health
OOP	Out-of-pocket payment
PEN	Package of essential noncommunicable disease interventions
PHC	Primary health care
RBF	Results-based financing
SDC	Swiss Agency for Development and Cooperation
SGBP	State-guaranteed benefits package
SPHD	State Programme for Health Development
SWAp	Health and Social Protection project
UHC	Universal health coverage
USAID	United States Agency for International Development
WDI	World Development Indicators



1. Scope of the report

This report takes stock of three cycles of health financing reform in Kyrgyzstan under three national health strategies implemented over the last 10 years. The report seeks, in particular, to synthesize lessons learned and recommendations of previous reports produced by national research and development partners, such as WHO, with a normative role in supporting future health-sector actions. It is timely to do this as the country looks to embark on the next national strategy: *Healthy population – prosperous country*, the State Programme for Health Development (SPHD) 2030, which adapts the United Nations Sustainable Development Goals to the Kyrgyz context and fosters the path towards universal health coverage (UHC).



2. Background of the first two successful state health strategies

The first national health strategy, called *Manas*, implemented reforms during 2001–2005 and achieved a positive impact on the health financing goals of improved financial protection for the poorest 40% and increased the efficiency and equity of service delivery. The strategy achieved these results through **the combination and coordination of financing and service delivery measures**. The financing measures of the reform encompassed resource mobilization (explicit co-payments which reduced informal payments for medicines and food, plus retention of savings from efficiency gains in the health sector), a purchaser–provider split, a state-guaranteed benefits package (SGBP) with targeted co-payment exemptions, and new provider payment methods (primary care capitation and hospital case payment) (1). Evaluations have also credited new provider payment methods – primary health care (PHC) capitation and inpatient case payment – with creating incentives for efficiency and greater geographical equity in allocation of funds in the reformed service delivery system (2,3). A less-studied element of reform implementation was the introduction of activity-related bonuses for health facility staff from the new and more flexible sources of revenue mobilized for health (mandatory health insurance contributions, co-payments and special revenues). It seems plausible that this was an important driver of productivity improvement.

Service delivery measures implemented alongside these reforms helped to reduce out-of-pocket payments (OOPs) and to increase efficiency and equity. The major service delivery reforms included reduction in the number of hospitals and consolidation of facilities, which released substantial efficiency gains. This freed up resources for more spending on direct patient care costs (medicines, supplies, food) and so reduced informal payments for these items. Another major plank of reform – development of primary health care – included introducing family doctors and training family medicine staff. This helped to increase equity of access by providing access in rural areas and free primary care for all.

The second national strategy (2006–2010), known as *Manas Taalimi*, built incrementally on the earlier gains. This second strategy attempted to mobilize more resources for health and to stabilize the budget, using a target for increasing the share of general government expenditure spent on health to at least 13%. While the strategy succeeded in increasing public, pooled financing from 10.5% of government spending in 2005 to 13% in 2010, the adverse macroeconomic conditions during 2008–2011 undermined the impact of this fiscal effort as the real value of general government expenditure declined. Reviews of the second programme noted a slowing of implementation progress in the latter years in the context of political and economic instability (4).

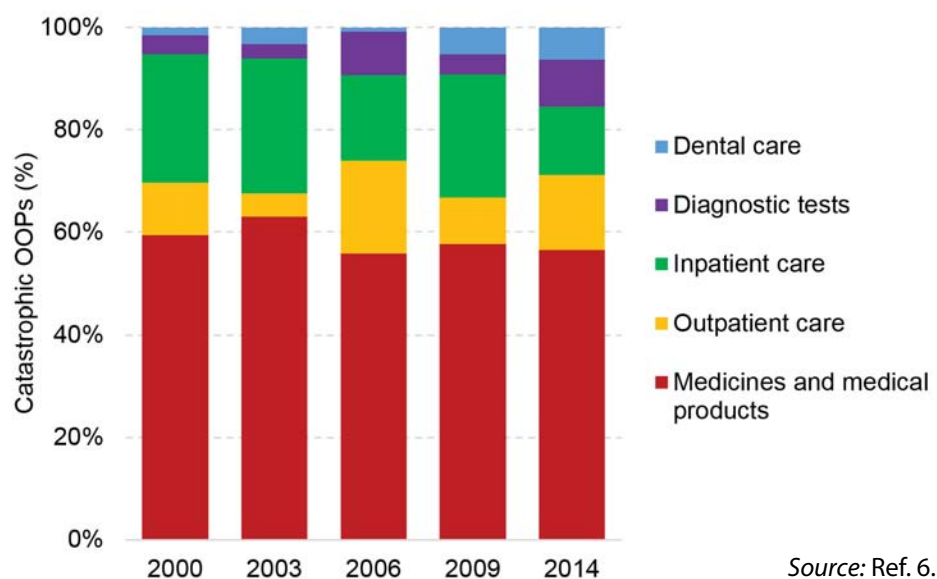


3. Stalling of progress under *Den Sooluk*

Even after economic stabilization and recovery, the third health sector strategy – *Den Sooluk* (2011–2018) which focused on service quality – made slow progress in implementation and resulted in little or no growth in indicators of quality, health outcomes and financial goals (5). There has been progress in implementing some financing policies, notably in pooling of additional financing – from Bishkek City and Ministry of Health (MoH) specialized programmes – as well as in the Mandatory Health Insurance Fund (MHIF) in 2016, and in adopting new laws and regulations for the MHIF budget in 2017. These provide a platform for future improvement in incentives for efficiency, although this potential has not yet been realized. **A partial reversal of financial protection indicators** has been achieved by earlier reforms since 2009.

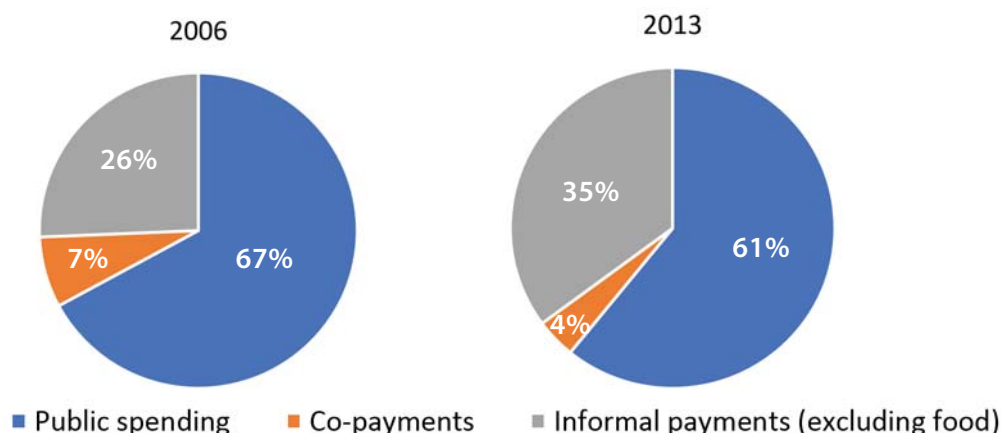
Across several financing indicators, there was a pattern of improvement under Manas from 2000 to 2006, followed by a deterioration around 2009, and then some limited improvement by 2014. There are signs that this improvement is due more to falling poverty rates (which fell from 40% to 25% of households between 2007 and 2017 based on the national poverty line) and the growth in household incomes rather than to health system performance. The deterioration in financial protection since 2006 has been **driven by high and growing OOPs for medicines, and particularly for outpatient medicines and medicinal supplies**. These were the main areas of reduction in OOPs by 2006 following reform implementation although they remained the largest contributor to OOPs (1,6). For upper-income quintiles and in the cities of Bishkek and Osh, growing OOPs for dental care, diagnostic tests and outpatient care are also contributing to rising catastrophic expenditure (Figure 1) (6).

Figure 1. Medicines driving growth in catastrophic out-of-pocket payments



OOPs on medicines, supplies and personnel have also grown in the hospital system. Between 2006 and 2013, **the financing gap in hospital care met by informal payments increased from 25% to 35% of costs** that should be covered in theory by the SGBP (Figure 2).

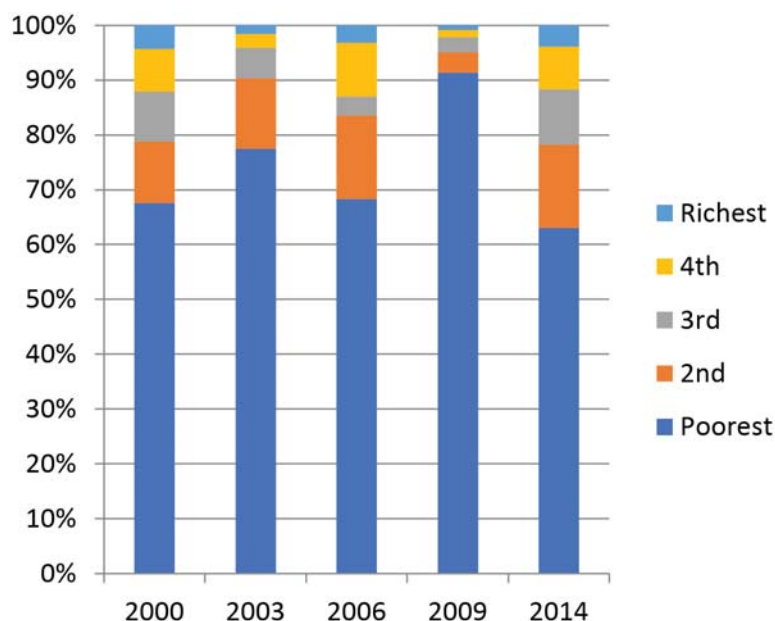
Figure 2. Rising financing gap met by informal payment in hospitals



Source: Ref. 6.

However, although the poorest quintile experienced high growth in OOPs after 2009 and continues to have high rates of catastrophic payments, **the financial protection policies of the SGBP are still protecting the poorest quintile**. There has been a slight fall in the rate of catastrophic expenditures for the poorest quintile since 2009, though to a rate that is still higher than in 2006 after implementation of the *Manas* (Figure 3). The fall since 2009 may be due to falling poverty rates and rising household incomes. The rising household incomes have led to a fall in impoverishing expenditures for all quintiles over this period (6).

Figure 3. Growth of catastrophic payments

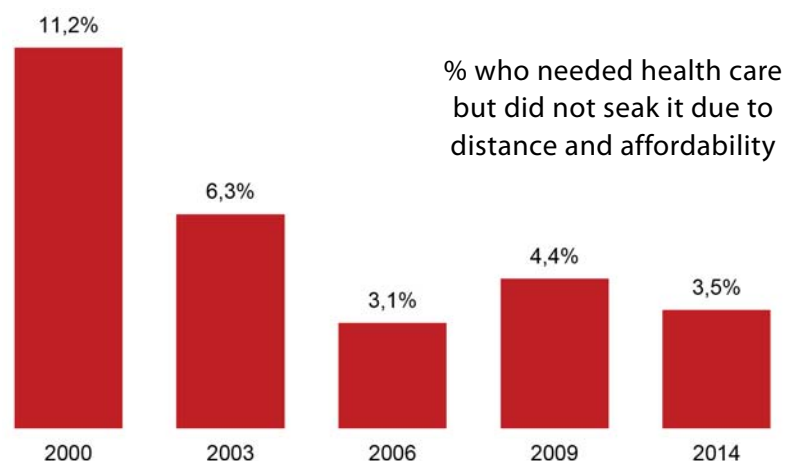


Source: Ref. 6.

Survey of those who did not seek health care when they needed it due to distance or financial reasons show a similar pattern: by 2009 there was some reversal of the sharp reduction in unmet need achieved by 2006 under *Manas*, but the rate of unmet need has fallen slightly since 2009 (Figure 4). However, this appears to be due to economic growth

and poverty reduction rather than to health system performance, because survey evidence from the Kyrgyz integrated household budget survey shows that, **compared to 2009, a higher share of households in 2014 report that it is difficult or very difficult to pay for health expenditure and that more use household coping strategies to pay for health care** (e.g. use of savings, support from relatives, cutting consumption). Evidence also shows that, when sick, over half of the population relies on self-medication rather than consulting a health professional, thus leading to high OOP on non-prescribed medicines (6).

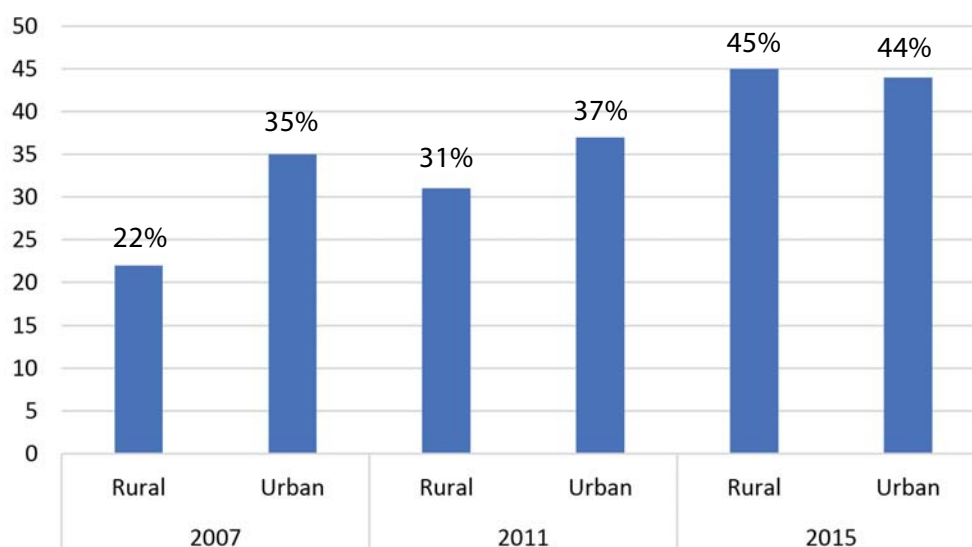
Figure 4. Unmet need due to distance or financial barriers



Source: Ref. 6.

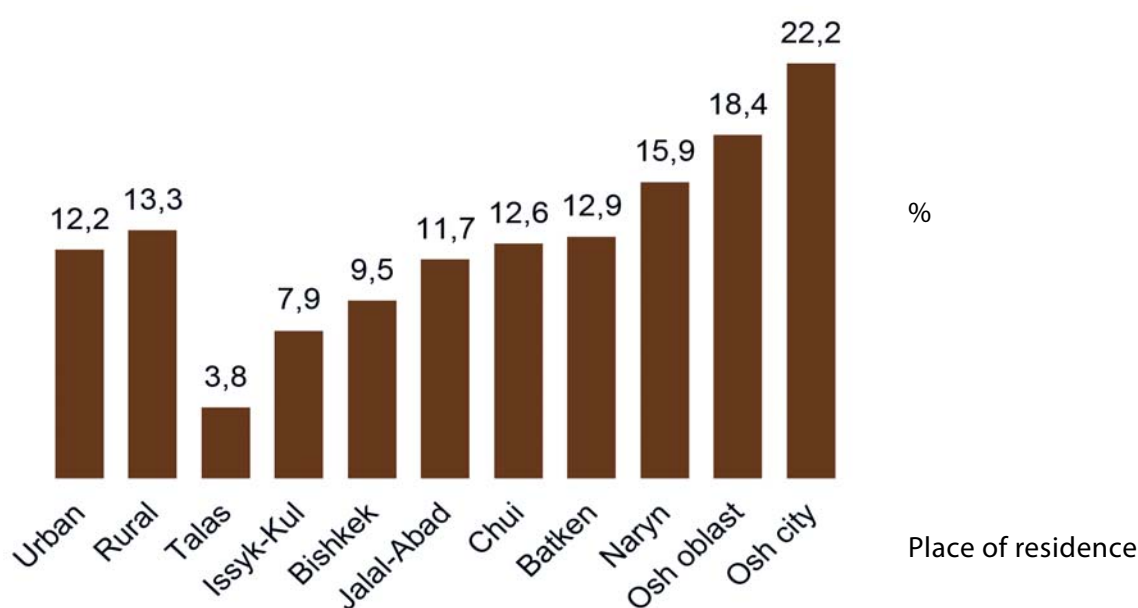
On a more positive note, equitable financing and co-payment-free access to PHC – together with village health committees – has continued to provide a platform **for progress to improve access, coverage and equity for priority conditions** (Figure 5). However, **these gains are now vulnerable to a workforce crisis in rural family medicine** and a lack of plans for financial sustainability of village outreach work after development project support ends.

Figure 5. Closing the rural–urban gap in primary care outreach for hypertension



There are regional inequalities in financial protection for health care, as shown in Figure 6. High rates of catastrophic payments are found in both some urban locations (notably Osh) and some remote or mountainous regions (e.g. Batken and Naryn), thus suggesting a need for targeting greater protection in the poorest regions as well as tackling some of the health-system causes of higher informal payments in urban contexts.

Figure 6. Regional distribution of catastrophic payments (2014)



4. Causes of the stalling of progress

Behind this stalling of progress over the last 10 years are a number of unresolved issues in health financing, governance and complementary non-financing policies.

4.1. | High- and fast-growing spending on medicines – in terms of both price and volume growth – is the main **immediate driver** of rising OOPs for medicines. This indicates problems in medicines policy, regulation and management leading to high medicine prices, poor availability in some facilities, irrational prescribing and fast-growing sales of medicines without prescription. Most of the problem is related to spending on outpatient medicines, including prescription medicines (7). The mid-term review of *Den Sooluk* found that the strategy did not give sufficiently high priority to medicine policy issues (5). However, increased focus since then has led to the adoption of a new Pharmaceutical Law which can provide the foundations for implementing price regulation policies and other improvements, **although this will require a substantial increase in the level and capacity of resources applied to implementation of pharmaceutical regulation.**

4.2. | Health budget formulation is allocating insufficient resources to medicines coverage and PHC provision. Very low budget allocation to the Additional Drug Package (ADP) is leading to excessively stringent limiting of access to highly cost-effective treatments for priority conditions. The ADP budget for prescription medicines was 1.7% of total government spending on health in 2017, equivalent to only around US\$ 0.70 per capita. It is heavily rationed by limits on the number of prescription forms given to family doctors each month, which are estimated to meet around one third of patient need for prescription medicines in primary care. In 2017 only 1.2 million prescriptions were issued, compared to an estimated 1 million patients needing regular prescriptions for hypertension medication alone (8). The ADP budget has not been increased rapidly enough to ease this stringent rationing or to cover the growth in demand. There has been significant real growth in the co-payments paid for ADP medicines, indicating that reimbursement levels of the ADP have not been adjusted adequately for price changes to maintain the depth of coverage. (These price increases include some “justifiable” changes due to depreciation of the Kyrgyz currency [KGS].)

There are also issues with the allocation of budgets for medicines by hospitals: **the share of hospital budgets allocated to medicines and other direct patient care costs in many facilities is now below the 20%** level seen before reform, while demand is rising. Increasing the budget share for direct patient costs was important under *Manas* for reducing informal payments on medicines and supplies.

The share of the MHIF **budget allocated to PHC relative to hospital care has not been increased sufficiently to enable the role of PHC to expand** or, as envisaged in the national health strategies, to shift activity out of hospitals (by reducing unnecessary hospital admissions for conditions such as simple hypertension and common minor childhood illness) to PHC. In 2018, the MHIF financed results-based payments (i.e. results-based financing, or RBF) for PHC by top-slicing funds from this static PHC allocation. RBF payments are intended to raise the quality and expand the activities of PHC in case-finding, diagnosis and treatment of priority diseases. However, without an expansion of the total PHC budget to increase resources, and a funded strategy to attract and retain more doctors in family medicine and to raise PHC workforce skills, it is doubtful that PHC facilities have sufficient skilled staff and financial resources to raise PHC quality and expand their activities.

4.3. | More generally, there is little systematic use of analysis and evidence as a basis for forecasting demand and cost-drivers, and allocating the health budget on the basis of costing gaps in the SGBP and ADP in order to reduce rationing and the financing gap for priority services – estimated at over one third of hospital care costs (9). While the MoH makes some use of the 13% target in negotiating its budget, there is no systematic analysis or use of evidence in determining what share of the budget to allocate to the SGBP, or to major components of the SGBP, as opposed to other programmes. The Ministry of Finance (MoF) uses historic actual expenditure, with ad hoc adjustments for new policies (such as transfer of specialized programmes to the MHIF or expansion of haemodialysis purchased from the private sector), as the basis for determining the MHIF budget for the SGBP. In considering medium-to-long-term cost-drivers, projecting **wage pressures** (to address outmigration and shortages in the health workforce) is already important, and projecting the impact of

private health-sector development will become increasingly important over time. Private providers offer the potential to raise quality but, unless it is well regulated, the private sector has powerful incentives to use marketing to increase demand for inessential and ineffective services, in addition to essential ones, and so can increase the financing gap and reduce financial protection.

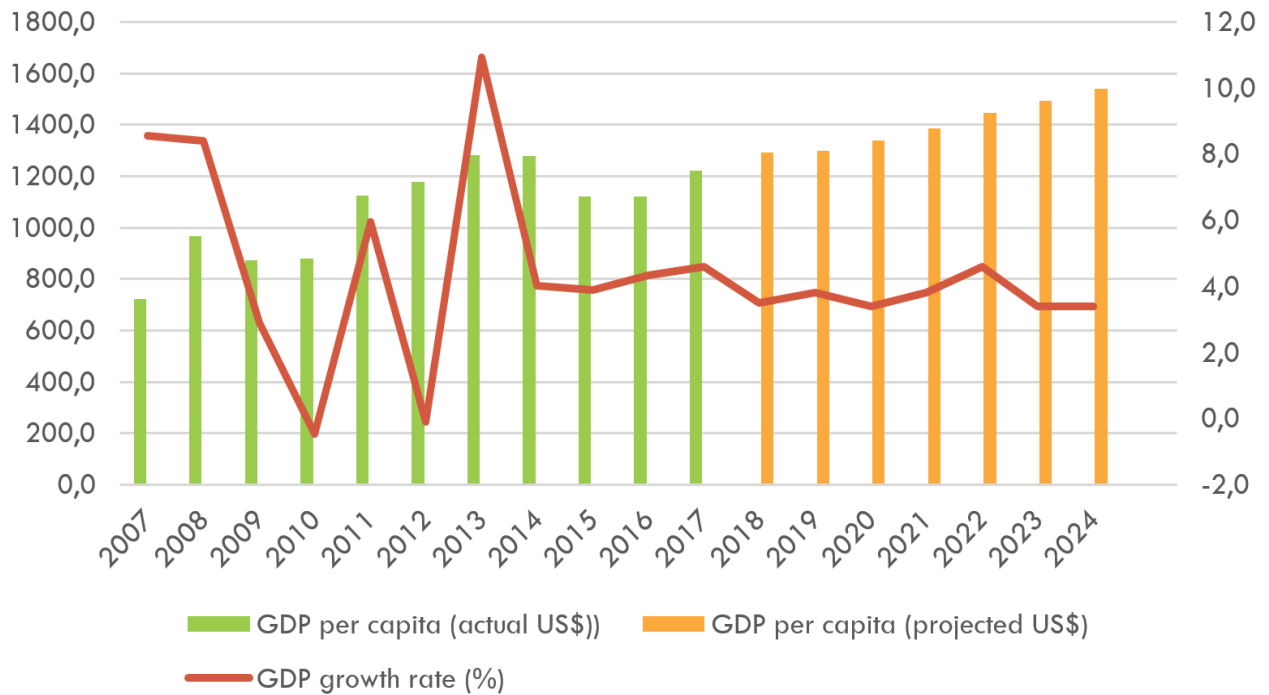
There are also other issues contributing to the problems of weakening financial protection:

4.4. | Resource mobilization for health has weakened, as the 13% “target” for the share of general government expenditure spent on health seems to be interpreted now as a “ceiling” rather than as a “floor”. During the period of *Manas Taalimi* in 2008–2011, weak resource mobilization reflected the impact of the global financial crisis, and in 2010 reflected political instability. Political stabilization and higher (but still volatile) economic growth saw an increase in budget allocations for health in 2012–2013. Nevertheless, resource mobilization from the Republican budget has again been flat for the remaining period of *Den Sooluk*. This is seen in a flattening trend in real per capita health spending since 2012, and in the share of general government expenditure allocated to health which has weakened from a high point of 14.8% of general government expenditure for health in 2013 to 13.0–13.2% since 2015. The health budget allocation target appears to be functioning as a “ceiling” or cap rather than as a “floor” or minimum standard – although the original intention was for 13% to be a minimum standard to protect the health sector during periods of fiscal austerity. By contrast, other priority sectors in Kyrgyzstan – such as education – have increased their budget share steadily over this period (NB: the education budget increased from 16% to 24% between 2010 and 2016, compared to 13% for health in both 2010 and 2016). (See Figures 7, 8 and 9.)

Internationally, as countries’ economies grow – as Kyrgyzstan’s economy has – the countries usually allocate a higher share of GDP to pooled health financing arrangements. In Kyrgyzstan, the MoF uses a non-standard measure (negotiated with development partners) for the 13% health expenditure target which includes investment expenditure. This does not, however, provide a good measure of changes in the adequacy of funding for the SGBP and ADP and other recurrent public health and service delivery costs. The MoF/development partner measure of the health target is not useful for international comparisons. It inflates the health spending figure for Kyrgyzstan by about 3 percentage points, compared to the standard System of Health Accounts measure that is used in international comparisons. **There is a good case for reviewing the health budget spending target measure and clarifying that it should be interpreted as a minimum standard to protect health spending in difficult economic circumstances, and not as a “gold standard”**, given that this level of funding is insufficient to finance the current SGBP.

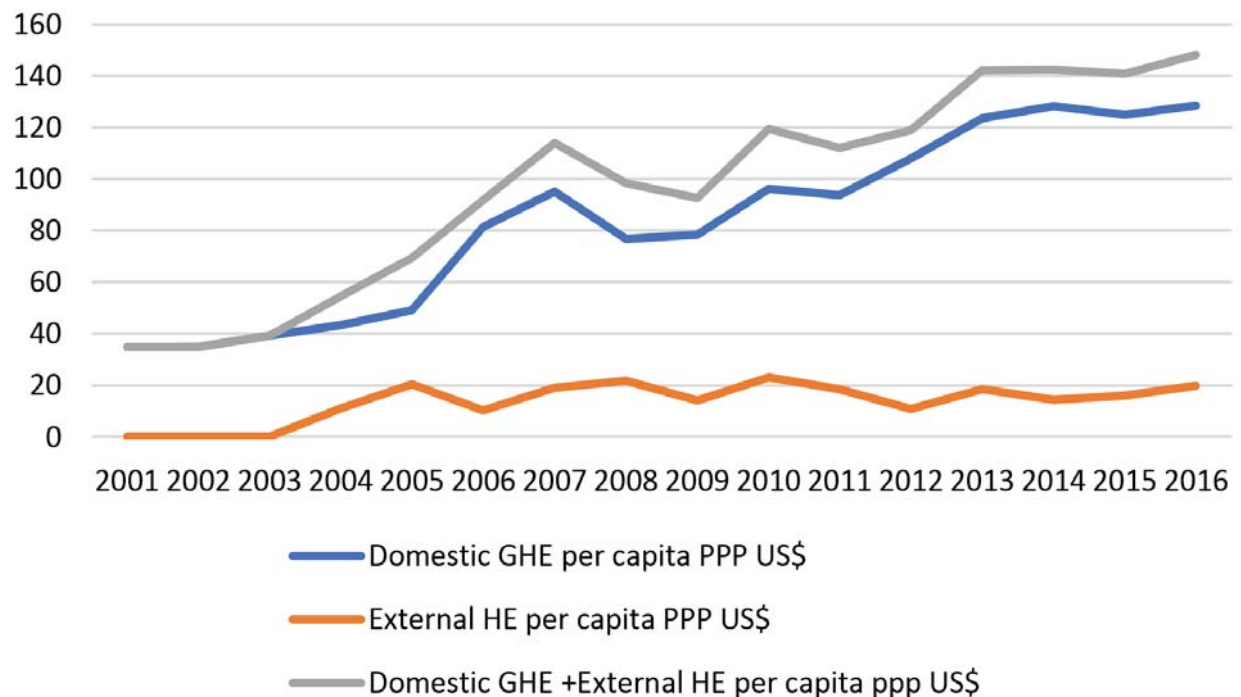
Additionally, co-payment rates have not been adjusted regularly and have not kept pace with inflation or growth in real wages; this factor, together with poorly targeted expansion of exemptions, has reduced hospital co-payment revenue from 7% to 4% of total hospital expenditure (Figure 2, above).

Figure 7: Volatile GDP per capita (actual 2006-2017; est. 2018; projected 2019-2024)



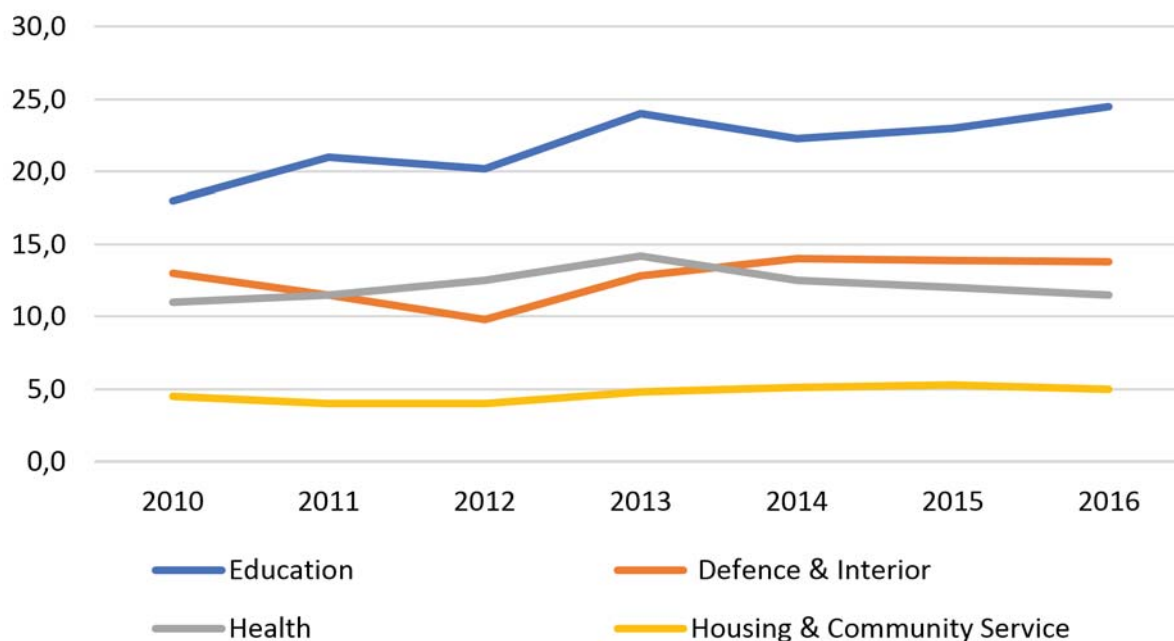
Source: WDI actuals 2006-2017; IMF (2019) est. 2018 and projected 2019-2024 (10).

Figure 8. Stagnation in growth of per capita government health expenditure since 2013



Source: World Bank: World Development Indicators data.

Figure 9. Weakening resource mobilization for health from the government budget

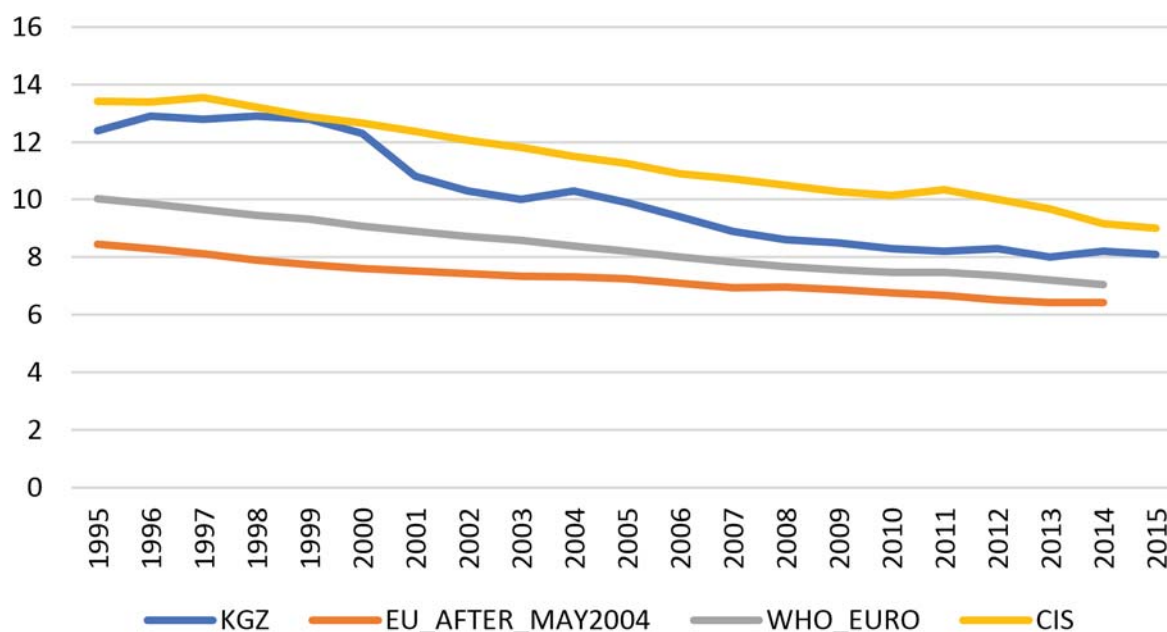


Source: World Bank calculations using national budget reports (World Bank, 2018).

4.5. | Mandatory health insurance contribution collection is weak. Mandatory health insurance contributions from the formal and informal sectors and from farmers are poorly enforced, with some 26% of the population not contributing although the scheme is mandatory (6). An MoF pilot project in one oblast is trialling the transfer of responsibility for collection from the Social Fund to the State Tax Service, which is under the MoF, and this shows potential for improving collection.

4.6. | There is persistent, substantial inefficiency in hospital services. The average length of hospital stay has levelled off since 2010 at about 8 days following sharp falls between 2000 and 2010 (Figure 10). However, there has been no general shift to day-patient and outpatient care as seen internationally. Rates of day surgery are low; procedures such as tonsillectomy, cataract surgery and hernia repair, which are usually performed on a same-day basis, have average lengths of hospital stay of 6.5, 7 and 8.3 days respectively (MHIF data). Unnecessary hospital admissions for ambulatory conditions such as simple hypertension remain high. Since the first stage of hospital closures and consolidations under *Manas*, there has been a lack of progress in tackling the fragmentation and excess capacity in Bishkek and Osh. New hospital investment in Bishkek by non-traditional donors runs the risk of adding to this problem. There is also scope for further optimization of poorly configured and multisite hospitals in other regions. A new masterplan is to be drawn up as a basis for a further round of rationalization, but lessons from the past indicate a need for strong political will and more attention to communication and change management if the plan is to be implemented.

Figure 10. Average length of stay in hospital (acute care hospitals)



Source: WHO, HFA database 2016.

4.7. | The lack of progress in efficiency in part reflects a stalling in development of strategic purchasing, with limited progress in using contracting and the provider payment system to drive improvements in quality, efficiency and health outcomes.

a. Hospital and specialized services payments: The simple case payment system for inpatient care has been updated incrementally four times since its introduction. This has enabled the case payment system to reflect case–cost differences for surgical cases, treatment of children and short-stay cases, and also to expand to some additional specialized services and tuberculosis services that are added to the single-payer system.^a However, the case payment system does not adjust payments for cases of higher complexity or complications, and there are calls for a more comprehensive review in order to ensure that the payment system allocates resources appropriately between lower-level and higher-level hospitals. WHO has been providing consultancy support to the MHIF to enable the fund to begin work on further developing its case classification system.

Additionally, other than one UNICEF-supported project which has developed hospital day-treatment rates and supported associated service delivery changes with significant impact in reducing avoidable hospitalizations (11), there is no provider payment mechanism for outpatient specialist care or same-day surgery. Thus hospitals have a strong incentive to admit inpatients who could be treated as outpatients or same-day-cases.

b. Contracting and data: Due to deficiencies in the data used by the MHIF for hospital contracting and the lack of capacity for data analysis and contract specification, the fund

^a “Single-payer system” in Kyrgyzstan refers to the health financing system comprising the MHIF and the services and providers it funds.

has not yet been able to specify and monitor contracts adequately. Thus it has not been able to control the volume of services, provide feedback to providers or shift the mix of inpatient care to improve cost-effectiveness and address health priorities. In the last two years the MHIF, with WHO's support, has begun work to develop strategic purchasing by analysing hospital activity by major disease categories. Pilot projects have begun at oblast level to use this data and analysis to initiate more strategic contract specification, negotiation, monitoring and provision of feedback. WHO has also supported the MHIF in improving data collection and developing central analytical capacity. The pace of development of strategic purchasing is constrained by the need to address concerns about data and information and by the over-burdened capacity in central and regional MHIF offices.

- c. Primary health care payment:** Apart from some pilot programmes in selected areas, payment for PHC has relied on a simple capitation formula since the earliest phase of Kyrgyzstan's reform, which has not supported an expanded role for PHC in the health system. A successful pilot project, supported by USAID, to shift most tuberculosis diagnosis and treatment to primary care, is also planned for scale-up by the MHIF. Pay-for-performance pilots supported by the World Bank and the Swiss Agency for Development and Cooperation (SDC) began implementation in some rayons during 2017–2018.
- d. Results-based payment: There is potential to make more use of financing levers (including appropriate use of pay-for-performance – i.e. results-based financing (RBF) – to support improvement in the detection and treatment of priority conditions, the quality of care and the desired shift of care from inpatient to day-patient and primary care settings.** A World Bank-supported pilot RBF scheme has been implemented in rayon hospitals, and preliminary results from impact evaluation (due to be published in 2019) are positive (12,13). The MHIF has allocated funds to scale this up to cover oblast hospitals and to extend coverage of PHC facilities by the end of 2018, drawing on lessons from pilots supported by the World Bank and SDC.

Some of the **foundations for developing the provider payment system are already being developed, although full implementation will require further strengthening of capacity, data and information systems in the MHIF and the corresponding provider systems.**

Most of these **provider payment developments need to be coordinated with service delivery and human resources measures by the MoH** in order to improve quality of care – e.g. by updating service delivery models, related facilities and equipment investment, and by promoting changes in clinical practice through training and the development of guidelines. As an example, expansion of the role of primary care will require a combination of changes both to payment methods and to human resources policies (to better train and reward family doctors and nurses) as well as improvement of access to diagnostics in PHC. Development of day-surgery will also require reconfiguration of buildings, equipment, training and protocol development.

5. Public financial management, norms and incentives: barriers and enablers

The slow pace of public financial management and civil service reform has been a factor in holding back health financing reform from achieving its full potential.

At the level of national budget formulation, the MHIF's budget ceiling is set by the MoF on the basis of historical actual expenditure. The fact that the budget ceiling for the MHIF is no longer set on the basis of input costs of health care organizations (HCOs) is a major step forward. Nevertheless, adjustments to the budget for inflation are still based on input costs (specifically, increases in wages are applied to approved numbers of staff posts) which continues to create disincentives for the health sector to rationalize excess vacant posts. A bigger concern is that budget formulation does not use any methodology for projecting growth in the cost of the SGBP to meet rising needs/demands due to population growth and ageing. Nor is there a methodology or strategy to close the financing gap by better costing of the SGBP over time. Such an approach would be preferable for setting the budget ceiling than the current reliance on a 13% target for total government health spending (which in practice is closer to 10% on nationally and internationally comparable measures), with no evidence-based methodology for determining the share of this budget allocated to the SGBP. Nor is evidence used to review priorities for allocating budget resources across programme categories (e.g. the balance of allocation to PHC versus specialized services or contracts with private providers) in line with national strategy priorities.

At the level of HCOs, facilities have continued to struggle with rigidities and disincentives in the public financial management system. As a result, HCOs have little scope to respond to incentives that the payment system seeks to create for them to increase efficiency. Plans since *Manas Taalimi* to give facilities greater autonomy to respond to financing incentives have not been supported by the MoH, although a pilot initiative supported by SDC in three rayons was given support in July 2018. The pilot has established that health facilities can achieve substantial autonomy under existing legislation, through changes in regulations under the control of the MoH and MHIF.^a

A new MHIF Budget Law implemented in 2018 provides a platform for increasing financial autonomy of facilities. The MHIF is proceeding very cautiously in offering flexibility, and facilities are even more cautious in exercising the new flexibility in the first year of implementation. The MoH has also been slow and cautious in approving regulations drafted by the MHIF to enable the transition to fully pooled budgeting and reporting of expenditure and greater financial flexibility for health facilities. However, in spite of these obstacles, there is some progress in addressing in-year bottlenecks in accessing cash for priority needs. There is potential to build on these early steps over time.^b

^a The end of Phase I evaluation report: Health Facilities Autonomy Project in Kyrgyzstan. Bishkek: Swiss Agency for Development and Cooperation; 2018 (Unpublished).

^b Mission reports of technical experts advising on MHIF on governance, strategic purchasing, development of case payment and data. Bishkek: World Health Organization Country Office for Kyrgyzstan; 2017–2018 (Unpublished).

There are systematic disincentives for health facilities (or the MoH) to optimize the number of staff posts in order to increase efficiency and allocate adequate budgets for direct patient care costs or maintenance of facilities. These arise primarily from the combination of the legacy of post-Soviet **staff norms and Labour Code provisions** that are interpreted in the health sector as allowing facilities to redistribute salaries of vacant posts to other staff indefinitely. This makes facility managers reluctant to give up posts even if the workload is not sufficient to justify them. If these disincentives are not tackled, increased facility autonomy cannot be expected to lead to significantly increased efficiency or quality. Facilities' reluctance to give up unnecessary posts is reinforced by widespread concern that the MoF will take back the savings if posts are cut. This is no longer true, but the MoF still uses staff post numbers when there is budget sequestration and only protected items (base-level salaries) are funded and when the MoF adjusts the budget for an increase in approved health-sector salary levels. These factors continue to incentivize the retention of posts.

An earlier study of staff norms showed that there is a significantly higher number of approved posts nationwide than would be justified by the 2001 workload-based norms. The excess of staff numbers is highest in Bishkek, followed by Osh.^a In the SDC autonomy pilot in Issyk Kul, facilities are reducing their number of posts to a level based on the 2001 workload-based norms and are putting the savings generated by cutting posts into a bonus pool for paying salary top-ups according to a score card for performance. This scheme was approved for implementation by the MoH from 1 July 2018.^b Complete removal of staff norms would not be advisable until there is some minimum standard for staff numbers for patient safety. Although there is a budget norm requiring health facilities to allocate 15% of their budgets for medicines, this norm is clearly not enforced; incentives relating to staff norms are a more powerful influence on budget allocation by facilities.

The current system gives substantial discretion to heads of facilities to pay substantially higher salaries to staff. In the current human resources crisis, this is a coping mechanism that may be particularly important for rural facilities. However, the way the system operates means that facility heads cannot use this flexibility to recruit new staff to important vacancies by offering explicitly higher salary rates which are a multiple of the base salary, even though they are paying medical staff higher salary rates in practice. In addition, the structure of the base salary scale is biased against the recruitment of younger staff or those earlier in their careers relative to those near or past retirement age, and facility heads do not have the flexibility to change this (14).^c



^a Revision of staff norms of healthcare organisations under accompanying measures of sector program Health Care 2. (BMZ 2007.70.370). Final Report. Bishkek: Kreditanstalt für Wiederaufbauentwicklungsbank (KfW) & Ministry of Health of the Kyrgyz Republic; 2014 (Unpublished).

^b The end of Phase I evaluation report: Health Facilities Autonomy Project in Kyrgyzstan. Bishkek: Swiss Agency for Development and Cooperation; 2018 (Unpublished).

^c Mission reports of technical experts advising on MHIF on governance, strategic purchasing, development of case payment and data. Bishkek: World Health Organization Country Office for Kyrgyzstan; 2017–2018 (Unpublished).

6. Governance and stewardship weaknesses blunting reform momentum

Implementation of the *Manas* reform benefited from strong **political ownership**, well-coordinated **stewardship from the MoH and MHIF** and well-aligned support from major development partners. This provided an exceptionally supportive context during this period of reform that has proved not easy to sustain throughout the subsequent two strategies. Key features of the supportive environment were: 1) a period of stability in the MoH and MHIF leaderships combined with a shared vision and understanding of reform, 2) strong coordination of implementation across the two agencies, and 3) well-coordinated technical support from the larger development partners and technical partners.

The mid-term review of *Den Sooluk* noted that underlying institutional factors had hampered progress on implementation. There had been a failure to act in a prompt and concerted way to tackle issues raised in annual reviews of the national strategy. Some recommendations were agreed year after year in annual reviews but did not lead to the follow-up necessary to address the issues and achieve the desired results. There is also a disconnect between the ultimate outcome goals of the strategy and the chain of actions, outputs and intermediate results needed to achieve them. The MoH strategy documents plan and report on activities but there is often a reluctance to commit to challenging – yet realistic – performance targets for key intermediate results.

Reviews point to **weakness of stewardship and governance**, including a **lack of results-orientation**, overly centralized governance with **weak MoH links to regional levels**, fragmented and ineffective supervisory and advisory boards and committees, and **weak coordination of governance across the MoH, MHIF and MoF** (5).

Coordination between the MoH and MHIF became more complex during the *Manas Taalimi* strategy after 2006 when the MHIF was given independent status from the MoH. There are positive features of MHIF independence in that it creates stronger checks and balances in the system. However, it has led to new challenges of coordination and role clarification between the MoH and MHIF, as well as challenges of governance of the MHIF itself. With no regular processes to ensure coordination, this has depended very much on the individual qualities and relationships between the Minister of Health and the Director of the MHIF. **Lack of clarity and some overlap of the roles and responsibilities of the MHIF, MoH and MoF** create unnecessary friction. The situation leads to delays in legislative, regulatory and administrative decisions affecting reform of health financing.

Until very recently, the MHIF's supervisory board, chaired by the Vice Prime Minister for Social Affairs, has neither met regularly nor functioned effectively. At a practical level, there has been a lack of standard good practices and procedures for councils/committees and a lack of standard reporting. The MHIF's management has begun to address these issues, with WHO support, by **adopting standard operating procedures and reporting formats**

for its board and developing its institutional strategy – which is a key foundation for the supervisory board to hold the MHIF accountable. Proposals have also been developed to clarify the supervisory board’s charter and review its membership in order to address **current problems of conflict of interest of some members** and the presence of many passive members.^a

Governance, monitoring and inspection of public-sector HCOs is fragmented, weak and ineffective. Multiple committees and councils in the health sector (including three chaired by the Vice Prime Minister, two public advisory councils, and an MoH Consilium made up of health facility representatives) have unclear or overlapping terms of reference and typically limited powers or mandates. These governance structures are wasteful of the scarce capacity of the agencies that report to them, lacking in appropriate skills and expertise, and ultimately ineffective as mechanisms for accountability. **None of these bodies has a clear mandate to function as the forum for MoH– MHIF strategy coordination or as a mechanism of accountability for results** in delivery of the state programmes for the health sector. In practice, the MoF plays perhaps the key role in ensuring financial control and accountability in the single payer system. The MoF’s programme budgeting initiative is leading it to expand its role of holding the MoH and MHIF accountable into non-financial aspects of performance – with the lines of accountability linked to the budget running through the MoF to the government and parliament.

Fragmented governance leads to conflicting and confusing directions to HCOs, non-aligned regulations, inconsistent application of policy and regulations, and weak governance and accountability of health-care providers. Private health-care providers operate under a legislative and regulatory framework separate from that of public HCOs, and those contracted by the MHIF are also affected by uncoordinated governance. The MoH has the primary “ownership” responsibility for HCOs – appointing HCO directors, setting regulations for quality, infrastructure and human resources, and collecting data from HCOs. The MoH also licenses private providers. However, the MoH lacks capacity to monitor and review provider performance. A recent World Bank-supported pay-for-performance pilot project for rayon hospitals and PHC centres, which is now being handed over to the MHIF, has instituted a stronger system of balanced scorecard quality assessment for hospitals (similar to accreditation) undertaken separately from the MoH’s own accreditation commission. Additionally, multiple ministries and the Chamber of Accounts inspect HCOs under their respective regulations. These multiple checks on HCOs are poorly aligned, not coordinated, variably and inconsistently enforced and often non-transparent – imposing **high compliance burdens on providers and inducing a compliance-oriented culture of caution, without providing clear direction or support for quality assurance and quality improvement** (15).

The *Manas* health reforms gave the MHIF responsibility for financial monitoring and control of public HCOs, as well as responsibility for holding them accountable under contracts for service delivery which include some measures of quality. Through its regional offices, the MHIF has more capacity for financial and contract monitoring than the MoH. **Authority and responsibility for HCO financial performance and efficiency are misaligned between the MoH and MHIF.** The MHIF has the data and bears the financial impact if public-sector HCOs have deficits, but the MoH holds the key ownership and regulatory powers needed to push financially risky providers to address their problems.^a

^a Mission reports of technical experts advising on MHIF on governance, strategic purchasing, development of case payment and data. Bishkek: World Health Organization Country Office for Kyrgyzstan; 2017–2018 (Unpublished).

There is no government committee or council in which the totality of government health spending is considered. Since the new MHIF Budget Law was implemented in 2018, the MoH and MHIF budget processes have been completely separate within both the government and the parliament. The MoF (and the Cabinet of Ministers) is the only body that looks at both the MoH and MHIF budgets – other than the social protection/joint annual review (SWAp/JAR) processes initiated by development partners. The MoH budget is negotiated first and is part of the Republican Budget – the government’s annual budget law. In this context the MoH uses the health expenditure target of 13% of the whole budget and has the opportunity to bid first for any growth in the health budget over the previous year. The MHIF budget is decided slightly later in the year in a completely separate process under the annual MHIF Budget Law – outside the Republican Budget. The MoF’s **programme budgeting initiative provides a potential platform for developing realistic but challenging results, indicators and targets aligned to the new SPHD2030 and for consideration of the totality of government health spending**, but full implementation will take some years.

Reviews of MoH and MHIF practices have also identified the **need for greater transparency of purchasing, alongside better data and dynamic use of the data in monitoring performance and guiding the financing and purchasing system.** These are critical prerequisites for effective governance of the MHIF by the government, for effective governance of HCOs, for MoH stewardship of the health system as a whole, and for accountability to political decision-makers and the wider public. The MHIF has taken steps to improve transparency of purchasing and the use of data in governance reports. However, a challenging issue is cultural unfamiliarity with the use of governance bodies for strategic decision-making and accountability. The common practice is for individual ministers (or the Prime Minister or President) to have decision-making authority and for accountability to operate in vertical silos along management lines. Where multiple ministries and agencies have a role, their written comments and clearance are obtained to draft orders or regulations. The MHIF supervisory board, for instance, has little authority to approve decisions in its own right; most policy and strategy decisions affecting the MHIF are also subject to a round of approvals by the MoH and/or MoF.

Staff numbers and staff skills in key MoH and MHIF functions are too low for the complex oversight and organizational commitments that the national strategies are taking on. MoH staff are burdened with highly centralized handling of citizen/patient complaints and requests and with reactive responses to questions and concerns from parliament, the President and the Prime Minister’s administration. The two agencies are heavily reliant on consultancy support, which appears to work best when consultants are embedded in the relevant teams. In spite of a past track record making good use of embedded consultancy support under the *Manas* strategy, this has not translated into enough lasting improvement in capacity. Overcoming implementation bottlenecks requires **greater delegation and empowerment of staff at regional, municipal and city levels** through changes in regulations and capacity-building.^{a,b}

^a Revision of staff norms of healthcare organisations under accompanying measures of sector program health care 2. (BMZ 2007.70.370). Final Report. Bishkek: Kreditanstalt für Wiederaufbauentwicklungsbank (KfW) & Ministry of Health of the Kyrgyz Republic; 2014 (Unpublished).

^b Mission reports of technical experts advising on MHIF on governance, strategic purchasing, development of case payment and data. Bishkek: World Health Organization Country Office for Kyrgyzstan; 2017–2018 (Unpublished).

7. Financing issues in the SPHD2030 and action plan

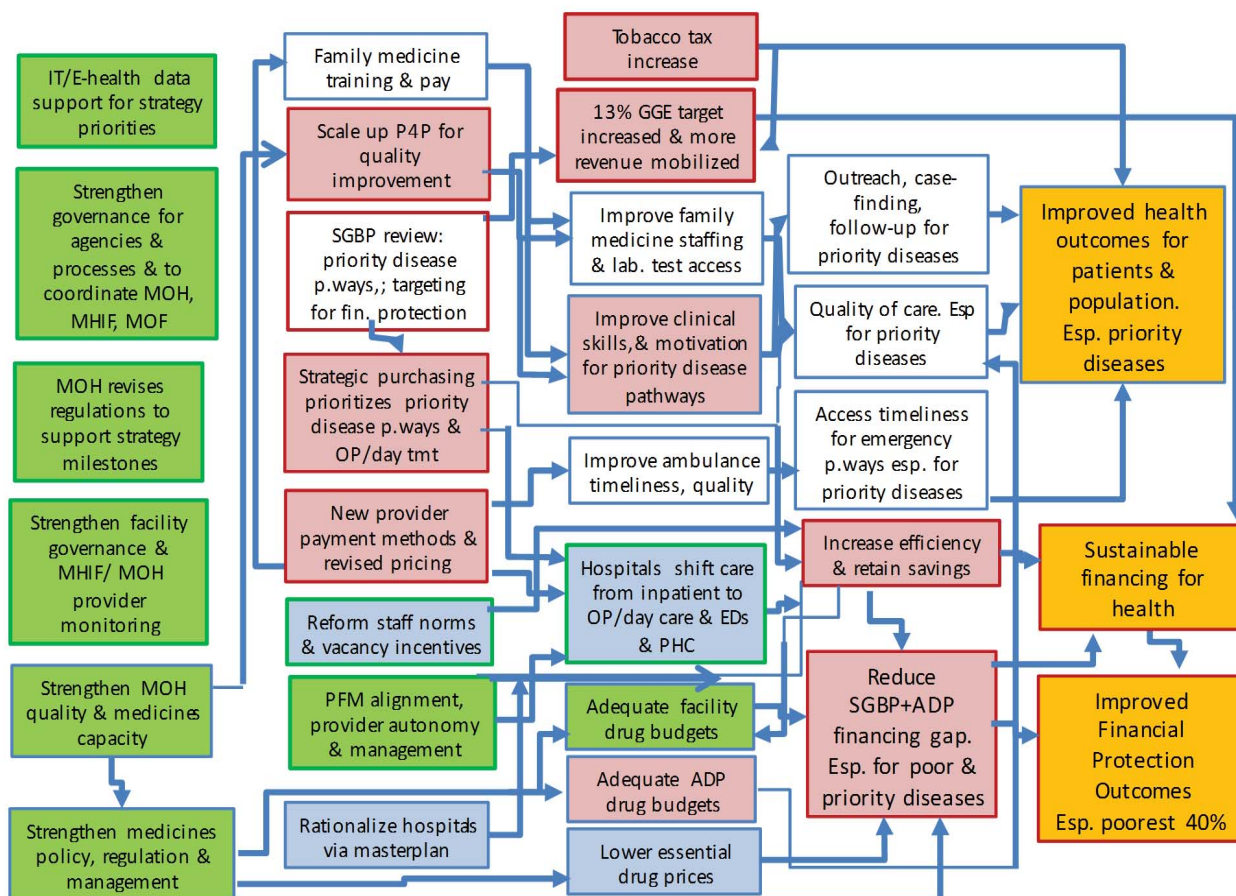
The government's draft strategy – the State Programme for Health Development (SPHD2030) – includes a range of strategies to address the problems noted above. The strategy is wide-ranging and ambitious. This report seeks to highlight critical linkages and priorities in the strategy, and also to summarize lessons from previous strategies that are likely to be critical to making renewed progress. **In the next 10 years, it will not be possible for the health financing pillar of the SPHD to be developed and implemented separately from other closely-related components of the strategy. Working in parallel silos will not deliver the strategy's results.** Figure 11 is a “logic model” or “results chain” diagram that illustrates why this is so.

Figure 11 shows three groups of SPHD2030 components that relate to financing:

- 1. Health financing components of the strategy directed at financial protection objectives, which can be achieved using health financing tools alone.** Only one major component of the strategy falls into this category – review of the SGBP to improve financial protection by better targeting of co-payments (red-outlined boxes with no fill in Figure 11). Kyrgyzstan is now at a point in its health system development where very few financing objectives can be achieved by MHIF alone. Even in this case, review of the ADP component of the benefits package needs to be coordinated with medicines policy and service delivery as well as with training policies for family physicians.
- 2. Non-health financing components of the strategy that need to be implemented in order to achieve the financial protection objectives of the strategy in a fiscally sustainable way** (blue -shaded boxes in Figure 11). Financial protection cannot be improved in a sustainable way unless medicines regulation and management improvements are implemented alongside health financing policies. Additionally, service delivery strategies need to produce substantial efficiency gains as the most feasible way of generating enough resources to close the financing gap for the SGBP. Key sources of efficiency gains are planned in the SPHD2030 to come from rationalization of the hospital network on the basis of the new masterplan and adoption and enforcement of revised staff norms to increase productivity.
- 3. Some key non-health financing components of the strategy that need to be supported by health financing in order to implement them effectively and thus improve health outcomes** (pink-shaded boxes in Figure 11). Many key service delivery components of the strategy depend on financing changes, including new provider payment methods, changes to the MHIF, strategic purchasing, and contract monitoring to target resources to high-priority disease pathways. In this category, PHC strengthening, a laboratory sample collection system, ambulance reforms, and improvement in coverage and quality of care all need to be supported by financing tools.

Figure 11 also highlights (in green-shaded boxes) that a number of key actions in the strategy require governance to be strengthened. In particular, stronger governance mechanisms are needed to ensure joint, well-coordinated action by the MoH and MHIF – and in a number of cases by the MoF too. A key example is the implementation of increased provider autonomy while also strengthening monitoring and accountability of providers. The SPHD2030 emphasizes that stronger coordination of stewardship and governance will be needed to make progress.

Figure 11. Results chain – key linkages in SPHD2030 related to financing



Notes: Red-outlined boxes are health financing components of SPHD2030.

Pink-shaded boxes are financing strategy components that are important to contributors to SPHD non-financing components and health outcomes.

Blue-shaded boxes are non-finance strategy components that are important contributors to financial protection outcomes.

Green-shaded boxes are governance components that require joint, coordinated action across MoH, MHIF and in some cases MoF.



8. Recent progress and areas for future action

8.1. | Improving financial protection – focus mainly on pharmaceuticals

Pharmaceutical policy and regulation: recent progress and future action

The Kyrgyz authorities have already laid foundations for action to address the problem of high pharmaceutical prices with the adoption of **new legislation for medicines price regulation** in 2017 and preparation of the necessary regulations in 2018. The new SPHD2030 strategy gives prominence to pharmaceutical policy actions to implement regulation of prices and to strengthen regulation of safety and quality in order to increase confidence in generic medicines. These types of regulation are extremely challenging to implement in countries with weak governance, low institutional capacity and a history of vulnerability to corruption.

Capacity and governance actions

The introduction of price regulation and the strengthening of safety/efficacy/quality regulation for medicines deserves **strong technical and financial support for implementation** from development partners. Successful implementation will depend on building new institutional capacity and strengthening existing capacity in a sustainable way. This will be a slow process requiring long-term commitment. There will be a need to prioritize the more feasible actions with highest impact and to phase in other parts of the strategy over time.

Alongside capacity-strengthening for implementation, governance actions are needed to:

- work on **building constituencies of support for price regulation and developing processes for transparency in implementation among civil society and other stakeholders**, and
- tackle the **financial and non-financial incentives that doctors have to prescribe brand-name medicines** and non-essential medicines and to refer patients to private pharmacies outside the hospital gate because of lack of confidence in the quality of generics and lack of effective regulation of marketing incentives offered by suppliers and private-sector pharmacies.^a

Complementary service delivery and governance actions

There is also a need for measures to **educate and encourage physicians to prescribe in line with evidence-based clinical guidelines** and to prescribe generic essential medicines which are available within the hospital as part of the SGBP.

Complementary financing and purchasing actions

Alongside price regulation, a number of financing interventions are needed to address the issues identified in Section 3 above:

- a. Increased budget allocation to the ADP. Given the very low budget allocation and the fact that the ADP meets only around one third of needs even for the small list of chronic

^a Vogler S. Presentation: Policy options for improving access and reducing out-of-pocket expenditure (on pharmaceuticals). Bishkek: World Health Organization; 2016 (Unpublished).

conditions covered, a **three-fold increase in the ADP budget is needed** (and is quite feasible) to increase the number of prescriptions issued to family physicians to meet more of the need and to support the price and list adjustments recommended below. Ideally, this should be accompanied by an improved methodology to align the distribution of prescriptions to the need (e.g. by using improved data on registered patients with chronic diseases).

- b. Aligned with price regulation, the MHIF needs to **revise its medicine reimbursement methods and increase the level of reimbursement** to improve the depth of coverage of the ADP. Similarly, pricing methods for hospital cases (which include medicines and supplies) need improvement to ensure that a greater link to costs (and price changes in inputs) is maintained over time.
- c. The list of medicines in the **ADP needs review on the basis of evidence and in line with updated clinical guidelines for the management of common conditions in primary health care.**
- d. At hospital level, there is a need for renewed focus on monitoring the availability of essential medicines alongside the share of the hospital budget allocated to health. Monitoring of medicine availability can be incorporated into regular quality monitoring by the MoH, and can be used as a quality indicator in contracts and RBF schemes. The MHIF is best placed to monitor the budget share of medicines but is not able to enforce regulations on the budget share to be allocated to medicines. There is a need to provide stronger incentives to HCOs to ensure availability of medicines.

Other health-financing actions

In addition to a major focus on the pharmaceuticals component of the benefits package, there may also be benefits from **reviewing the structure of co-payments and exemptions along patient pathways to better target exemptions for patients with the highest costs per episode of illness** or year of care for chronic conditions. For instance, patients with some conditions may face co-payments for diagnostic tests and consultations, as well as hospital stays and medicines for a single episode of illness. The benefits packages do not yet provide adequate financial protection for medicines and supplies that need to be taken over a longer period – such as in pregnancy or during chronic illness. This is one of the few policy areas where change in health-financing policy alone could improve financial protection. As such, it is likely to be less complex to implement than action to review the medicine benefits in the SGBP and ADP, which requires coordinated efforts across medicines policy and regulation, budget formulation and health-financing policy.

Tackling the contribution of informal payments to OOPs and catastrophic payments requires action on multiple fronts. Increasing the hospital budget share for direct patient costs was important under *Manas* for reducing informal payments on medicines and supplies that should be provided free of charge to inpatients, and it seems that this is again true. However, since the era of *Manas* there has been a proliferation of private pharmacies outside the hospital gates, even where hospitals have adequate supplies of essential medicines. This suggests that, in order to tackle informal payments, hospital managers need to ensure that physicians follow prescribing guidelines and prescribe essential medicines according to the list stocked by the hospital, rather than prescribing alternative medicines that are available only from private retail pharmacies. Previous evaluations have noted that it has proved difficult to reduce informal payments to staff, even when staff salaries were increased substantially (14,16). However, there have been promising early results from using provider payment incentives to reduce informal payments in rayon hospitals, suggesting that this may be a policy option to pilot and evaluate in other levels of care (17).

8.2. | Financial sustainability and reduced SGBP financing gap – strengthening resource mobilization

Macroeconomic analyses suggest that there is limited room to mobilize more general budget revenues for health over the next 5–10 years. However, some incremental options need to be explored for increasing tobacco tax, mandatory health insurance contributions and co-payment revenues. This is a critical issue because the government will need to mobilize more domestic resources to meet commitments to increased government cost-sharing from domestic sources for essential tuberculosis, HIV and immunization services. In addition, mounting pressure to increase physicians' salaries to reduce outmigration and address the rural workforce crisis will need to be addressed, and this will increase the SGBP financing gap unless resource mobilization for health increases steadily in real terms.

Health-financing actions

- a. There is a strong case for SPHD2030 to include a commitment to **increasing tobacco excise tax**. There is not a clear case for earmarking this increase for health, but increasing the tobacco tax will increase the prevention of cardiovascular and lung disease and will also have a progressive impact on household expenditures. Poorer households will benefit more than better-off households from reduced spending on health care. Compared to increases in direct taxes, tobacco tax raises additional revenue from both the formal and informal sectors and thus spreads the burden of taxation broadly.
- b. There is potential to **improve efficiency and effectiveness in collection of mandatory health insurance payroll contributions by transferring responsibility from the Social Fund to the tax agency**. A pilot initiative of the MoF is showing promising results and, following evaluation, scale-up could be supported by the health sector and development partners. The tax agency would be better placed to enforce MHI's obligations on employers, farmers and the self-employed and so reduce the share of the population that is uninsured.
- c. After the MHI's collection efficiency is improved, there is a case for **increasing the MHI's payroll contribution rate by a small amount – e.g. from 2% to 3%**. There is evidence that a small increase would not have adverse material impacts (12,13). However, because an increase in tobacco excise tax would produce health benefits and would be paid for by those earning in the informal sector as well as those in the formal sector, there are reasons to expect that a tobacco tax increase would be a more efficient and equitable way to increase tax revenue.
- d. There may be room for some **reallocation/reprioritization of budget resources to health** based on improved methodology for projecting the costs of the SGBP. However, it would be reasonable and appropriate for the government to set a condition for any reprioritization to health by asking the health sector to make internal efficiency gains.
- e. There is a case **for increasing co-payment levels and indexing them for inflation or wage growth** (9). There is also a case for narrowing the scope of some disease-based exemptions under the MoH's regulatory control. Co-payment exemptions for socially protected groups should be better targeted to the poor, but it has proved difficult to secure cooperation from the Ministry of Labour and Social Protection and support from the parliament for making changes to these categories (18,19).
- f. Because remittances make up a sizable share of Kyrgyzstan's GDP, it may be useful **to explore options for mobilizing revenue from Kyrgyz citizens working abroad**.

8.3. | Financial sustainability and reduced financing gap – increasing HCO efficiency

Attempts to repeat the *Manas* strategy of achieving substantial savings via **efficiencies from optimization of facilities in Bishkek and Osh and in the tuberculosis programme under the third Den Sooluk strategy have been disappointing**. Strong political will and coordinated leadership and governance are needed to take on the very complex task of optimization – particularly in Bishkek. The challenges of rationalizing the hospital network in Bishkek have now become more complex as traditional and non-traditional financiers are funding new hospital construction without any plans for these facilities to replace or consolidate existing obsolete capacity.

Service delivery actions

SPHD2030 includes commitment to implement a **new masterplan for the health facilities network, including new staff norms** and standards for major equipment. This will provide the basis for a new phase of facility optimization. Consultants have been engaged to produce the masterplan and have begun work as of the time of writing. This plan needs to take into consideration both the existing private facilities and the new facilities being financed by non-traditional international aid partners. Given private-sector development, there is a need to clarify the legal/regulatory process and institutional responsibility for planning of major new investments of this sort. The SPHD2030 includes a proposed government/MoF commitment to allow savings to be retained in the health sector. This will need to be reflected in changes in budget formulation methods:

- a. **Implementation planning for the masterplan will need to address challenges of communication and change management policies** – to provide assurance/support to staff affected by the changes and assurance to the public about the benefits for quality of care, alongside assurances about safe and timely access. **Policy consideration will also be needed about how to implement the masterplan**, particularly among private providers and the providers developed by non-traditional donors. Options include using legislation/regulation and/or strategic purchasing (with the MHIF contracting selectively with providers whose capacity and infrastructure is consistent with masterplan requirements).
- b. Masterplan implementation is likely to be slow and uncertain. Faster progress can be made to **increase efficiency of staffing in hospitals and some primary care facilities where staff have workloads below the MoH's current norms** by reducing unneeded posts and redistributing and retraining staff. There are some recent examples of progress in achieving this kind of efficiency: in the USAID-supported optimization of tuberculosis hospitals, in SDC-supported pilots of health facility autonomy, and in a case of MHIF-hospital negotiation to optimize use of staff in a hospital in financial deficit. Experience shows that optimization is most likely to succeed when HCO directors are committed. However, many HCO directors anticipate disincentives to optimize staff. The MHIF can continue to make use of negotiations with HCOs in financial deficit to press for staff optimization but the fund needs the support of the MoH (and in some cases other ministries), using “ownership” leverage and regulatory support where needed.

Complementary health-financing actions

These are needed in strategic purchasing to re-align contracts and review prices in line with the masterplan. Further action to increase providers' managerial and financial autonomy and capacity will help to support increases in HCO efficiency. These issues are dealt with below.

8.4. | Strategic purchasing: using health financing to achieve non-financial strategic goals for health care quality and population health improvement

The MHIF has been a passive purchaser for most of the time since it was established. The fund used clinical audit to challenge unnecessary admissions and deny payment for them “after the event”, but in general it has not used contracting to change how services are delivered to more efficient modalities (e.g. to increase outpatient and day-patient diagnosis and treatment in hospitals to reduce avoidable admissions, to expand the profile of PHC, or to concentrate specialized services into centres of excellence). Until 2018, the MHIF did not use RBF to reward improvement in coverage of interventions or quality. The fund lacked tools to control growth in the volume of inpatient cases, other than offsetting with price reductions which leads to an increased financing gap if efficiency improvements are not implemented. One indicator of weaknesses in purchasing and contracting of hospital services (and in the data and systems underpinning contracting) is that the MHIF currently does not pay for 15% of inpatient cases; payment is denied for a variety of reasons (such as errors and duplication in claims, unnecessary admissions, and lack of sufficient budget).

Recent progress

Under *Den Sooluk* a number of projects supported by development partners have piloted different types of strategic purchasing. In 2017–2018, the MHIF began institutionalizing and scaling up some of these initiatives, though effective and sustained scale-up will test the limits of MHIF capacity for implementation.

- The MHIF has started analysis and review of hospital activity by major diagnostic categories in pilot oblasts as a basis for future proactive contracting to reduce unnecessary and low-value admissions. This development is also being supported with advice on data quality, use of data, contract design and monitoring and feedback to contracted providers (with WHO support). The MHIF intends to scale this up nationwide in 2019.
- On the basis of pilots in PHC and district hospitals (supported by SDC and the World Bank), the MHIF is scaling up RBF to all PHC facilities and oblast multi-profile hospitals. The fund is seeking to consolidate the pilots and streamline the indicator monitoring regime.
- Day-patient treatment protocols are being developed and prices are being determined for day-treatment for a range of children’s conditions currently treated in hospital (with UNICEF’s support).
- A strategic purchasing initiative is under way in pilot oblasts to support change in the service delivery model for tuberculosis care. This has supported a change in the service delivery model from inpatient care to PHC-based ambulatory care. The use of case payments and staff bonuses are part of the design for this expansion of PHC.
- An SGBP costing study (with World Bank support) focused on high-volume hospital procedures is being commissioned to provide fuller information on the financing gap in hospital care and as a basis for price reviews by the MHIF.

The MHIF has also received technical assistance with WHO support on updating and improving the case payment system (to better reflect costs of complications, and to develop payment methods for specialized services recently transferred to the fund). Other development partners have also offered support for improving diagnostic-related groups, which will require coordination.

Two major impediments to strategic purchasing have been: (a) gaps and quality issues in data, and (b) lack of data analytical capacity in the MHIF. External analytical support from HPAC has not proved to provide the practical, dynamic, applied analysis needed for these types of initiatives. MHIF has now started a programme of data and software improvement and has established a small unit with analytical capacity in-house (with WHO support), which is playing a leading role in initiatives to develop strategic purchasing. MHIF is also committed to institutionalizing and scaling up RBF at PHC and rayon and oblast hospital level, drawing on the development partner pilots,

Areas for future action

- a.** The MHIF will need continuing support, particularly at local level, to use the data analytical methods currently being developed to evolve hospital contracts into a more proactive instrument for shifting the mix of hospital care in order to reduce unnecessary admissions and increase activity in high priority services. In addition, the MHIF needs to develop new and better ways of managing the growth of inpatient cases in hospitals – by considering the use of financial incentives (such as paying a much lower “marginal” rate for cases above the contracted volume) together with proactive contracting.
- b.** The MHIF’s commitment to more active monitoring and feedback on contracts to providers and to institutionalizing and rolling out RBF is ambitious. The fund needs support to review and refine the indicators used for contract monitoring and benchmarking, as well as for the balanced scorecard for RBF for 2019 and beyond. This will facilitate alignment with SPHD2030 priorities and will help to ensure that the indicators used are “SMART”, helpful for providers and routinely used by HCO managers and clinical teams. The MHIF cannot assume the burden of quality monitoring and assessment on its own. It is desirable to engage the MoH with the quality monitoring assessment component of RBF schemes through development of the ministry’s capacity for quality (e.g. through formation of a Quality Unit in the MoH).
- c.** For priority conditions – including high-burden NCDs – there is a need for the MHIF and MoH to work jointly to combine changes in purchasing with changes to service delivery and clinical staff training. The tuberculosis strategic purchasing pilot (supported by USAID) is a good example of how this can be done. Scaling up this project and institutionalizing it within the MHIF could be a demonstration of the type of strategy the MHIF needs in other priority disease areas of SPHD2030. Cardiovascular diseases and Type 2 diabetes are strong candidates for the next area that the MHIF might want to choose for applying this strategic purchasing-service delivery reform. Strategic purchasing for cardiovascular disease could build on previous pilots, including PEN protocols, for addressing hypertension.
- d.** SPHD2030 draws attention to some of the longstanding gaps in payment methods in the MHIF’s purchasing toolbox. It calls for development of new payment methods for emergency medical care, laboratory services (including sample collection), expansion of the scope of PHC and hospital day-patient/specialist outpatient services. All of these are important, but prioritization and sequencing of these major reforms must be considered because, to be successful, each of these provider payment developments will need to be part of a coordinated multi-agency project. It may be realistic for the MHIF and MoH to take on one project at a time. It would make sense to give priority to new payment methods that will have the biggest impact on efficiency gains and/or on improving coverage and quality for high-burden priority noncommunicable diseases. All changes in payment methods will need to be coordinated with changes in service delivery models, infrastructure, equipment, staff training and assignment and changes in how patient flows are managed.

- e. There is a risk – seen already in MHIF budgeting for the scale-up of RBF – that some of the payment innovations (such as new payments for day-patient care, or price increases for some services following review of diagnostic-related groups and selective SGBP costing) are funded by cutting prices for other services. This will increase the financing gap – unless compensating efficiency gains can be implemented in the affected providers – and it may also introduce distorted incentives to de-prioritize these services (e.g. if prices for core PHC capitation and inpatient case payment are reduced to finance new or higher payments for other services). To safeguard against this, there is a need to ensure that there is a comprehensive process for price review and price adjustment that looks across all levels of care and types of service. As part of this process, there is a need to develop a methodology for regular adjustments to the prices of services to avoid erosion in the value of payments. Although the reality is that the MHIF will not be able to adjust prices rapidly in line with costs, it is important to have a strategy for reducing the gap over time by a combination of measures which can be used in the context of negotiation of the MTBF and the annual budget formulation.

8.5. | Aligning public financial management reform with the health financing system to increase the impact of health financing on efficiency and quality

As noted in Section 5, one limitation of the *Manas* strategy was **slow progress in public financial management reform and limited engagement from the MoF**. At the level of national budget formulation, the budget process does not incorporate the methodologies needed to consider the cost of meeting SGBP commitments in the face of changes in population demand and input costs. Rather budget formulation continues to be based on historical actual spending. At the HCO level, it has proved very difficult for the health sector to implement “new financial management” style reforms, as envisaged in *Manas*, without wider public financial management reform. In addition, staff norms and labour-related regulations are creating systematic disincentives for HCOs to optimize staff posts and are reducing transparency. Moreover, *Manas* did not attempt reform of provider governance to give facilities greater autonomy and capacity to manage resources within the resource envelope derived from payments for services. The result of a lack of either public financial management reform or provider autonomy has been persistent misalignment of the new “single payer” system.^a

Recent progress

Significant progress was made on public financial management issues affecting HCOs in 2017–2018, with the benefit of a much greater degree of engagement from the MoF and with health financing coupled with a public financial management reform programme that includes phased implementation of programme budgeting. Some (though not all) of the financial management problems affecting HCOs can now be addressed through implementation of a new law on the MHIF budget. This law provides a potential basis for an incremental increase in facilities’ financial flexibility to pool cash disbursements during the year, to re-allocate budgets across line items and to retain unspent funds and inventory at the end of the year. When fully implemented, this will have the potential to increase incentives

^a Strictly speaking, there continued to be multiple payers until 2016 because the MOH, Bishkek City and Osh City budgets also financed some health facilities providing individual health-care services in the SGBP. Some health-care costs are still financed by the MOH budget and smaller non-pooled health budgets in other sectors that fund and manage health-care facilities for their employees and families.

for efficiency. It has had the unintended effect, however, of fragmenting the formulation of the national health budget into two parallel processes for the MoH and MHIF budgets. In the longer term, after full implementation, programme budgeting reform may also provide a platform for aligning public financial management and health financing without the need for a separate MHIF budget law and budget process.

The MoF is currently carrying out a sector-by-sector review of remuneration that looks at norms, incentives and pay. It is working with the MoH and MHIF on proposals for revised staff norms, but at the time of writing was awaiting their submissions. The MoF would like to reform the redistribution of norms and vacancies in order to improve incentives for efficiency and productivity.

Areas for future action

- a. National budget formulation.** An **improved approach and methodology for budget formulation is needed**, with systematic methods for 1) adjusting the budget ceilings for projected changes in demand for SGBP services (e.g. due to population growth and ageing), 2) making evidence-based adjustments for projected costs of policy changes and SPHD2030 strategic priorities (e.g. for strengthening PHC and expanding its scope of services), and 3) gradually reducing the SGBP financing gap. Where the budget process is obliged to set ceilings at a level below that needed to make such adjustments, budget formulation should involve explicit cost-saving or revenue-mobilizing policy changes and **realistic efficiency targets**. Better budget formulation needs to be institutionalized through appropriate legal acts, methodological guidance and capacity-building in the MoH, MHIF and MoF.
- b. Territorial and HCO level financial management.** More flexible budget execution at territorial and HCO level is feasible under the new MHIF law. However, it is unlikely to be implemented fully and yield potential benefits unless there is additional action. The MHIF, HCOs and MoH are currently cautious about letting go of inefficient controls on expenditure by source that create the illusion of financial control but not the reality. For instance:
 - i. There is a need for **systematic training and capacity-building** of MHIF regional offices and HCO management and finance staff, as well as changes in accounting software, in order to build confidence to manage budgets.
 - ii. Fiduciary assessments point to continued weaknesses in HCO financial management and in internal control. Tackling these will require action **to address the low salaries (even by public sector standards) of finance staff in the health sector**.
 - iii. Alongside increased flexibility over inputs, new data analysis methods are needed. Importantly, alternative ex-post methods for **monitoring provider financial management performance**, including indicators of financial control and of efficiency of resource use, need to be developed in the MHIF. Some of the indicators could also be reflected in the programme budgeting indicators of the MHIF.
- d. Optimization of staff posts.** Disincentives arising from the way in which staff norms and labour regulations are currently implemented need to be tackled. The health sector will require coordination between the MoH, MoF and MHIF – and potentially with other ministries. The current disincentives will prevent provider payment incentives from having the desired effect on efficiency and quality of care. This issue is currently not identified in

the SPDH2030 but deserves a higher place on the agenda. SDC's provider autonomy pilot is implementing a possible model of reform for staff norms and incentives, and lessons should be learned from this. The MoF review of staff norms and incentives, which provides an opportunity to tackle these issues in a better way, is likely to require technical support for issues such as:

- v. updating of staff and workload norms (coordinated with the masterplan study);
- vi. the design of alternative incentives, drawing on lessons from the SDC pilot implementation;
- vii. consideration of how to coordinate and consolidate the multiple staff incentive schemes operating in the health sector (the small productivity-based incentives paid from 20% of mandatory health insurance contributions), the RBF incentives, and potential additional incentives emerging from the MoF review.

8.6. | Strategic governance and stewardship of health financing

As Section 6 outlined, governance weaknesses need to be addressed at multiple levels – the whole-system level (requiring coordination across the MoH, MHIF and MoF), the MHIF level, and regional and health facility levels. Governance links between agencies and levels of the system must be strengthened.

Recent progress

As noted in Section 7, the MHIF's management, with WHO support, has begun to strengthen governance processes within its control. It has developed an institutional strategy, updated annually and approved by its supervisory board, which serves as a basis for standardized reporting to the board on progress and results. The MHIF has taken steps to increase transparency of its purchasing activities through this reporting and by publication on its website. The fund also has plans to increase monitoring and feedback to HCOs in order to strengthen accountability of providers.

Areas for future action

- a. It is an opportune time to rationalize the number and membership of committees and councils and to seek clarification of their terms of reference/mandates. There is a need **for a high-level council or committee to oversee implementation and results and to coordinate decision-making on the new SPHD2030 health strategy. Consideration could be given on whether to give this same high-level council responsibility to monitor the programme budgeting indicators and make recommendations on budget allocations across both MoH and MHIF budgets in line with strategy.** This has been suggested by the Expert Group for the SPHD2030, although an existing budget committee of the government could take on the role. Consideration needs to be given as to how best to involve the Presidential administration in oversight of recommendations on strategic budget allocation. Additionally, the role and forums for involvement of the Parliamentary Health Committee in oversight of the strategy implementation needs to be considered. This council/committee could be the forum for overall coordination of health budget recommendations, and for approving (or recommending to the government) major policy/strategy decisions affecting both MoH and MHIF.

- b. The MHIF supervisory board – again with the MoH, MHIF and MoF as members – will continue to be the governance body for the MHIF and single payer system – ideally with more streamlined membership from government, line ministries, the presidential administration and the parliamentary committee with regulatory and governance responsibilities related to MHIF and health financing. **Continued support for the MHIF supervisory board’s standard processes (agendas, reports etc.) and capacity-building for members is needed** to help focus the board on results and performance, and not just activities. Practical **solutions for dealing with the frequent changes of ministers and other members** could be developed to ensure continuity, and standard induction/training materials should be developed for new board members.
- c. **A conflict of interest policy** is needed for members of all committees and boards. If possible, this needs to be recommended to the Presidential administration for all public advisory councils. Where it is not possible to avoid having some members with a conflict of interest, clear policies on declaration and recording of conflicts at council/committee meetings, and procedural rules for handling situations of conflict of interest (e.g. recusal rules from some discussions and decisions), should be developed and adopted by the appropriate ministries.
- d. There is a need for a more **regular and routine forum for formal coordination between the MoH and MHIF, and agreed operational standards for each agency in responding to requests for information and approval from the other**. There is also a need to clarify the roles of the MHIF and MoH and to develop more formal processes for collaboration in relation to two areas, namely:
 - i. Governance of health-care providers responsible to the MoH. The MHIF is currently obliged to take on responsibilities for dealing with provider deficits although it lacks the “ownership tools” that the MoH and municipalities have, and which need to be brought into play in dealing with providers with persistent financial, staffing or quality problems.
 - ii. Quality assurance/quality improvement. The MHIF is playing an increasing role in monitoring quality indicators and will expand this role as RBF is scaled up. In the absence of an MoH unit responsible for quality-related policies, the MHIF is stepping into the gap. However, the MHIF cannot take on this responsibility alone; the cross-cutting nature of quality strategies means that the MHIF does not have all the authority or capacity needed to make progress on the various dimensions of a quality improvement strategy (e.g. clinical skills and training). The MoH needs to build up – and build the capacity of – its staff team working on quality monitoring, accreditation, evidence-based medicine, clinical guidelines development and continuing medical education into a Quality Unit. Once the MoH has established a Quality Unit, it will make sense to begin by defining the role of this unit in supporting the quality monitoring and assessment processes for RBF, in coordination with the MHIF and its regional offices.
- e. Increasing provider autonomy requires development of a governance mechanism for more autonomous providers. The evaluation of the SDC-supported pilot in HCO autonomy concluded that autonomy can be implemented under existing legislation, with appropriate amendments to the regulations. As such, clear MoH commitment to the policy is needed. However, other lessons from the evaluation were that the process was complex and would take time to deliver benefits in efficiency, required technical advice

and training for HCO managers, and is best undertaken with willing volunteer HCOs. Given the scale of the challenge, scaling up provider autonomy may be better achieved in the later years of the SPHD2030, though some incremental steps can be taken to prepare for autonomy and tackle regulatory bottlenecks.

- f. There is a need to fill the gap in institutional design for an adequate oversight and accountability regime to provide governance for autonomous providers. In the absence of a clear new governance mechanism, the MoH and MHIF are cautious about autonomy and this caution contributes to the bottlenecks found in the SDC pilot. Given the extensive limitations in the MoH's stewardship capacity and the other priorities in the SPHD2030 (e.g. in quality regulation/assurance and improvement, in taking over the "principal recipient" role for money from the Global Fund), oversight and governance of autonomous providers may be a lower/later priority. Careful consideration will be needed about the division of roles and responsibilities between the MoH, local authorities, the MHIF and MoF. Although the MoH holds most of the "ownership levers" regarding providers, in practice financial monitoring and control capacity and access to financial data for most health-care facilities resides in the MHIF's regional offices and in the MHIF and the MoF's centralized financial information systems. Given the scarcity of financial and other monitoring capacity in the Kyrgyz health system, it will be important to avoid duplication of responsibility. A first step would be to commission technical advice and undertake consultation about the design of the governance regime for autonomous health-care providers. Additionally, Section 8.5 recommends development of MHIF's systems and practices for monitoring provider financial performance as a key component of the governance system for more autonomous providers.



9. Conclusion

The new SPHD2030 contains a very ambitious and comprehensive set of reforms. The agenda implies a large workload for both the MoH and MHIF. Financing actions by the MHIF will be needed to support the service delivery part of the strategy to achieve objectives for quality and access to health-care, and in which service delivery, pharmaceuticals and governance actions will be required to support health financing to achieve objectives for financial protection, sustainability and efficiency. This paper highlights strategies and actions related to both of these elements of the SPHD. It also notes one or two gaps in the strategy.

A review of lessons from previous national strategies shows that implementation capacity is very limited, and implementation that requires coordination across agencies is very difficult to sustain in the Kyrgyz context. Embedded technical assistance can help, but the capacity of the MoH and MHIF central offices to absorb technical assistance across multiple projects and thematic areas is also a constraint. This points to the need to prioritize health-financing actions in the strategy even more rigorously than has been attempted in the past, particularly with regard to elements that require coordination across agency boundaries. Prioritization would focus on identifying actions in the strategy that combine greater feasibility (i.e. are less demanding of capacity) and greater impact on the ultimate goals of the strategy (i.e. health improvement, equity, financial protection, sustainability).



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