

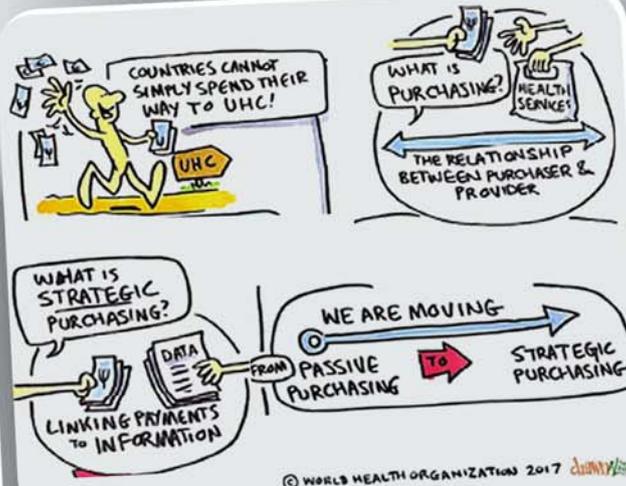
GOVERNANCE FOR STRATEGIC PURCHASING IN KYRGYZSTAN'S HEALTH FINANCING SYSTEM



STRATEGIC PURCHASING

Governance

Payment methods



Benefits

Information management



World Health Organization

HEALTH FINANCING CASE STUDY NO. 16

GOVERNANCE FOR STRATEGIC PURCHASING IN KYRGYZSTAN'S HEALTH FINANCING SYSTEM

Jarno Habicht
Loraine Hawkins
Melitta Jakab
Andres Rannamäe
Aigul Sydakova



**World Health
Organization**

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TABLE OF CONTENTS

Acknowledgements	4
List of abbreviations	4
Executive Summary	5
1. INTRODUCTION	9
2. GENERAL GOVERNANCE CONTEXT AND HEALTH FINANCING SYSTEM	11
3. GOVERNANCE OF THE KYRGYZ HEALTH CARE PURCHASING SYSTEM	14
3.1. Setting of strategic direction: national health sector reform strategies and implementation plans	14
3.2. Alignment of public financial management with health purchasing reform	15
3.3. Coordination of development finance and the role of development partners	17
3.4. Challenges common in single-purchaser systems: credibility of the budget constraint, pressure to protect public providers	17
4. GOVERNANCE OF THE KYRGYZSTAN PURCHASING AGENCY: THE MANDATORY HEALTH INSURANCE FUND (MHIF)	19
4.1 Clear, coherent role and decision-making authority	19
4.2 Autonomy and authority of the MHIF to act strategically	20
4.3 Coherent lines of accountability supporting transparency: emerging accountability focused on results	23
4.4 Effective oversight	24
4.5 Inclusive and meaningful stakeholder participation: the Public Advisory Council	27
4.6 Relationship between provider governance and MHIF governance	27
4.7 Summary assessment of governance at the health purchasing agency level	29
5. ASSESSMENT OF FACTORS CONDUCTIVE TO EFFECTIVE GOVERNANCE OF STRATEGIC PURCHASING	32
6. CONCLUSION: KEY CHALLENGES AND POSITIVE ACHIEVEMENTS AND LESSONS	35
6.1. Governance of the health purchasing system	35
6.2. Governance of the purchasing agency: the MHIF	36
6.3. Conducive factors relevant to good governance	38
7. RECOMMENDATIONS	40
7.1. Strengthening the authority and capacity of the MHIF Supervisory Board to bring multiple lines of accountability together	40
7.2. Developing more balanced and meaningful stakeholder participation	40
7.3. Supporting MHIF internal management and capacity – factors conducive for good governance	42
7.4. Considering alternatives to the “classic” model for governance of an independent health purchasing agency	42
8. REFERENCES	44

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LIST OF ABBREVIATIONS

CEO	chief executive officer
CHE	current health expenditure
EHIF	Estonian Health Insurance Fund
GDP	gross domestic product
JAR	joint annual review
MHI	mandatory health insurance
MHIF	Mandatory Health Insurance Fund
MOF	Ministry of Finance
MOH	Ministry of Health
PAC	Public Advisory Council
PFM	public financial management
SB	supervisory board
SGBP	state-guaranteed benefit package
SWAp	sector-wide approach
VHI	voluntary health insurance
WHO	World Health Organization

EXECUTIVE SUMMARY

This paper is part of a series of country case studies on governance for strategic purchasing. It describes and assesses governance in the single-payer system of the Kyrgyz Republic. The case study is

structured around four assessment areas listed in the box below, in line with a recently published WHO methodology for assessing governance arrangements for strategic purchasing (WHO, 2019).

Assessment areas:

1. The broader, political and general governance context and overview of the health financing system
2. Governance of the health care purchasing system
3. Governance arrangements of an individual purchaser
4. Conducive factors for effective governance for strategic purchasing

One of the smaller and poorer countries of the former Soviet Union, Kyrgyzstan reached lower-middle-income country status in 2014. Comprehensive health financing reforms over the period 1996–2006 created a single-payer health financing system. Most public funding is pooled in the Mandatory Health Insurance Fund (MHIF), which introduced provider payment reform alongside a better-defined benefit package with explicit co-payments and exemptions for priority services and for vulnerable groups. As a result of the reform, financial protection improved but out-of-pocket payments still account for around half of current health expenditure (CHE). The health financing reforms have remained in place with reasonable policy stability over a period in which the country has weathered a series of political and economic crises.

At the level of the **health purchasing system**, governance in Kyrgyzstan benefits from relatively comprehensive consolidation of public expenditure in a single pool, which potentially gives the MHIF strong leverage

for strategic purchasing. However, this potential is not fully realized because of weaknesses in strategic coordination with the Ministry of Health (MOH), and a history of misalignment between health financing reform and public financial management policy and processes. Recent progress has been made through stronger cooperation between the MHIF and the Ministry of Finance (MOF) to increase alignment of public financial management (PFM) and give the MHIF greater financial autonomy.

The MHIF is an independent public administrative agency which, since 2009, has been subordinate to the Cabinet of Ministers. In the early stages of reform implementation, the MHIF was an agency subordinate to the MOH, which proved helpful for close coordination. The current more independent status of the MHIF has been important for enabling it to consolidate its technical and administrative systems for purchasing, and to sustain these with a high degree of stability, in spite of many changes of government and ministers.

At the level of **governance of the MHIF**, however, challenges remain. Legislation governing the MHIF does not set out a clear division of authority between the MOH and MHIF nor does it formalize coordination and oversight arrangements. The MHIF has a supervisory board (SB) established by the Cabinet of Ministers but, because its role is not enshrined in legislation, it does not have real authority. It plays a largely passive role in approving operational strategies, budgets and the annual report. As a result, the MHIF's SB and management lack sufficient autonomy to make decisions needed to enable strategic purchasing. The MHIF has multiple lines of accountability to the SB, the MOH, the MOF and a separate Public Advisory Council (PAC) of citizens, making it difficult to achieve sustained coherence between these lines of accountability. The governing agencies or bodies have not established results-oriented governance. There are no rules for preventing or managing conflict of interest in the SB or the PAC. The MOH itself has some conflict of interest because the public provider network is subordinate to the MOH, meaning that it is not well-placed to be a neutral steward over both the purchaser and providers of the health system. However, perhaps the greatest challenge to effective governance for strategic purchasing in the Kyrgyz Republic is the lack of a credible budget constraint due to a very large financing gap between MHIF revenue and the cost of the benefit package it is expected to cover. This makes it difficult to hold the MHIF accountable for the core financing objectives of improving financial protection, service quality and access.

Addressing these challenges in the Kyrgyz context is difficult. Strengthening governance through the SB will take time because there is little experience in the country of the "western" model

of performance-oriented corporate governance, and consequently limited capacity available in any sector for governance boards. The new model of governance was overlaid on top of an only partly reformed Soviet-legacy system of centralized norms and regulation of inputs in the health system, accompanied by multiple inspections and sanctions. In addition, building the **conducive factors for effective governance**, such as data and analytical capacity to support results-oriented governance, has been constrained by the scarcity of human resources and the limited administrative budget in the MHIF.

In spite of these constraints, the chief executive officer (CEO) of the MHIF has taken steps in recent years, supported by WHO, to put in place basic good governance practices in strategy formulation, agenda-setting and reporting to the SB, and induction training has been offered to SB members. Providing practical technical support for these initiatives, together with support for improvements in data analysis and presentation used in reporting, has proved to be a useful entry point for strengthening governance.

Another lesson from the Kyrgyz experience is that it is important to dovetail the new governance mechanisms of an SB with the existing lines of accountability and authority and to clarify how these should interact. Focusing the membership of the governance body on representation of agencies with key roles in MHIF statutory accountability (notably the MOH, MOF, Prime Minister or presidential administration, and the parliamentary health committee) allows use of the SB as a mechanism for bringing multiple lines of governance together and coordinating them. Devising mechanisms to ensure there is some continuity of board membership during government transitions would also be helpful. The Kyrgyz

experience also brings out the importance of support for developing both ends of the accountability relationship – i.e. clarifying the MOH stewardship roles and building relevant capacity to play a major role in MHIF governance.

Tackling the mismatch between the state-guaranteed benefit package (SGBP) and the MHIF budget constraint – an important enabler for stronger accountability for financial performance and financial protection – will continue to be very difficult in the context of low- and lower-middle-income countries like Kyrgyzstan. This challenge will require greater discipline

over un-funded decisions to reduce co-payments and expand benefits as well as sustained commitment over the long term by the Kyrgyz Government to mobilizing resources for health. Nonetheless, the Kyrgyz case demonstrates there is scope for the MHIF to use its purchasing levers to achieve efficiency improvements and re-invest these gains into improvements in quality of care. These improvements could be more substantial if there is close coordination with the MOH and its facilities in planning, regulation and health human resources policies.

1. INTRODUCTION

PURPOSE

This paper is a case study that aims to document and review the experiences with governance of the health purchasing system and the MHIF of the Republic of Kyrgyzstan. It also discusses the initiatives taken to strengthen governance arrangements, including their impact, remaining barriers

and challenges. The case study is structured along WHO's recently published *Analytical framework to guide a country assessment of governance for strategic purchasing* (WHO, 2019), as outlined in the box below, and contributes to a series of country case studies of governance for strategic purchasing.

Assessment areas:

1. The broader, political and general governance context and overview of the health financing system
2. Governance of the health-care purchasing system
3. Governance arrangements of an individual purchaser
4. Conducive factors for effective governance for strategic purchasing

METHODOLOGY AND DEFINITIONS

The paper synthesises analyses and findings from published and grey literature on the governance of the MHIF, the health financing system and related PFM issues in the health sector in Kyrgyzstan. These include the reviews and evaluations of three generations of health sector strategies, and studies commissioned by the Kyrgyz health authorities and development partners. The assessment is largely based on findings of an unpublished 2016 assessment of MHIF governance commissioned by WHO, updated with information included in reports on governance and PFM support activities of WHO and other development partners. It also draws on discussions with key informants currently or formerly working in the MHIF.

This paper draws substantially on the definitions of governance and framework for assessing governance of mandatory health insurance set out in Savedoff & Gottret (2008), which has also informed the WHO framework. Their framework speaks about a *narrow* definition of governance that looks specifically at the mechanisms that are used to set strategic directions and objectives for the MHIF and ensure they are achieved. This definition is concerned with issues such as the design of the governance mechanisms which define and regulate the balance between the managerial autonomy of the MHIF and the direction and control by the government, the MHIF's accountability mechanisms and transparency requirements and the roles given to stakeholders in these

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stakeholders, health-care providers, other insurers (though this is not a significant consideration in Kyrgyzstan where private health insurance accounts for less than 1% of current health expenditure), the news media and civil society. This definition has informed the WHO framework's conception of governance of the health-care purchasing system. The latter also draws on conceptualization of governance for health financing in Phua (2017). The WHO framework proposes to integrate those narrow and broad definitions of governance into an analysis of governance arrangements applying to purchasing from the system to the agency level (WHO, 2019).

This paper also draws upon another complementary framework for characterizing, analysing and structuring the assessment of governance institutions and governance practice of the MHIF in Kyrgyzstan. This is the *Good governance standard for public services of the United Kingdom*, developed in 2004 and in use from 2006. It is applicable to all organizations that work for public good goals using public money. The standard is useful for understanding and applying common principles of good governance in the narrow definition – i.e. principles for the structures and processes of oversight and accountability for the MHIF. It is used to assess the strengths and weaknesses of current governance practice and to formulate recommendations to improve it. The United Kingdom standard reflects principles and practices widely accepted in high-income countries in Europe (Independent Commission on Good Governance in Public Services, 2004). The paper discusses whether the classic western European model of corporate governance, which is the context for development of this standard, is transferrable to the context of a lower-middle-income country with a different history and culture.

2. GENERAL GOVERNANCE CONTEXT AND HEALTH FINANCING SYSTEM

Kyrgyzstan became independent in 1991 and numerous changes have been introduced since then in all the sectors, including health care. The Kyrgyz Republic's first health reform strategy (the *Manas National Program of Health Care Reforms*) was applied in 1996–2005. Over the years the country's economy has undergone a gradual transition from low-income to lower-middle-income status. The gross domestic product (GDP) per capita increased from US\$ 280 in 2000 to US\$ 1160 in 2017 (World Bank data current US\$). The population grew over this period from 4.9 million to 6.2 million. The poverty headcount rate reduced to 19% in 2016 from over 30%. This progress has been achieved in spite of a series of political and economic crises that Kyrgyzstan weathered over the past 20 years.

A World Bank review of progress in economic development, poverty reduction and health sector performance after *Manas* implementation was positive.

However, the review noted that “a weak governance environment remains the major impediment undermining a more speedy reduction in poverty and acceleration of growth” (World Bank, 2008).

The country inherited from the Soviet Union a public delivery system of health facilities under the MOH and regional (oblast) administrations financed from the government budget. Like other post-Soviet countries, Kyrgyzstan also inherited a system of very detailed input planning and control for health-care providers. In 1997, Kyrgyzstan established the MHIF to administer a national health insurance system financed by a 2% payroll tax, in order to improve revenue mobilization and financial protection for health. This funding flowed to facilities in addition to general budget allocations which were known to be insufficient to cover the costs of care. Facilities were given increased financial flexibility in the use of this incremental funding.

Table 1. Key (socio-)economic, health and health expenditure indicators

	2000	2005	2010	2015
Total current health expenditure (CHE) as % GDP	4.4%	7.5%	7.1%	8.2%
Per capita CHE current US\$	\$12.29	\$36.11	\$62.59	\$92.08
Per capita CHE PPP US\$	\$72	\$160	\$194	\$287
Domestic general government health expenditure as % CHE	48%	51%	48%	45%
Out-of-pocket payment as % CHE	51.6%	42.6%	42.3%	48.2%
Domestic general government health expenditure as % general government expenditure	7.1%	12.8%	9.2%	9.9%
External health expenditure as % CHE	Not available	6.4%	9.5%	6.9%
% external health expenditure channelled through government	0.0%	0.0%	55.9%	20.2%

During 2001–2004, Kyrgyzstan implemented a health financing reform model that was widely recommended at that time in post-Soviet countries with public delivery systems; consequently a purchaser-provider split was phased in over five years and a single-payer system was developed. The previous general government budget allocations to facilities (financed from general taxation) and MHI payroll contributions were pooled and managed by the MHIF. Initially, pooling was at regional (oblast) level, and was managed by MHIF regional offices. In 2006 pooling of funds shifted to the national level, which allowed the MHIF to distribute funds more equitably across oblasts. (Kutzin, Jakab and Shishkin 2009; Kutzin, Ibraimova et al. 2009). In the latest phase of reform, starting in 2016, the Government pooled into the MHIF most of the remaining parallel funding from the MOH budget (largely for specialized services) and the Bishkek City health budget. The MHIF now manages around 80% of government health spending (O’Dougherty et al. 2016).

In line with international advice, the MHIF sought to move away from line-item budgets for providers and to introduce new payment mechanisms to improve incentives for efficiency, increased cost-effectiveness and equity. The intention was, over time, for the MHIF to contract private providers too, but until now the private health sector remains small except for private providers offering diagnostic services, and specialized services for cardiovascular disease in the capital Bishkek. The MHIF introduced capitation payments for primary care and a simple case-based payment system for hospital care. Other key components of the health financing reform were a more explicitly defined SGBP with official patient co-payments alongside exemptions for poor and vulnerable groups. In conjunction with these financing reforms, the MOH implemented a major downsizing of excess

capacity in the hospital sector, closing smaller rural district (rayon) hospitals, releasing substantial savings that were reinvested in health. The combined impact of these reforms improved health-care provider efficiency and financial protection for the poor (Jakab, 2007; Purvis et al. 2005, Jakab et al. 2005; Kutzin et al. 2010; World Bank, 2013). However, much less attention was paid to the reform of provider governance and management in the first phase of reform. The MHIF contracts with some private providers, mainly retail pharmacies, but also some specialist facilities, including haemodialysis services.

It is remarkable that the MHIF has survived the political and economic crises the country has experienced since it was established and has maintained a substantial degree of continuity and stability in the health financing system. Important contributors to this have been the coordination of local reform leaders and supporters and the development partners who have supported the single-payer system. The willingness to adapt governance of health-care purchasing over time has also played a part. Several revisions to the governance arrangements for the MHIF have affected its legal status and its relationship with the MOH, wider Government and civil society, as well as its oversight and accountability arrangements.¹ Since 1996 there have been several phases of technical support for the development of the MHIF’s governance and management capacity.

The main strategic challenge facing the health financing system in Kyrgyzstan is that although it now pools most public financing for health care in the MHIF (almost 80% in 2017), the MHIF pools only around 40% of total recurrent health spending because the largest share (48% in 2015) is out-of-pocket expenditure – principally on pharmaceuticals – followed by inpatient care. Informal payments

¹ This section of the report draws on a presentation by the MHIF’s CEO, Dr Murat Kaliev, to the Joint Annual Review of the health sector strategy in 2016, entitled: *20 years of MHIF in Kyrgyzstan: achievements and challenges*.

contribute to out-of-pocket spending. The share of out-of-pocket payments and the rates of catastrophic expenditure have risen since 2009, partially eroding gains made during the first phase of the financing reform, though the financial protection policies of the SGBP are still protecting the poorest quintile (Akkazieva et al., 2016;

Jakab et al., 2018). This situation reflects the fact that the budget allocated to the MHI system is insufficient to finance the relatively comprehensive benefit package at current levels of efficiency, to pay prices that enable facilities to ensure a continuous supply of medically necessary inputs and to remunerate staff adequately.

Table 2. Mapping of main purchasers and providers

	Ministry of Health	Other central ministries (President's administration, Interior, Defence)	Mandatory health insurance fund	Voluntary health insurance (VHI)
Sources of finance (e.g. general taxation, earmarked taxes, local taxes, compulsory contributions, rest of world)	General taxation	General taxation	General taxation (national government budget), 2% payroll contributions, fixed premiums for farmers, informal sector...	Voluntary or employer contributions. (minimal share of CHE)
Population covered and as share of the total population	100%	Small numbers. Data lacking. Employees of these ministries are also covered by the single-payer system	100% for primary care, emergency care & referred hospital care, 74% for most prescription drug coverage	Very few.
Services covered (e.g. inpatient care, outpatient care, medicines, preventive, promotive)	Population-based public health services, a few clinics & facilities not transferred to MHIF single-payer system		Comprehensive package of primary care, hospital care, palliative care, rehabilitation	Data lacking. Private VHI accounts for under 1% of health expenditure.
In each column: Are these single or multiple purchasers?	NA	NA	Single	Multiple
If multiple purchasers, are they competing?	NA	NA	NA	Not competing with MHIF. Compete within private VHI market only.
Types of providers from whom services are purchased	Public providers, directly managed by MOH	Public providers directly managed by the respective ministry	Mostly public providers. Contracts with private pharmacies & private haemodialysis providers	Private providers

NA, not applicable

3. GOVERNANCE OF THE KYRGYZ HEALTH CARE PURCHASING SYSTEM

At the level of the **health care purchasing system**, governance in Kyrgyzstan benefits from comprehensive consolidation of public expenditure in a single pool. The MHIF pools around 80% of government spending on health, with most of the other 20% being allocated to population-based public health services, health education and MOH administration. This was not always the case. Until 2016, Bishkek City government budget funded primary and secondary health care within the capital city, and specialized health services continued to be provided by institutions attached to the MOH. Bishkek City and the MOH funded their facilities from their budgets based on historic line-items, with no possibility for strategic purchasing. From 2017, however, this funding was transferred to the MHIF and these facilities were brought into the single-payer system. The high level of

pooling in the MHIF has the potential over time to give the MHIF relatively strong leverage for strategic purchasing. However, the high financing gap for the benefit package and heavy reliance of public facilities on informal and out-of-pocket payment weakens this leverage. From a governance point of view, in a single-purchaser system such as Kyrgyzstan's, the governance of the MHIF as a purchasing agency (discussed in Section 3) is the main entry point for improving governance for strategic purchasing.

However, there are several challenges at the health-system level that reduce the potential for the MHIF to act as a strategic purchaser and drive improvement in health-care efficiency and quality that need to be addressed above the level of the MHIF's own governance.

3.1. SETTING OF STRATEGIC DIRECTION: NATIONAL HEALTH SECTOR REFORM STRATEGIES AND IMPLEMENTATION PLANS

An acknowledged strength of the Kyrgyz health system governance has been the adoption by the Government of a series of comprehensive national strategies for health sector reform and development which were also ratified by Parliament. These strategies have brought together health financing policies with other health system pillars – service delivery, human resources, information, pharmaceuticals. They have been used to define the main objectives and responsibilities of the Government, MOH, MHIF and health-care providers in implementing the health

strategy in the medium term, and to coordinate public finance and development assistance. The first such strategy – *Manas* covering 1996–2005 – did this coherently and successfully. It was evaluated as achieving a positive impact on financial protection, particularly for the poor, through coordinated action on revenue mobilization, benefit package definition, formalizing co-payments with exemptions for the poor, hospital restructuring and provider payment reform (Jakab, 2007). Strong coordination of strategy formulation and implementation was facilitated in this

period by the positioning of the MHIF – its director was a Deputy Minister of Health.

The latter two national health strategies (*Manas Taalimi* and *Den Sooluk*) have not achieved the same level of strategic direction and coordination of financing with service delivery and pharmaceutical reforms. There has also been weaker political buy-in to the strategy partially due to changes of government, leading to some major decisions which were not consistent with the strategy. In spite of this, there has also been a substantial degree of stability and consistency in the major parameters of health financing policy during this period. At times of political crises there have been proposals for changes in policy and structure, questioning the single-payer health insurance system, but so far these have been rejected.

A weakness has been the failure of the MOH or wider governmental authorities to translate the medium-term national strategies into concrete time-bound, measurable institutional plans for the organizations involved in implementation, including the MHIF. The independent status of the MHIF since 2006, in the absence of specific structures and regular processes of coordination between the MOH, MOF and MHIF, has adversely affected alignment and coordination of implementation plans for more recent health strategies. As a result, the strategic direction of the MHIF is set by its own CEO rather than by any external stewardship and governance structure or process.

3.2. ALIGNMENT OF PUBLIC FINANCIAL MANAGEMENT WITH HEALTH PURCHASING REFORM

The MHIF single-purchaser system has been hampered by misalignment with the public financial management system, though significant progress has occurred in recent years in tackling this. The new output-based provider payment mechanisms introduced by the MHIF operated alongside rigidly controlled input-based line item budgets for health-care providers and unreformed Soviet legacy systems of planning and control of staff and other physical inputs based on norms (Cashin et al., 2017). The MHIF is responsible for allocating pooled funds from four sources² to health-care providers in a single process and uses capitation or case-based payments to do this. However, all state health-care providers are subject to the same PFM rules and processes as on-budget agencies such as the line ministries. The funds they receive from the MHI system have to be

executed within these PFM rules. Until 2018, not all of the pooled expenditures of the MHIF appeared in the budget presented to Parliament, which presented only MHIF expenditure financed from general tax sources. The MHIF revenue from MHI contributions was “off budget”. Initially, the MOF required input-based budgets to be formulated and adopted by Parliament for all health-care providers. The MHIF budget submitted to Parliament was listed as input-based budgets for providers funded from the single-payer system. In 2006, a special single line item for MHIF’s payments to providers was added to the national economic budget classification. Although this helped to simplify MHIF budget formulation, providers were still subject to rigid line-item budget controls as part of budget execution under MOF and MHIF rules.

² General budget funds, MHI contributions from 2% payroll tax, projected official co-payment revenue of providers, and projected “special revenues” of providers from provision of private health services and non-health services.

The rigidities inherent in this system were made much worse by the budget execution system, which required providers to prepare separate input budgets for the four sources of MHIF revenue. Providers planned, executed, accounted and reported on each source separately. Virement (rules giving flexibility to move funds) across the four sources was impossible while virement across line items within each source's budget were difficult and slow. Control was exercised on month-by-month cash plans, with virement across months with bottlenecks impeding re-profiling of cash across months within the year. All stages of formulation and execution of these provider budgets were approved by both MHIF and MOF. Unspent funds from the government budget (the majority of funds) to providers reverted to the Treasury at year end. Above-norm stocks of drugs and supplies at year end resulted in deductions from the budget for the following year. These budget-execution rigidities and disincentives continued until 2017. The rigid rules and cumbersome procedures applied to official co-payments making informal payments more attractive.

While the single-payer financing reforms enabled more equitable and rational allocation of budget resources across health facilities, the rigidities in the public financial management system largely prevented the MHIF from using provider payment innovations to create incentives for efficiency and performance improvement.³

Additionally, the old system of Soviet input-based planning norms has not been repealed and replaced, though there have been incremental reviews and the relevance of the norms and rigour of enforcement has diminished over time.

This has locked in place an inefficient input mix biased towards the hospital sector and towards oblast (region) centres and national capital cities. Until recently, the MOF reduced the health budget if facilities closed or reduced bed or staff numbers. Although this has changed since 2017, many of the norms continue to operate as "ceilings" on staff inputs (not as minimum standards for safety /quality). But because institutions can redistribute salary budgets from unfilled vacancies to supplement salaries of other staff, they have therefore no incentive to reduce the number of staff posts.

A new MHIF Budget Law implemented from 2018 removes the role of the MOF in approving provider budget plans and budget execution decisions and gives the MHIF power to change the old system of input planning, execution controls and reporting by four sources. However, the MHIF is understandably cautious about moving away from line-item controls for providers because it lacks data and systems to monitor hospital use of resources in more output- and results-oriented ways (such as data on cost per case). In addition, public health-care providers have well-documented weaknesses in financial management and control and there are no plans to establish an alternative system for ensuring internal control and external accountability for providers. The MOH continues to exercise control over provider resource use through a range of input-based norms and is responsible for addressing the identified shortfalls in management capacity and systems in providers. This too is an area where split accountabilities, and lack of aligned and coordinated plans impedes governance of the providers in the single-payer system.

³ This section of the paper draws on an unpublished note produced for development partners by S. O'Dougherty and dated October 2016 (on SGBP Payment systems funds flow and corresponding facilities autonomy) and an unpublished mission report produced by E. Dale for WHO dated July 2018 (on alignment of PFM and health financing reforms).

3.3. COORDINATION OF DEVELOPMENT FINANCE AND THE ROLE OF DEVELOPMENT PARTNERS

Kyrgyz health financing and system reform and development has been supported by development assistance since independence. Since 2006, a varying share of this support has been channelled through government systems under a sector-wide approach (SWAp) based on the national strategies and monitored through a joint annual review (JAR). Over the years an increasing number of development partners have supported the reforms, while not all the development assistance is pooled. SWAp funds have supported budget allocations to health and the SGBP, based on an agreed target of 13% of general government expenditure to be allocated to health. The SWAp and JAR processes

have encouraged a focus on performance indicators and accountability for results, including some activities and indicators reported by the MHIF (Government of Kyrgyzstan and development partners, 2013–2017). However, the SWAp and JAR processes have not reached across into the Government's own accountability processes in any formal or systematic way. With weaker government ownership of the most recent national strategy (*Den Sooluk*) and reduction in SWAp resources, the influence of the JAR recommendations on actual implementation actions in the MOH and MHIF has weakened, resulting in a lack of progress on key recommendations made year after year.⁴

3.4. CHALLENGES COMMON IN SINGLE-PURCHASER SYSTEMS: FISCAL REALISM OF THE BENEFIT PACKAGE, PRESSURE TO PROTECT PUBLIC PROVIDERS

As in many low- and lower-middle-income countries, Kyrgyzstan's MHIF has to live within the budget allocated by Parliament each year, and there have been periods when part of the approved budget is sequestered due to government revenue shortfalls. Likewise, public providers are unable to run cash deficits. The budget constraint is thus very firm. But it is not credible to expect the MHIF to meet its SGBP commitments within the budget, nor to expect providers to limit patient charges to the official co-payments specified in the SGBP because of a large and long-standing **gap between the costs of the SGBP and**

available resources, estimated to be over one third of the cost of hospital care (Kaliev et al. 2012) and as much as two thirds of the needs for the outpatient drug benefit. Weaknesses in budget formulation and policy processes have contributed to this gap. Budgets ceilings are set based on historic spending levels, without systematic projection of changes in the future cost of the SGHP. SGBP policy changes have been adopted (such as decisions to reduce co-payments or extend exemptions) without adjusting budget provision and prices for services to reflect the resource implications. It is therefore not straightforward to hold

⁴ This finding is reported in two unpublished papers: (1) by Oxford Policy Management (OPM), entitled *Independent review of Den Sooluk and project in support of mid-term review*, produced for the MOH and development partners and disseminated in 2016, and (2) *Health sector coordination in Kyrgyzstan: further strengthening the sector wide approach*, produced for the WHO Kyrgyzstan Country Office in 2017 by Maria Skarphedinsdottir, René Dubbuldam and Aigul Sydakova.

the MHIF accountable for implementation of the SGBP. While the MHIF has demonstrated that it has some potential to reduce the gap through increased efficiency by better contract negotiation and use of other elements of strategic purchasing, cooperation of the MOH is needed too in order to close such a wide gap (e.g. by optimizing the hospital network and reducing excessive staff numbers in hospitals with deficits).

As in many countries (including high-income countries) with a single-payer system and predominantly public health-care providers, the MHIF has not been given freedom to undertake selective contracting of public providers. Only

when there has been an MOH-approved strategy for closing or optimizing public health facilities, has the MHIF been able to rationalize the network of facilities it contracts with. Additionally, where a public provider has a financial deficit because it cannot cover its costs under the prices MHIF pays, the Government has intervened with regulations requiring the MHIF to cover all salary, medicine and food costs of these providers – in effect, paying higher prices to these providers. In spite of this, the MHIF has adopted a policy of phasing out these higher payments over a planned time frame and has sought to negotiate with overstaffed providers to reduce costs where feasible.

4. GOVERNANCE OF THE KYRGYZSTAN PURCHASING AGENCY: THE MANDATORY HEALTH INSURANCE FUND (MHIF)

Initially in 1997 the MHIF was an independent public-sector organization but it was soon incorporated into the structure of the MOH as a semi-autonomous operational arm, under the management of a Deputy Minister of Health and so directly accountable to the Minister of Health. It had no supervisory board (SB) or any other form of external input to governance. This organizational position facilitated very close coordination between the MOH and MHIF in the implementation of health financing reforms that needed to be coordinated with health-care provider reforms.

The MHIF was again turned into an independent public agency in 2006 after the “revolution” of 2005, then briefly brought back again under the MOH. Since 2009, the

MHIF has again been operating as a legally independent public administrative agency subordinate to the Government (Ibraimova et al., 2011; Kaliev & Meimanaliev, 2016).

The MHIF’s CEO (called the “Chair”), appointed by the Prime Minister, is thus at a similar level in the government hierarchy to the Minister of Health but does not attend Cabinet meetings. In practice, the Vice Prime Minister responsible for social affairs became the responsible Cabinet member for the MHIF but the legislation governing the MHIF does not clearly specify MHIF accountability and oversight arrangements. To address this gap, the Government in 2012 put in place an SB for the MHIF, with government-approved membership and terms of reference.

The following sections explore various elements of the governance of MHIF in more detail, by looking at core governance requirements that should be in place for a purchaser to operate strategically (cf. WHO 2019).

4.1. CLEAR, COHERENT ROLE AND DECISION-MAKING AUTHORITY

According to the law, the MHIF’s role is purely operational: to implement the SGBP and the provider payment system. In European Union countries typically any policy decision authority given to an independent MHI agency would be reserved for the SB and not delegated to management, but the MHIF SB has no policy or regulation-making powers and cannot even submit

proposals to the Government (Institute of Directors, 2018a). The Government (and Parliament for key issues), MOF and MOH have decision authority over most health financing policies (SGBP, co-payments and exemptions, annual budget ceiling and high-level budget allocation, payroll tax rate, permitted types of provider payment, various input norms for health facilities,

regulations protecting or guaranteeing payment of salaries, drugs and some other inputs). The MOH and oblasts, as owners of public health facilities, have greater leverage over organization and resource use of service providers than does the MHIF. The MHIF has very limited leverage over prices for pharmaceuticals in private markets (which are largely unregulated and characterized by limited competition), and its budget is too small to provide comprehensive coverage of medicines and lower-priority non-urgent health services. The Social Fund, rather than the MHIF, is responsible for collecting MHI payroll contributions, while most revenue for the MHIF comes from the state budget. Consequently, it is not fully within the power of the MHIF's management to achieve the health financing goals of universal coverage

and financial protection, nor can the MHIF maximize the contribution of health financing to other health goals (efficiency, equity, care quality, health status) without enabling policies and joint action by the MOH and local authorities.

In practice, however, the MHIF's CEO, managers and senior staff have much of the country's expertise in health finance policy and strategy. The MHIF is often best placed to **formulate** policy proposals and draft regulations to improve health financing, and in practice does so – submitting drafts to the MOH and/or MOF for approval. There has also been a major role played by external technical assistance and advice from development partners in influencing financing policies and providing technical input to these policies.

4.2. AUTONOMY AND AUTHORITY OF THE MHIF TO ACT STRATEGICALLY

Tables 3 and 4 compare the Kyrgyz MHIF's autonomy and decision rights on health policy and financial matters with the Health Insurance Fund (EHIF) in Estonia – another former Soviet health system with a single purchaser. It is relevant to distinguish the authority of the SB from the authority of management. By comparison with Estonia, the MHIF SB in Kyrgyzstan has little formal autonomy over health financing policies.⁵ At the level of the management board, Kyrgyzstan and Estonia have quite similar limits on their autonomy. What is also important in Estonia is a clear shared understanding of the role of the EHIF management and staff in **formulating** health financing policy proposals which are submitted to its board, and the roles of the

MOH, MOF and the Government for each step in reviewing, providing feedback, and agreeing on policy proposals prior to final adoption by whichever body has formal decision authority. This includes clear roles in the processes for design and approval of benefit package, contracts, selective contracting strategy and clinical guidelines. By contrast, the MHIF management and staff in Kyrgyzstan tend to play a less proactive role in formulating and influencing policy, though this depends very much on the CEO. There is no clear delineation of the roles of MHIF staff and management versus the MHIF SB, MOH and MOF in health financing policy formulation in Kyrgyzstan, nor are there clear processes for making shared decisions.

⁵ Note that, in Estonia, the SB is chaired by the Minister of Health and includes an MOF representative.

Table 3. Division of authority and MHIF autonomy on health purchasing decisions: Kyrgyzstan MHIF compared to Estonian EHIF

Issue	Kyrgyzstan MHIF	Estonia EHIF
Benefit package (individual services)	Parliament adopts law (sets broad scope, protected groups); Government adopts regulations (MOH proposes, MHIF management consulted)	Parliament adopts law (broad scope); Government adopts regulations (EHIF management proposes, SB formulates opinion, MOH presents to Government)
Provider payment method	Government adopts (MHIF management usually proposes, SB may be consulted, MOH approves and presents to Government)	Government adopts (EHIF management proposes, SB formulates opinion, MOH presents to Government) together with benefit package
Pricing/tariffs	Government adopts (MHIF management proposes, SB may be consulted, MOH approves and presents to Government)	Government adopts (EHIF management proposes, SB formulates opinion, MOH presents to Government) together with benefit package; the methodology of pricing MOH adopts (EHIF management proposes, SB formulates opinion)
Contract development & award	Government approves template, MHIF management proposes, SB may be consulted (no selective contracting and little private sector contracting)	Parliament adopts law (criteria for contracts); EHIF SB approves the budget (higher level than contracts) and details of selection criteria; EHIF management prepares and negotiates template and procedure (selective and private contracting); EHIF must contract hospitals in government-approved masterplan but can vary mix and volume of services in line with minimum service availability standards set for hospital types adopted by MOH)
Quality standards/ accreditation	MOH adopts (licensing for private sector, accreditation for public facilities), MHIF management approves quality indicators for contracting including P4P scheme	State agency under MOH - Health Board - licenses doctors and facilities; independent Quality Board under MOH handles patient complaints; EHIF manages quality standards within contracts and indicator system including primary health care quality bonus
Reimbursement of prescription drugs	Joint MOH-MHIF adoption of Order (MHIF management proposes list of drugs and reimbursement percentage)	Government adopts regulation on reimbursement price/share reimbursed by disease groups; MOH approves list of drugs (EHIF management proposes, SB formulates opinion); MOH adopts pricing methodology (EHIF management proposes, SB formulates opinion)
Clinical guidelines	MOH develops and approves	EHIF supports the process; guidelines development methodology approved by Medical Faculty of University of Tartu. Guidelines development is coordinated by University of Tartu.

Until 2018, the MHIF in Kyrgyzstan had substantially less financial autonomy than the Estonian EHIF, but from 2018 a new law has increased its financial autonomy, although not to the extent of the Estonian EHIF. In particular, the MHIF does not hold

reserves and its SB does not have primary authority to approve the MHIF budget and financial policies – the MOH and MOF remain the primary authorities, even if the SB is consulted and invited to endorse proposals for ministerial decisions.

Table 4. Division of authority and MHIF autonomy on financial decisions: Kyrgyzstan MHIF compared to Estonian EHIF

Issue	Kyrgyzstan MHIF	Estonia EHIF
Payroll tax rate/ budget contribution	Parliament adopts (MOF sets budget ceiling in budget formulation process based on actual historic spending; MHIF participates in negotiation meeting)	Parliament adopts payroll tax rate and annual ceiling for the budget (EHIF management prepares and EHIF SB approves annual budget)
Reserves	None	EHIF has 3 types of reserves: Solvency reserve: 5.4% of total budget since 2018 (8% in 2001-2004, 6% 2005-2017) – government decision; Risk reserve: 2% of health insurance spending (introduced in 2002) – SB decision; Accumulated surplus: non-mandatory reserve as difference between revenues and expenditures; accumulated before last global financial crisis
Allocation of MHI budget to service programmes	Parliament approves allocation to functional (service categories), with single line of economic classification under each function. (Until 2006, Parliament approved budget by economic classification)	Parliament only approves single line (budget ceiling); EHIF SB approves service category allocation
Allocation and execution of provider payments according to line-items (economic classification)	Provider budgets by economic classification line items are approved and executed by MHIF through the single treasury system. MHIF is obliged to cover protected input costs – wages, drugs, food even if this amount exceeds payment for performed services. Until 2018, MOF local treasury offices also approved provider budget allocation and execution	EHIF pays providers one-line (lump sum) payment covering all necessary costs for performed services according to payment method. Autonomous or private health-care providers allocate these resources to line items and pay own bills using commercial banks
Retention or carry-forward of savings	MHIF and providers since 2018 are able to carry forward unspent funds from all revenue sources	EHIF savings could be added to reserves which was the usual practice before last global financial crisis. Providers fully retain savings

4.3. COHERENT LINES OF ACCOUNTABILITY SUPPORTING TRANSPARENCY: EMERGING ACCOUNTABILITY FOCUSED ON RESULTS

Even though the MHIF SB formally lacks authority over financing policy, there is a case for holding the MHIF accountable to some extent for **results** – for progress towards health financing objectives and not just for operational implementation of SGBP and regulatory compliance – because of the MHIF’s *de facto* ability to initiate and formulate policy proposals, to build consensus among key ministries and stakeholders at SB level and to use the MHIF’s recently increased financial autonomy. However, there is inevitably **shared accountability** with the MOH for results, because the MHIF cannot act without MOH approval and needs MOH cooperation over complementary actions in other health system pillars – notably service delivery, quality management and medicines policies. In a context where respective responsibilities and accountabilities of the MOH and MHIF for formulating and approving health financing policies (such as benefit package) and implementation plans are not clearly defined, this shared accountability dilutes both the MHIF’s and the MOH’s accountability. In the Kyrgyz context of accountability and management control centred on institutional hierarchies, joint decision-making and accountability across institutional boundaries is unfamiliar and difficult to operationalize.

The MHIF CEO has multiple lines of control and reporting, operating in silos, that fragment governance. Formally, one would expect the MHIF’s primary line of accountability to be to its SB, but the legal basis does not make this clear. Legislation puts in place controls and reporting obligations directly to various ministries, with the MOH and MOF being the most important, to Cabinet processes and to

the parliament health committee. There are also multiple government committees chaired by the Vice Prime Minister with the MOH, which have overlapping roles in coordinating aspects of health policy, health-sector performance and public health strategy. These committees’ roles also touch on the MHIF, but none has a mandate to hold the MHIF accountable for results. In theory, the SB could follow the Estonian example and convene and coordinate these decisions because the MOH and MOF are represented. However, in practice there is no coordination of the multiple governance mechanisms in use to ensure that decisions of governance actors are aligned, to set a coherent direction for the MHIF, or to take a coordinated approach to reviewing the decisions the MHIF takes and to monitor performance of the single-payer system towards achieving intended strategic outcomes. This is made difficult by the culture of hierarchical management and control within institutional silos. The multiplicity of overlapping bodies and processes also exceeds the country’s very limited capacity for coordination, leading to practical problems of infrequent, poorly attended meetings, poor preparation and lack of follow-up. It devalues governance.

One example of the lack of coordination noted above is the financing gap for the SGBP. Reducing this requires coordination of public sector policy levers and strategies towards shared goals, including revenue mobilization (MOF lead role), public sector efficiency improvement (MOF and MOH shared role), review of the SGBP (involving all three agencies), better targeting of co-payment exemptions (MOH and Ministry of Labour and Social Affairs) and improvement of the MHIF purchasing/contracting (MHIF

role).⁶ Another example has been lack of the necessary legislative framework and limited institutional capacity to regulate the pharmaceutical and retail pharmacy sectors, combined with limited competition in the market for many pharmaceuticals, resulting in high prices and mark-ups and high private out-of-pocket payment for

medicines (Jakab, Akkazeieva & Habicht, 2018).⁷ The MOH began to take steps to tackle this issue in 2017 with the adoption of new legislation to underpin development of price and margin regulation for essential medicines. This also requires cooperation with the Anti-Monopoly Commission.

4.4. EFFECTIVE OVERSIGHT

Supervisory Board membership, functions and functionality

The SB's terms of reference give it the roles of coordinating, monitoring and advising the MHIF's CEO and approving matters already within the authority of the MHIF's management. The creation of the SB was an attempt to put in place the kind of governance structure seen in most social health insurance or health purchaser organizations in EU countries. However, unlike in these countries, the legislation governing mandatory health insurance was not amended to give statutory authority and duties to the new SB, nor is there any general legislative framework governing such boards for public agencies in Kyrgyzstan – except for the separate Public Advisory Councils introduced for all public agencies and ministries, but which do not have a governance role. As a result, the SB does not have clear decision authority in its own right, it is largely up to the CEO to decide whether to seek SB endorsement for any proposal. Nor do SB members have clear accountability or any liability for carrying out their oversight of the MHIF appropriately.

The MHIF SB is chaired by the Vice Prime Minister for Social Affairs, with the Minister of Health and MHIF CEO as deputy chairs. A Deputy Minister of

Finance is a board member. Others on the 13-member board include the chair of a separate Public Advisory Council of the MHIF representing civil society (discussed below), representatives of the Social Fund, the employers' organization, the trade union of health-care workers, the Union of Social Protection (representing socially vulnerable groups including people with disabilities) and the pensioners' association. The terms of reference of the SB have weak status (an administrative act, without any basis in legislation) and content: they are very general and unclear about role and duties, and do not give clear decision authority to the SB in relation to the MHIF management. The terms of reference encompass consideration and approval of MHIF strategies and (unspecified) internal policies, coordination, monitoring, advice, and approval of annual reports. The SB does not have any role in selection and appointment of the MHIF CEO or other MHIF managers nor in review of their performance. Board members are not paid for this role (though most members are salaried public officials). There are no clear criteria and description for board member competencies, and the SB has no mandate to carry out self-assessment.

⁶ This paragraph draws on the work of the MHIF/MOH Health Financing Expert Group, which presented its analysis at a 2017 Thematic Meeting in a PowerPoint presentation: *Management of financial resources and strengthening health financing arrangements*.

⁷ Also reported in an unpublished paper by Oxford Policy Management (OPM), entitled *Independent review of Den Sooluk and project in support of mid-term review*, produced for the MOH and development partners and disseminated in 2016.

An assessment of the functionality of the SB was commissioned for the MHIF with WHO support in 2016 as a basis for planning actions to strengthen governance.⁸ This found that although the MHIF SB formally approves the annual plan, budget and annual report of the MHIF, the SB's role is passive, in line with its limited formal mandate. Its agenda and discussion do not typically cover strategic issues. At that time, the SB met infrequently. It did not exercise effective accountability by active monitoring of outputs produced and other performance indicators, questioning or challenging results or performance where necessary. For example, while there has been evident public concern and MOH policy concern about inadequate financial protection and persistent informal payments, this issue was not discussed by the SB. The limited SB discussion of financial reports focused on inputs and timely payment but has not, for example, discussed the very high share of budget spent on salaries versus direct patient care

costs such as medicines and supplies which lead to informal payment. Minutes of SB meetings have been sketchy in content.

There were no policies for declaring or dealing with conflicts of interest of SB members. The role of the MOH on the SB creates particular issues because it is the owner of almost all public health facilities in the single-payer system. Thus the MOH has some conflict of interest when the MHIF seeks SB approval to use its contracting relationship to challenge inefficient providers. The MOH may have an interest in using its role on the SB to protect influential providers. In a well-functioning governance board, this interest would be balanced by other interests on the board, and the MOH would be constrained to act under the collective obligation to ensure that MHIF resources are used efficiently and effectively. But the SB lacks a clear set of governance duties and lacks capacity to function in this way.

The Ministry of Health as steward, supervising ministry and owner of health facilities

While the MOH has a stewardship role over the health financing system and the MHIF, and the Minister is a Deputy Chair of the SB, the MOH does not have the mandate to hold the MHIF accountable nor the authority to intervene in management and operations of the MHIF. The MOH has decision-making authority on all policies and regulations (other than budget and treasury regulations) that the MHIF needs enacted to carry out its health purchasing functions, including many operational regulations such as MHIF regulations for financial oversight of health facility

expenditure of MHIF funds. However, the MOH lacks capacity to lead and innovate in health financing policy and tends to react to policy initiatives taken by others – including the MHIF. Nevertheless, it has authority to review and approve all MHIF regulations. Although the MOH could use its role on the SB actively to play a role in monitoring and accountability, and could devote some of its staff capacity to advising and briefing the Minister for SB meetings, it does not monitor outputs and performance of the MHIF. The MOH has not addressed concerns about data reliability

⁸ This section of the report draws on a report commissioned by WHO Kyrgyzstan Country Office: Rannamäe A & Danilov H. Strengthening Mandatory Health Insurance Fund of Kyrgyz Republic, May 2016, and on subsequent presentations and mission reports by the consultants who conducted the assessment and provided follow-up advice to the MHIF.

for monitoring; provider outputs reported by providers to the MOH and National Statistics Bureau differ markedly from those reported to the MHIF's case payment database, for example.⁹ At times, the MOH has advocated policies opposing the MHIF's autonomy and opposing aspects of the health financing reforms, putting the MHIF in the position of advocate and defender of health financing reform.

Weaknesses in strategic coordination and communication and conflict in the relationship weaken the potential influence of the MOH on the MHIF's performance via its membership of the SB. It is not uncommon to find tension, communication concerns and even conflict in the relationship between an MOH and an independent health insurance agency. But it is of concern that in Kyrgyzstan, coordination and communication appear

to have weakened compared to the first phase of health reform under the *Manas* strategy. This has contributed to calls from some government actors to make the MHIF subordinate to the MOH, as it was in the *Manas* period. It is not clear whether changes in strategic coordination are due to this structural change but it is clear that in the Kyrgyz context, in the absence of a tradition of using formal governance structures and the absence of well-defined procedures for coordination, the system is unduly dependent on collaborative personal relationships among key individuals. It may be that there is a trade-off between choosing structures that aid coordination through MHIF subordination to MOH and structures that strengthen checks-and-balances through greater MHIF independence.

Financial control and accountability: the relationship with the MOF, the budget and the public financial management system

The MHIF has a strong line of accountability and governance relationship to the MOF and the PFM system. The MHIF plans its budget allocation according to output-based provider payments and has regular interactions with the MOF in the budget formulation process. It reports quarterly to the MOF according to aggregated input-based line-item expenditure of the providers it contracts with. The MOF thus monitors the MHIF's financial position and that of the public health-care facilities in the single-payer system. The single Treasury

account system is used to monitor, control and account for expenditure of MHIF funds and the expenditure of facilities in the single-payer system. This integration of the MHIF into the budget and treasury management system provided Parliament and citizens with assurance of financial control and accountability for use of inputs, including external audit by the state audit authority – the Chamber of Accounts. The MOF does not, however, monitor outputs or efficiency of the system.

⁹ Finding of interviews with health-care providers conducted by Information Systems and data consultant commissioned by WHO in 2017–2018.

¹⁰ This section of the report draws on an unpublished paper by Oxford Policy Management (OPM), entitled *Independent review of Den Sooluk and project in support of mid-term review*, produced for the MOH and development partners and disseminated in 2016.

4.5. INCLUSIVE AND MEANINGFUL STAKEHOLDER PARTICIPATION: THE PUBLIC ADVISORY COUNCIL

After the 2010 overthrow of a government criticized for centralizing power and non-transparency, Kyrgyzstan adopted legal requirements under a new Constitutional Regulation on Government, putting in place a Public Advisory Council (PAC) for all government ministries and agencies, including the MHIF, with the aim of increasing citizen participation and transparency. The 2016 WHO assessment found that the MHIF PAC does not have a clear governance role and its role overlaps with that of the SB. It lacks any decision-making authority. Its role is to monitor the organization. It is able to raise issues to the Government and in the media.

Any interested citizen can apply to publicly advertised posts as members of the PACs who are appointed by the Presidential Administration. There are no requirements for sector-specific or particular governance skills or experience for being a PAC member, nor is there any regulation of conflict of interest for PACs. The MHIF's PAC includes members from the private health insurance

industry, health-care providers and health nongovernmental organizations. PAC members have two-year terms, with no overlap of terms, limiting the scope to build capacity, institutional memory and constructive ongoing engagement with the MHIF.

The role of the MHIF PAC is not well-defined, there is no systematic basis for setting agendas, some issues raised overlap with the SB role, and some seem to be selected randomly. While this Council meets frequently (every two weeks), it has neither the mandate nor capacity to hold the MHIF accountable, nor does the MHIF report regularly to it on performance. The conflict of interest issues noted above would need to be addressed before it could play a stronger role in governance. In theory, the PAC chair, as a member of the SB, could play a role in aligning and coordinating the work and recommendations of the two bodies; however, in practice this does not happen in the absence of a clear and focused role for the PAC.

4.6. RELATIONSHIP BETWEEN PROVIDER GOVERNANCE AND MHIF GOVERNANCE

Since 2006, subnational as well as national public health-care facilities have been subordinated to the Minister of Health, who now appoints all public-sector facility directors. In Kyrgyzstan, health facilities do not have autonomous legal status – they are budget agencies. By contrast, high-income countries like Estonia and the United Kingdom gave autonomy to, or corporatized, state-owned providers as part of their purchaser-provider split reforms, enabling the Ministry of Health to step

back into an arms-length governance and stewardship relationship with providers.

In Kyrgyzstan, the MOH's role is dominated by its responsibilities as a health-care provider. This is reinforced by a Consilium of the MOH – a body that has existed since the Soviet era and is composed of public health facility directors – which advises the minister. Thus, the MOH is not well-positioned to function as a neutral health system “steward” across both the financing/

purchasing and provision functions in the health system. Furthermore, the MOH does not have capacity or standard operating procedures or an internal culture for arms-length governance of autonomous health providers. It does not regularly monitor the performance of its subordinated health facilities, although its attached agencies collect data that is used to produce statistics and populate reports to the JAR. It has no subnational staff, apart from part-time oblast health coordinators – positions which are reliant on uncertain donor support.

A related distinctive feature of the Kyrgyz purchaser-provider split is that, as noted in the previous section, the MHIF was given the role of controlling and monitoring the expenditure of public health facilities financed through the single-payer system. The MHIF did this jointly with the MOF until 2018 but has carried out this task alone since the reform. The MHIF took over the oblast-level role and staff of the MOH – the oblast health departments – in monitoring and controlling health-care provider activity and expenditure. This was a pragmatic way of coordinating the MHIF provider payment system and unreformed, misaligned public financial management systems in the Kyrgyz context. It also made best use of the very limited available staff capacity for provider monitoring. Kyrgyzstan was simply unable to afford or staff both MHIF monitoring of contracts with providers on the one hand and, on the other, a separate provider performance monitoring by the MOH as “owner” of facilities.

As a result, the MHIF is now the repository of data on hospital activity (in its case payment database) and on public health facility expenditure and revenue (its provider-based budget planning and execution data). The MOH can access this hospital data only by coordinating with the MHIF. The MOH captures other hospital data (such as bed and staff numbers, occupancy rate, mortality) and

holds data on primary care registration, outpatient activity and disease registries. Information exchange between MOH and MHIF is in practice delayed and difficult. The MOH usually considers financial data on providers for reactive investigation of problems in specific providers, rather than routinely for all providers. Conversely, the MHIF does not yet have routine on-line access to data on health-care providers held by MOH and its agencies. Thus, no single agency has data as well as capacity to play an effective governance role over providers. No ministry or national agency takes an active interest in clinical quality or the efficiency of health-care providers although there are plans for the MOH to establish a quality unit and begin collecting and reporting quality data under the next national health strategy.

The MOH also lacks any financial incentive to address the governance challenges of providers. Currently, some 39 hospitals have financial deficits. A number of these facilities are in urban areas and could be downsized or rationalized without jeopardizing access to care. This is a task for the MOH which has the necessary regulatory and governance levers over facilities. Yet the MOH has no financial incentive to do so because the MHIF is obliged to subsidize these providers under a regulation requiring it to guarantee to cover planned salary, drugs and food costs for hospitals even if this exceeds case payment revenue of the hospital (although this is no longer a formal legal requirement under the new MHIF Budget Law). Normally in health systems with a “purchaser-provider split” the owner or founder of a hospital bears both financial and governance responsibility for addressing hospital deficits.

Unclear and overlapping roles between the MOH and MHIF in oversight of providers are thus exacerbated by fragmented health data systems and reinforced by mismatch of financial and governance responsibilities for public health facilities.

4.7. SUMMARY ASSESSMENT OF GOVERNANCE AT THE HEALTH PURCHASING AGENCY LEVEL

Several themes emerge in recent reviews of MHIF governance:

- a. The model of corporate governance recommended for the MHIF – with an SB that should be the primary oversight body – was very recently introduced in Kyrgyzstan for both the private and the public sectors. Results-oriented governance with a focus on ex-post reporting and monitoring runs counter to the legacy of Soviet prior administrative control and punitive responses to performance shortfalls. It is therefore difficult for the Kyrgyz authorities to find SB members or staff for the corporate secretary role with knowledge or experience of this model of governance and of the appropriate governance culture to operate this model.
- b. A combination of pervasive unfamiliarity with the role of governance boards and limited internal capacity in the MHIF led to a situation where basic governance processes of convening the board, setting agendas and reporting were not implemented for many years.
- c. The new governance mechanism of the SB was overlaid on top of existing lines of control and accountability to the MOH and MOF and did not replace them. It tended to add a layer of reporting and decision-making that may have seemed redundant to SB members because all the necessary decisions could be taken even if the SB met very rarely.
- d. The legislative framework for the work of the SB is weak. The status, authority and duties of the SB are weaker and accountability of board members is less stringent than those of corporate governance bodies in the private sector and in corporatized or autonomous public bodies in many western European countries.
- e. Although there is a clear need for coordination across the multiple lines of accountability of the MHIF, and although this is one of the stated functions of the SB, the legislative environment and the administrative practices and public-sector “organizational culture” in the Kyrgyz public sector reinforces parallel vertical lines of accountability in silos. Without a clearer legislative and regulatory basis, and standard operating procedures spelling out how joint or shared decision-making should operate, this is difficult to change.
- f. The MOH does not have a formal mandate to monitor the MHIF’s performance because the MHIF is not subordinated to it. The MOH’s capacity for sector stewardship is weak, even if it were to be given this role. It lacks data and analytical capacity to monitor MHIF performance and to provide robust feedback on MHIF institutional strategy and plans.
- g. The limited competencies, knowledge and motivation of SB members to oversee the MHIF are an overwhelming constraint. Board members do not appear to understand why the SB was established or what is involved in the governance role, and most have little familiarity with the business they are monitoring. Board members are unpaid and do not have any other incentive to take responsibility for making decisions on strategy or for seeking to influence policy and performance. Board members face no pressure to meet or to participate actively when they do meet. Some stakeholder members see the SB primarily as a forum for pursuing narrow interests.

Table 5 summarizes the assessment of governance of the MHIF – the purchaser agency level of governance, using the dimensions of analysis set out in the WHO Framework for assessment of governance for strategic purchasing (WHO, 2019).

Table 5. Summary assessment of governance aspects at purchaser level

Governance arrangement and desirable features	Assess whether the respective relevant governance arrangements are in place
<p>Legal provisions determine a clear and coherent division of labour and define the decision-making authority for key aspects of purchasing between the purchaser, MOH and other relevant parts of government.</p>	<p>Legal provisions for the MHIF SB would ideally be in primary legislation. Clarifications of the SB terms of reference have been proposed, listing specific tasks, but as of the time of writing have not been adopted.</p>
<p>Both a public interest mandate and clear objectives for strategic direction are formalized in legal or regulatory provisions.</p>	<p>Not formalized in law or regulations, although the series of national health strategic plans/ programmes have played a positive role in the earlier periods of reform.</p>
<p>The purchaser has sufficient autonomy and authority, commensurate with its capacity to achieve its objectives.</p>	<p>The MHIF SB and CEO lack authority to develop strategic purchasing unless the MOH approves and the MOF aligns financial management processes.</p>
<p>An effective (expert) oversight body and mechanisms are in place to increase accountability for results and balance increased autonomy.</p>	<p>The MHIF SB is unable to hold MHIF accountable for results.</p>
<p>There is inclusive, meaningful stakeholder participation, with checks on conflicts of interest.</p>	<p>Stakeholder participation in SB and PAC is ineffective and suffers from conflicts of interest.</p>
<p>The multiple lines of accountability are coherent, allowing clear direction for the purchaser and clear attribution of responsibility.</p>	<p>Multiple lines of accountability are not always coherent. They are based more on prior control and inspection than on setting direction and attributing responsibility.</p>
<p>There is a firm, credible budget (constraint) in place, so that it has clear responsibility for balancing expenditure and revenue, with credible sanctions in case of breaches of the budget constraint.</p>	<p>Budget constraint is not credible. There is no possibility to breach the budget constraint – instead the financing gap is transferred to providers and patients.</p>
<p>The head of the purchasing agency is selected on the basis of appropriate skills. There are performance incentives for the head and other relevant staff to guide operations.</p>	<p>The MHIF has had some strong, well-qualified leaders, but also some periods of weaker leadership. The values and intrinsic motivation of appointees is the main incentive for performance.</p>
<p>There are specific regulations in place on the management and control of public funds, financial management and control of public or semi-public agencies or rules that apply to insurance agencies, and these regulations are implemented.</p>	<p>MHIF funds are managed in the single Treasury system and until 2018 execution was subject to prior MOF control. It is audited by the Chamber of Accounts.</p>

What are the reasons for the deficits in governance arrangements (e.g. gaps in institutional or technical capacity)?	How do these governance arrangements foster or hinder strategic purchasing?
It may be difficult to achieve stable political consensus to amend MHIF legislation due to periodic opposition to the MHIF's independent status.	Strategic coordination is weak. However, strategic purchasing could be strengthened under existing legislation through capacity-building for contracting and data analysis.
Traditional model of legislation and regulation, based on central controls of inputs and processes rather than objectives and results.	The system is reliant on the MHIF's CEO to initiate strategic purchasing and to advocate for it. National health sector strategic programmes also play a role. MHIF governance mechanisms do not drive strategic objectives or monitor them.
Difficult to maintain a stable political consensus supporting MHIF autonomy.	Strong MHIF CEOs have been able to make some progress, with support of local reform advocates and development partners.
Lack of legal basis for SB, vague terms of reference, too many passive non-expert SB members, lack of country experience with this model of corporate governance.	The MOH, MOF and Chamber of Accounts play stronger roles than the MHIF SB, but none of these governance actors provides effective results-oriented oversight.
Weak legal basis for SB and PAC.	Governance bodies do not add value and cannot be relied on to give the MHIF direction or hold it accountable for results.
The MHIF faces high compliance and reporting costs and to a large extent has to set its own direction – though national health sector strategic plans/programmes play a role in setting direction.	Strategic plans/programmes have recently been translated into concrete MHIF institutional strategies at the MHIF CEO's initiative, but the SB is not yet active in using these to hold MHIF to account.
Budget formulation does not reflect cost of benefits package. Political will is not there to introduce more explicit rationing or to target co-payments better to the poor.	Providers reduce quality and patients finance the gap through informal payments.
Appointment of health-sector leaders with appropriate skills is achieved through informal advocacy for strong leadership by reform supporters. Inappropriate appointments are challenged by a free press.	The MHIF has progressed in strategic purchasing when leadership has been strong and when the relationship with the MOH is constructive.
The single-payer system has suffered from excessively rigid input-based controls and bottlenecks in the PFM system. Since 2018, these have been addressed through legislation to increase MHIF financial management autonomy.	Input-based budget execution controls and protection of loss-making providers have blunted the financial incentives for efficiency created by MHIF's output based payment methods.

5. ASSESSMENT OF FACTORS CONDUCTIVE TO EFFECTIVE GOVERNANCE OF STRATEGIC PURCHASING

For governance to be effective, some conducive factors in the realm of **internal management and capacity** need to be in place. At the level of the MOH as health system steward, there is a need for 1) health financing and system performance data, 2) an organizational unit or units with assigned responsibility and work processes for setting health financing strategy and for oversight of performance of health financing, 3) staff with health system knowledge and analytical skills, and 4) a leadership focus on health financing strategy and performance. As noted above, the Kyrgyz MOH, with the wider Government and development partners' participation, has been able to mobilize resources for setting long-term strategies for the health sector, and with external support has been able to review these annually. This is a creditable achievement given that the MOH itself is very constrained in data quality and in staffing (with a complement of around 70 staff and permanent unfilled vacancies), particularly in analytical skills. As noted above, it does not have dedicated staff responsible for monitoring MHIF performance and has no established routine work processes for doing so apart from the externally supported annual health strategy review. Leadership challenges include frequent changes of government and minister, and a high reactive workload – notably for responding to individual complaints and requests from citizens, and parliamentary queries.

At the level of the health purchasing agency, the MHIF's governance body needs to receive competent proposals for strategic orientations and policies and reliable reports based on accurate data from the MHIF's management and staff. At this level too, effective governance requires adequate data and information systems, analytical capacity and organizational processes within the MHIF – supported by a management commitment to openness and transparency to the SB. For the governance body to drive improvement in MHIF performance and corrective action on any problems, the management must take responsibility and must be able to respond to governance directions, which in turn requires appropriate organizational structure, staff technical capacity and standard operating procedures for ensuring follow-up to governance decisions. In addition, the quality relationships between the multiple governance actors, the MOH, the MHIF, the MOF and other SB members and key stakeholders need to be conducive to results-oriented governance. A culture of constructive, open relationships can facilitate the formal processes of government.

The MHIF's management, with WHO support, has begun to strengthen aspects of governance processes that are within its control, in response to the recommendations of WHO's 2016 assessment. The MHIF has developed a multi-year rolling institutional strategy, approved by its SB, which serves as

a basis for standardized reporting to the SB on progress and results (MHIF, 2017). The MHIF management has instituted standard operating procedures for supporting the SB – i.e. timely production of agendas, papers and minutes and regular standardized financial and performance reports. The MHIF has taken steps to increase the transparency of its purchasing activities through SB reporting and publication on its website. It also has plans to strengthen monitoring and feedback to the health facilities it contracts with in order to strengthen the accountability of providers.

These commendable steps have faced some limitations. Although the data available to the MHIF on hospital care and some performance information through its administrative systems is much better than in many lower-middle-income countries, data quality still needs further improvement in order to provide a robust basis for using contracting as a lever for strategic purchasing. The MHIF does not yet have online or timely access to data held by the MOH and its agencies on population health, primary health care and outpatient services because the data systems of the two agencies are not integrated. Data and analysis on financial protection performance has to date depended on external technical assistance. At the same time, the experience in the past decade shows the ability of the authorities to use various data sources in the country and to prepare valuable policy briefs and analytical tools for decision support.

Secondly, changes to structure and staff mix of the MHIF have proved difficult to make in practice because of fiscal and pay constraints, and scarcity of key skills. Yet without changes to structures and functions, it is not possible to build capacity sustainably in areas that are vital for the development of strategic purchasing and other priorities in the MHIF strategy. Specifically, the MHIF is lacking structures and appropriate staff with primary responsibility for some critical

areas – including health economics, data collection, data management, costing services, developing case mix, setting prices, analysis of utilization as well as provider performance and capacity, analysis of patient demand and access, and the pharmaceutical and pharmacoeconomic capacity to develop and oversee the drug benefit package, drug reimbursement and pharmacy contracts. The MHIF does not have structures and staffing for these functions, although some data analysis is conducted by a strategic planning and analysis team. External analytical capacity supported by development assistance has proved unable to meet the need for timely, responsive operational analysis. Further, not all the knowledge is institutionalized within the organization, which is a risk for sustainability. This needs in-house capacity, with close links to management and operational divisions of the MHIF. External technical assistance has focused on improving data and in-house data analysis capacity in existing teams, but simply adding new responsibilities to the already very stretched staff will allow only incremental improvement. A process of organizational development and change management across the whole MHIF would be needed to bring about sustainable, institutionalized change in practices.

Subnational capacity and skills-mix is also variable, leading to a variety of practices in contracting in different oblasts, influenced for example by whether the local leadership has a chiefly medical, economics or finance background. A combination of national analysis of data, training of subnational staff and development of standard operating procedures is being used to help address regional variations and to improve the use of data for initial steps towards strategic purchasing. There is a need to build corresponding capacity in providers to build a shared understanding of data, activity and performance.

A third limitation is that the legacy of organizational culture and work practices is more suited to control and compliance than to the strategic use of finance for health-sector development and performance improvement. The MHIF (like the public sector more widely) lacks tools and ways of working that would enable it to hold managers and teams responsible for the completion of outputs and activities.

Finally, there is a limit to which MHIF management can be expected to lead efforts to improve governance and strengthen a weak and inactive SB; this really amounts to managers holding themselves to account. A weak board can readily be avoided or influenced in its decisions by strong managers in any country. In a post-Soviet context where reporting poor or even disappointing performance to any oversight bodies usually leads to punishment

regardless of whether it was due to factors beyond management control, managers are understandably reluctant to set challenging performance targets for their organizations or to report problems openly to the SB. The MHIF also faces periodical calls for its abolition or incorporation into the MOH from constituencies opposed to the reform model it represents, along with calls for changes of leadership on political rather than performance grounds. These forces are sometimes represented on its SB. This is a very different context from the western European concept of a board of directors as a constructive “critical friend”, supporting the management to strive for improvement (Institute of Directors, 2018b). It can be a risky and unrewarding activity even for a very good CEO to put effort into developing and working with the SB.

6. CONCLUSION: KEY CHALLENGES, POSITIVE ACHIEVEMENTS AND LESSONS

6.1. GOVERNANCE OF THE HEALTH PURCHASING SYSTEM

A major strength of the Kyrgyz health financing and purchasing system is the fact that there is a single purchaser, pooling some 80% of public expenditure and almost all spending on personal health services. This minimizes the issues of fragmentation noted in the WHO assessment framework as a major challenge in many health financing systems.

At the health-system level, the WHO assessment framework for governance brings out the importance of **consistency and coherence** across the multiple bodies involved in governance functions. Because the MHIF's CEO and management board have multiple lines of accountability under the current organization of the health financing system in Kyrgyzstan, an effective **triangle of coordination and accountability** – MOH, MOF and the MHIF's SB – needs to carry out the four main tasks of governance. Unless these three bodies align their policies and implementation plans for the health system, and coordinate their oversight, they will be hampered in their ability to hold the MHIF accountable for making progress on the interrelated objectives of improving financial protection against catastrophic expenditures and improving access to cost-effective health services of reasonable quality. The paper has documented how the lack of coordination across these bodies, as well as specific shortcomings within each body, has hampered the effective exercise of governance functions.

This triangle of governance has operated effectively (in coordination with the Prime Minister's administration) in setting a broad

health-sector vision and strategy, though the SB itself has not played a significant role. There has been reasonable stability in health system strategy and structures over time, and the latest strategy for 2019–2030 “Healthy Person – Prosperous Country” was recently approved. Until now, however, none of the three oversight bodies has played a role in ensuring that the strategy is translated into specific goals for the MHIF – measurable desired achievements, followed by specific initiatives and programmes to be performed by the MHIF to reach these goals – for which they could hold the MHIF management accountable. As noted earlier, inconsistent or conflicting policies and operational actions have sometimes been adopted by the three oversight bodies. One example of policy inconsistency which has proved to be an obstacle to good governance in the last decade is the wide financing gap for the SGBP. Longstanding failure to address the mismatch between the SGBP and the MHIF budget constraint (combined with lack of MHIF autonomy and influence noted below on key health financing decisions) undermines the ability to hold the MHIF to account for financial protection or access to SGBP services. But there are also examples of MHIF using its contracting and payment leverage to achieve efficiency gains and some performance improvement. As well, there are examples of alignment of action across the MOH, key providers and the MHIF in some priority areas of the strategy, particularly in priority disease areas such as increasing detection of hypertension and improving efficiency in tuberculosis control services.

6.2. GOVERNANCE OF THE PURCHASING AGENCY: THE MHIF

Importance of clear and coherent division of decision-making authority among the governance bodies and the MHIF

The division of roles and authority to take decisions between the MHIF management and its multiple governance bodies – principally the MOH, SB, MOF and PAC, but also the Prime Minister who appoints the CEO – is not always clear and coherent. The SB's role largely overlaps with those of the MOH and MOF. Where there is role overlap, the SB could be the forum for regular processes for coordination of decision-making between the MHIF, MOH and MOF, but until now it has not carried out this function.

The legal framework and status of the SB does not give it the formal level of decision authority, duties and responsibilities found in company boards of directors or trustees of private nonprofit-making organizations. The boards of comparable MHI entities in the region, such as Estonia, have much greater influence over innovation of payment methods, can fine-tune details of the benefit package through clinical guidelines or protocols, and have more freedom to contract innovatively and selectively for some services. Because the MHIF has no authority to issue regulations, it requires MOH approval even for very operational matters which are usually delegated to an MHIF's management. This diverts the MOH's focus away from a results-oriented approach to MHIF accountability and perpetuates the legacy of detailed prior controls over operations.

Importance of strengthening supervision and focusing it on results in the public interest

Although the MHIF's SB has a formal mandate to supervise the MHIF with regard to its results (outcomes for the public), and not just its activities, the SB has only recently taken steps towards this. It has

Giving greater decision-authority to the SB would give it the potential to act as the primary oversight authority, and the forum for coordinating decisions across other key governance actors: notably the MOH and the MOF.

On the other hand, the MHIF has responsibility for, and an implementation role over, some aspects that in many countries are the responsibility of the MOH and its attached agencies. In the absence of an MOH-led system of quality management, the MHIF sets quality indicators and targets and monitors them as part of a new quality-based payment initiative. Similarly, in the absence of any active ownership role by the MOH to monitor provider financial performance and efficiency (e.g. to take action where public providers have financial deficits), the MHIF is responsible for financial monitoring of public providers and for negotiating solutions for unsustainable MOH providers (such as changes in staffing and optimization of some facilities). To enable the MHIF to focus on its primary purchaser role, an alternative governance body should be responsible for addressing ownership issues of public health-care providers, such as financial non-sustainability and mismanagement, and for making decisions on investment and disinvestment in the public health facility network.

recently begun to institute more regular meetings. In 2017 the SB approved the MHIF's first institutional strategy, and since then it has received regular reports from MHIF management. However, this has

been an initiative of the MHIF's CEO; the SB and the other two oversight bodies (MOH, MOF) have been relatively passive.

Current management initiatives to improve reporting to the SB are helpful initial steps but will inevitably face limitations as a basis for generating challenging (but realistic) results objectives and indicators, given the history and context of punitive responses to performance issues. At this stage, the SB has not demonstrated capacity to be the main governance body for the MHIF. Other elements of the formal government environment in line ministries, together with informal mechanisms through networks of supporters of reform, have taken the weight of responsibility for responding to major challenges and managing risk facing the MHIF and the single-payer system. To a large degree, this reflects the country context. In sectors other than health, we do not see examples SBs or corporate governance boards playing a steering role or holding organizations accountable for results. In the absence of familiar examples of this model of governance, the Kyrgyz Government, civil society and the MHIF SB members themselves do not expect the SB to play such a role.

The MOH does, however, convene the Joint Annual Review of the health strategy with development partners at which the MHIF, along with other agencies of the health system, reports on implementation progress in the strategy at a high level regarding the strategy's objectives. Although the prospects for increasing MOH capacity

to provide the technical support for this process are very constrained in the Kyrgyz context, external support can continue to strengthen the process, with benefits for governance. Some stakeholders (including parliamentarians and development partners) raise challenges over results as well as activities in these reviews, drawing on externally-supported technical inputs as well as national expertise. Recent review of the ongoing third health sector strategy called for a more results-oriented approach to monitoring and accountability by the MOH.¹¹ However, a significant barrier to strengthening the MOH's role in holding the MHIF accountable for results is the tension between the MOH's stewardship role (focused on outcomes for the public) and its role as owner and sponsor of the public-sector provider network.

Complementary reform – the MOF's programme budgeting reform – has led the MOF to initiate a process of putting in place a more results-oriented reporting regime for MHIF alongside the budget, though SMART¹² indicators and realistic targets have yet to be developed and will have to align with the monitoring indicators used in the health sector strategy and by the MHIF for reporting to the SB. In a best-case scenario, the MOF role in advocating for results-oriented monitoring through the budget framework for both the MOH and MHIF could provide an entry point for greater alignment of oversight between the MOH and MOF.

Benefits of increased transparency and public information

The documents that form the main focus of the MHIF's governance relationship with its SB – its institutional strategy and regular reports – are not yet readily available to the public. Nevertheless, the

MHIF's management initiative to submit these documents to its SB represents an increase in transparency. The MHIF has also increased internal transparency in its relationships with providers by introducing

¹¹ This section of the paper draws on an unpublished paper by Oxford Policy Management (OPM), entitled Independent review of Den Sooluk and project in support of mid-term review, produced for the MOH and development partners and disseminated in 2016.

¹² That is, Specific, Measurable, Achievable, Relevant, Time-bound indicators.

standard operating procedures that reduce undesirable local management discretion and make the MHIF a more predictable and understandable counterpart for providers. These are important steps. Yet meaningful reporting, information to enable the SB to take robust decisions, identify and manage risks and exercise real accountability have been hampered by very deep-rooted weaknesses in the range and quality of data available in the MHIF and MOH information

systems and weaknesses in capacity to analyse the data. Issues with data on health service provision and quality of care also hamper the MHIF's ability to carry out its purchasing functions and produce information for policy formulation.

There remains room for improvement in the transparency of MHIF reporting to the public, and this should be complemented by addressing conducive factors.

Importance of balanced, capable stakeholder participation with attention paid to conflict of interest

The MHIF SB and PAC provide for stakeholder participation in governance structures from contributors, worker representatives and civil society. In practice, this has not resulted in meaningful engagement of stakeholders in governance functions. Stakeholder representatives without governance experience or health-sector knowledge on these boards have proved to be passive SB members, unprepared and cautious about taking on governance responsibilities. Lack of clarity about how stakeholder members of the SB and PAC are themselves accountable to the constituencies they

represent, and lack of rules to address conflicts of interest also lead to reluctance to give stakeholder participation a greater role.

It should be possible in the Kyrgyz context to address these challenges to a greater extent, although this will require action beyond the health sector. The PAC legislation, in particular, is cross-sectoral, applying to all public sector bodies. Review of civil society representation on the SB could be initiated by the health sector.

6.3. CONDUCIVE FACTORS RELEVANT TO GOOD GOVERNANCE

Lack of familiarity and experience with the role of governance bodies affects all the members of the SB. The result is an SB that lacks capacity to assess the proposals it receives from MHIF management and to provide an appropriate balance of challenge and value-adding, supportive oversight and advice to the MHIF CEO and management team. A recent initiative to train board members attempts to tackle this. In addition, proposals to revise the membership of the SB have been developed

to ensure it has members with knowledge of the health sector, strategy, law or MHIF functions, as well as financial skills which are required to participate in an audit committee.

In the MOH and MOF divisions that have governance roles in relation to the MHIF, there is also insufficient understanding of results-oriented governance, although these organizations do have a small number of staff with health-sector and

public financial knowledge relevant to MHIF governance. In the MOH, very small numbers of staff, high vacancy rates and turnover will present ongoing challenges to the development of these organizations' roles in governance.

The MHIF itself has proved to be a positive entry point for developing conducive factors: the MHIF has a strong interest in improving data, strengthening its analytical skills, and systematizing its internal strategic planning and reporting processes. The MHIF has welcomed support from WHO

and other development partners in these areas, and they all have positive spill-over benefits for MHIF's relationship with its governance body and the quality of inputs the SB receives.

The initiative to strengthen MHIF governance in Kyrgyzstan has come from its management, with support from development partners. Having a management team in the MHIF that has a culture of holding itself accountable and striving for improvement creates conditions for governance to add value.

7. RECOMMENDATIONS

Experience with MHIF governance over 20 years has demonstrated that it is very difficult to create new governance mechanisms for an autonomous public health insurance agency in a context with little experience of classic “western European” corporate governance and limited governance capacity. At the same time, the multiple lines of accountability of the MHIF have

provided effective checks and balances, and there is a process for bringing health-sector stakeholders together periodically to develop national strategies. Greater focus on clarifying and dovetailing the new governance mechanisms which guide how the SB interacts with the existing lines of accountability and authority could have been helpful.

7.1. STRENGTHENING THE AUTHORITY AND CAPACITY OF THE MHIF SUPERVISORY BOARD TO BRING MULTIPLE LINES OF ACCOUNTABILITY TOGETHER

In the last two years, efforts by the MHIF CEO and management team, supported by WHO, to put in place basic good governance practices in strategy formation, reporting to the board and transparency of board decisions have been put in place, and training has been offered to SB members. Very practical support to the MHIF management and board members along these lines has proved to be both necessary and helpful as an entry point for strengthening governance. However, these can only be first steps. Ultimately, the management of an agency cannot be expected to set itself challenging targets and openly disclose disappointing performance and unanticipated problems to a weak SB. This is a major issue in a context such as that of Kyrgyzstan where this type of accountability is not well established and where there is a history and culture of hierarchical control, exercised in sometimes arbitrary and punitive ways.

Strengthening the process of translating the high-level health sector strategies into institutional strategies for all of the implementing agencies – the MHIF, but

also the MOH and regulatory agencies – can help to make policy formulation more realistic. The MHIF has made a start on this, but there is a need for coordinated action to do this in other agencies in the health sector.

It is inevitable that the MHIF will continue to have multiple lines of accountability: this is not unusual for similar agencies internationally. With some changes to its membership and charter, the SB could be developed into the body that brings these multiple lines together – the MOH, MOF, prime minister’s administration, other involved government bodies and the parliamentary health committee. The SB could further be clearly mandated to coordinate the MHIF’s institutional strategies and implementation plans with the wider sector strategy and to monitor the MHIF’s progress. The SB could become the approver of the MHIF strategy, structure and annual reports, and could make agreed binding recommendations on policies and regulations proposed by the MHIF to the respective ministries (usually MOH or MOF) or Government (whichever

has statutory authority). Strengthening the role of the SB will require regulation and carefully brokered agreement, reinforced by clear standard operating procedures.

Although the Kyrgyz MHIF has limited capacity, it has higher capacity on health finance than the MOH has. The health system would benefit from giving the MHIF clearer authority and greater influence on health financing policy and regulatory decisions. In the Kyrgyz context, any suggestion to increase the autonomy of the MHIF is widely misunderstood to mean that the MHIF management (as distinct from the SB) would be given greater power. Consequently, any recommendations for increasing the authority of the MHIF SB need to be communicated carefully to emphasize that checks and balances are vital. In a well-governed system, the mandate and autonomy given to the MHIF should be matched by commensurate accountability – to the SB (and via the SB to the Government) – and the necessary capacity for making and implementing the decisions within its authority (Svedoff & Gottret, 2008). This increase in accountability is not feasible without continuing to address the weaknesses in capacity of the SB, as described in this paper, through regular induction training of new board members. In addition, further work to put in place good governance practices and to strengthen reporting to the board would assist the SB to focus on strategic issues and to monitor results in order to hold the agency accountable in the public interest.

In order to empower the SB, it might be necessary to clarify its decision authority in primary legislation. Without this, it will remain difficult to get the members – in particular the MOH and MOF – to take their SB roles seriously and use the SB as the key forum for discussing and reaching joint agreement on policy and strategy. A legislative mandate would be able to make the SB the primary accountability

body and forum for coordination. The SB could be given authority to make decisions on aspects of health financing policy and strategy matters currently assigned in law variously to the MOH and other line ministries. It might be possible, for instance, as with the Estonian Health Insurance Fund, to give the SB the role of being the forum in which key strategic policies and regulatory decisions currently made by the MOH and MOF separately are made in a single joint process, allowing greater coordination and enabling a balancing of views of the key government agencies with a role in health financing. As in Estonia, the SB could become the body that discusses and approves proposals on the benefit package, strategic budget allocation, provider payment and pricing before they are submitted to the Cabinet of Ministers.

In this context, focusing the membership of the governance body on representation of agencies with key roles in MHIF accountability (notably the MOH, MOF, prime minister's or presidential administration, parliamentary health committee) may be appropriate, using the SB as a mechanism for bringing multiple lines of governance together and coordinating them. However, devising mechanisms to ensure there is some continuity of board membership during government transitions would also be helpful.

It is also worth considering whether to give the SB a role in making recommendations to the Government on the selection of the MHIF's CEO. This is usually a role of the governance board. In some countries, board involvement can help to reduce politicization of the appointment and reduce instability in the post. But in the Kyrgyz context, given that most SB members themselves are political appointees and subject to turnover when the government changes, it is not clear that SB involvement in the appointment would make a difference.

7.2. DEVELOPING MORE BALANCED AND MEANINGFUL STAKEHOLDER PARTICIPATION

The MHIF experience suggests that the SB is not an effective forum for wide or representative public and stakeholder participation. It leads to an unwieldy board with many passive members. Stakeholder representation at SB level requires members who also have governance and sector knowledge in order to have confidence to participate in meetings. They need to be accountable to the public. Representation of the parliamentary health committee on the board meets these criteria. The Kyrgyz experience with PACs highlights the need for this type of public representation mechanism to have both requirements on skills and rules on conflict of interest. Nevertheless, the positive experience of the Kyrgyz health authorities with widespread consultation over strategy formulation demonstrates the willingness of the health system to communicate with and listen to stakeholders. There seems to be potential to amend the selection criteria and balance of membership on the MHIF PAC and ensure longer terms for members in order to make it a more constructive and engaged forum for providing civil society input to the MHIF SB's key decisions. As with the SB, there is a

need for induction training and for putting in place good practices for setting board agendas and reporting to and from the PAC.

There is a case for reducing the number of passive stakeholder members in the SB, streamlining representation of external stakeholders and civil society, and developing alternative mechanisms for the MHIF to engage stakeholders in decisions that affect them, drawing on these more positive experiences. For instance, public participation might be enhanced through consultation over decisions on the benefit package, strategic purchasing priorities and service changes initiated through contracting, or obtaining input on patient experience as part of quality monitoring

Wider civil society input on health financing policy and MHIF performance would be enhanced by increased transparency to the public – e.g. through publication of the institutional strategy, plans and reports on the website. Publication of information could help to create citizen and stakeholder pressure for improvement in the work of the SB (Kaplan & Babad, 2011).

7.3. SUPPORTING MHIF INTERNAL MANAGEMENT AND CAPACITY – FACTORS CONDUCIVE FOR GOOD GOVERNANCE

There is likely to be potential to make faster progress in tackling the challenges of strategic purchasing in the Kyrgyz single-payer system by focusing on strengthening the internal management and capacity of the MHIF in key areas – such as data analysis, contracting, refining of provider payment methods, and financial management. Developing results-oriented

governance at the level of the SB is likely to be a much slower process, although it is an important complement. These key areas of internal capacity development are in any case conducive factors for more effective governance.

Although the Kyrgyz health system has had some very positive experiences of technical

assistance and support from development partners, the MHIF's experience also suggests that there is no substitute for building internal capacity for analysis for contracting providers and reporting to stakeholders and that technical assistance works best when it is embedded and works closely with relevant internal staff (World Bank, 2016; World Bank, 2018).

Practical help to the MHIF's management to put in place the basic governance practices of institutional strategy formulation, board agenda-setting and board reporting has shown promise in the Kyrgyz context, and would have been beneficial when the MHIF was first established as an independent agency.

7.4. CONSIDERING ALTERNATIVES TO THE “CLASSIC” MODEL FOR GOVERNANCE OF AN INDEPENDENT HEALTH PURCHASING AGENCY

The above recommendations are built around an aim of making the “classic” model of governance of an independent MHIF by an external SB work more effectively in the Kyrgyz context. However, it is perhaps worth considering alternatives to the “classic” model of governance in this type of country context. One option would be to focus on continuing to build strong internal management, systems and capacity in the MHIF and strengthening processes for coordination with the MOH and MOF – the main triangle of accountability. It could make sense to develop and formalize this coordination of government oversight and accountability for the MHIF within the existing system of Cabinet committees chaired by the Vice Prime Minister or presidential administration. Under this option, the SB could continue to play a role as a forum for discussion and consultation with key stakeholders, rather than as the main or primary oversight body. The SB could still have value as a complement to traditional governance mechanisms based on hierarchical line-ministry controls. The Government could consider merging the role of the SB with one of the multiple

other government-appointed committees for overseeing health policy and strategy in order to reduce the number of parallel processes.

The Kyrgyz experience brings out the importance of support for developing both ends of the accountability relationships – clarifying the MOH stewardship roles and the MOF oversight roles, and building relevant capacity to play a major role in MHIF governance. This is important under both the “classic” model of governance or the alternative suggested here and focused on using the SB as a forum. In particular, there would be benefit from building the MOH's and MOF's internal capacity and business processes for reviewing MHIF institutional strategy, aligning it with budget formulation, monitoring results, and responding to MHIF policy and regulatory proposals. Health-sector investment in these capacities would benefit from wider multisectoral efforts to strengthen general government processes for coordination and accountability lines – such as the Cabinet committee processes and the budget processes.

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For additional information, please contact:

Department of Health Systems Governance and Financing
World Health Organization
20, avenue Appia
1211 Geneva 27
Switzerland

Email: healthfinancing@who.int
Website: http://www.who.int/health_financing

