CORRUPTION IN THE HEALTH CARE SYSTEM IN KYRGYZSTAN:INFORMAL PAYMENTS

By

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Abstract

After the break up of the Soviet Union, Kyrgyzstan has undergone from planned to market economy, which led to significant changes in all key sectors of the country. Actual change to the Kyrgyz health care system happened when the reformation process has started, which promised the universal coverage for every citizen, ensuring affordability and accessibility to healthcare services. However, due to the rise of informal market, the health care reforms, which proposed the principle of universal coverage, aimed at refinancing the system, increasing affordability and accessibility to health care seem to fail to implement its goals. Thus, the following questions arise: Why informal payments become an integral part of the health care system in Kyrgyzstan? Why informal market turn to be a major impediment to health care reforms? This paper is concentrated at identifying the causes of informal payments in the system, by looking at the vulnerable populations that are most susceptible in accessing healthcare services.

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Introduction

The health care sector is considered to be one of the most corrupt sectors in many developing countries, Former Soviet Union (FSU) states and Central Eastern Europe (CEE).[1] Corruption in the health care sector includes different practices such as absenteeism, fraud and theft of medical supplies, informal payments, diversion of supplies in the distribution system for private gains and embezzlement of health care funds.[2] Each of these practices alone represents a major challenge in many developing countries.

It has been revealed that the health sector is identified as the most corrupt in many developing countries[3], and informal payments are considered to be one of the forms of corruption. Corruption can be defined as 'use of public office for private gains'.[4] While informal payments or so-called out-of-pocket payments have been defined as 'payments to individual or institutional providers in-kind or cash that are outside the official payment channels, or are purchases that are mean to be covered by the health care system'.[5] According to some researches, it has been recognized that trend of out-of-pocket payments for health care became common for the Central Asian region.[6] The decline in government spending of the health care sector has been an increase in private expenditures by household, both in terms in terms of official charges

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1 Waly Wane, "Informal payments and moonlighting in Tajikistan's health sector", The World Bank

2 United Nations Development Programme, "Fighting corruption in the health sector: methods, tools and good practices", 2011

3 Waly Wane, "Informal payments and moonlighting in Tajikistan's health sector", The World Bank

4 Bardhan, "Corruption and Development: A review of issues", Journal of Economic Literature , Vol. ,35, No. 3. (Sep., 1997), pp. 1320-1346, http://links.jstor.org/sici?sici=0022-0515%28199709%2935%3A3%3C1320%3ACADARO%3E2.0.CO%3B2-6

5 Angela Saschieri, Jane Falkingham, "Formalizing informal payments: the progress of health reform in Kyrgyzstan", December 2006, 25(4), 441-460, p.442

6 Jane Falkingham, Baktygul Akkazieva, Angela Baschieri, "Trends in out-of-pocket payments for health care in Kyrgyzstan", 2001–2007

and informal payments.[7] Unfortunately, informal payments constitute a significant component of overall spending in the health care not only in Kyrgyzstan but also in other FSU states; in addition such payments became a major obstacle to healthcare reforms.[8] Therefore, the following questions arise: Why informal payments become an integral part of the health care system in Kyrgyzstan? Why informal market turn to be a major impediment to health care reforms?

Kyrgyzstan is one the FSU countries that has stepped onto the road of democracy right after its independence, trying to build a democratic republic and embed these ideals to its system. It's has been considered that the most successful reformation of the health care system of FSU countries took place in Kyrgyzstan. However, due to its inability to manage the problems, such as poor governance, corruption, misuse of power and political instabilities posed threats to the well being of its citizens. The health care reforms which proposed the principle of universal coverage, aimed at refinancing the system, increasing affordability and accessibility to health care seem to fail to implement its goals, being unable to fight with the corruption in the system.

After the break up of the Soviet Union Kyrgyzstan have experienced the economic upheaval accompanying from a planned to market economy.[9] Its health sector faced with insufficient financial resources, inability to contain inherited from the Soviet period, a strong infrastructure with a predominance of the hospital sector and excessive specialization of health services.[10] A key concern of the country was to build a strong

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[7] Ibid, p.446

[8] Ensor T; Savelyeva L (1998) Informal payments for health care in the Former Soviet Union: some evidence from Kazakstan. Health Policy Plan, 13 (1), pp. 41-49.

[9] Angela Saschieri, Jane Falkingham, "Formalizing informal payments: the progress of health reform in Kyrgyzstan", December 2006, 25(4), 441-460

[10] Ibid.p.442

financial health system which will secure additional financing for health care services through non-budgetary sources, such as payroll taxes, premium-based insurance and increased private financing through patient cost-sharing.[11]

During the Soviet time the health system was based on Semashko model, which proclaimed the principles of universal access to free medical services, state provision of health and the preventative orientation of health care.[12] Following these principles, the health care system was controlled by the state and was designed to provide all citizens with access to a basic level of care. The Soviet health system was a single-payer scheme, where the government was the main provider of all health care free of charge. The system was divided into three divisions: republican, regional (oblast) and district (rayon). Republic-level health ministries were responsible for implementation Moscow's policies through oblast-level health departments, which in turn were responsible for rayon and city health administrations. [13] The Soviet health system was built in such a way, that every citizen was assigned to certain polyclinic that assumed responsibility for the person's health, providing the basic care. But the disadvantage of system was that financing mostly was based on funding hospitals according the their bed quantity but not the number of patients. Such treatment required a large number of beds, which led to low occupancy levels.[14] This was one of the accompanying reasons of the Soviet system's failure at not meeting the expectations of populations in providing universal healthcare coverage; in addition to that no private health care or health insurance was permitted during that time, which also had influenced on its failure. The collapse of the

[11] Ibid.p.444

[12] Martin Mckee, Ainura Ibraimova, Bernd Rechel, Adilet-Sultan Meimanaliev, "Health Care System in transition", Kyrgyzstan 2005

[13] Ibid p.14

[14] Ibid p.22

Soviet Union meant the collapse of a unified health system, which forced FSU states to undergo a comprehensive reform of its health care to rationalize financing and to emphasize primary care.[15]

The most institutionalized, complete and the most successful reformation has taken place in Kyrgyzstan.[16] The initiation of reform process has started in the late 1990s, where the Government of the Kyrgyz Republic approved a number of key legislation for creation a platform for systematic and holistic healthcare reform with the objectives of: reducing inefficiencies, improving equity and access (geographically and financially) and improving quality of healthcare services.[17] The two major national programs, which were aimed at restructuring the health care system, were developed in the country starting from 1996. *Manas* (1996-2006) and *Manas Taalimi* (2006-2010) and the latest program that was launched 2 years ago, *Den Sooluk* (2012-2016) are oriented on reforming the health care delivery system, financing system, improving quality of health care and providing universal coverage to the population.[18] These programs have achieved the extensive results by implementing the Co-payment system and the Single Payer system under the state-guaranteed benefit package (SGBP) that were designed to create a new financial and organizational structure, which encourages more efficient and more equitable use of resources.[19] Moreover, the country has

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15 Genevieve Gramba, "Central Asian Public Health:Transition and Transformation"

16 Balabanova, McKee, Mills, Chapter 5, Kyrgyzstan: A regional leader in health system reform. 'Good health at low cost' 25 years on. What makes an effective health system? London: London School of Hygiene & Tropical Medicine, 2011

17 Martin Mckee, Ainura Ibraimova, Bernd Rechel, Adilet-Sultan Meimanaliev, "Health Care System in transition", Kyrgyzstan 2005

18 Ibid, p.99

19 Who/Manas Health Policy Project, "Single Payer System of the Kyrgyz Republic", Policy Brief

introduced social health insurance (SHI) as the main instrument to transform the entire system of health financing.

During the Soviet time, the phenomenon of informal payments was not identified as one of the reasons in limited access to healthcare, though phenomenon existed for a number of decades. Most of the people would consider them as gratitude or gift to a doctor. It is likely that during the Soviet time they were perceived as illegal, and the issue was difficult to discuss openly.[20] However, today with the promises of the government to provide universal coverage and access to every citizen seems to fail in its implementation. It is reasonable to look at the nature of informal payments in the country relying on experiences of CEE and FSU states, because they violate the transparency in the financing of the health care systems, jeopardize the accountability of the providers, and also lead to inefficient use of health care resources and inequalities in access to health care services.[21]

Taking into the consideration that informal payments are one of the forms of corruption, the purpose of this paper is to look at informal payments in health care system as one of the constituents of corruption, which may threaten the goal of universal health coverage and increase inequality and accessibility to healthcare services, especially amongst the vulnerable populations. The burden of corruption in the health care system influences the vulnerable populations at most, given their limited access to healthcare services. The hypothesis of this paper is that the informal payments cause a major impediment in accessing healthcare services of vulnerable populations, which

[20] http://www.biomedcentral.com/1472-6963/10/273

[21] Petra Baji, Milena Pavlove, Wim Groot, "Exploring consumers' attitudes towards informal patient payments using the combined method of cluster and multinomial regression analysis - the case of Hungary"

poses a threat to the well being of its citizens, having effect on health indicators such as infant and child mortality, increase of dangerous infections such as HIV/Tuberculosis, and irrational health spending. [22]

At first, in order to set the ground for exploring the phenomenon of informal payments, it is reasonable to look at the historical background of the health system in the Kyrgyz Republic, because the reformation of the system has taken place during the transition period. Then it is important to examine corruption in the health care system, by building a framework that consolidates some of concepts that were developed before. The third step is to look at the experiences and lessons of FSU and CEE countries dealing with informal payments to see to what extent it is widespread in the health care system. And the last step is to present findings of the research and to make recommendations on how to reduce informal payments in the health care sector and improve access of healthcare to vulnerable populations.

The research method that was used in this work is a qualitative and quantitative approach. There is lack of information on vulnerable groups in the Kyrgyz Republic overall, and it was difficult to find reliable sources, so that's why the information was gathered through survey and interviews. The survey (see in the appendix I) I conducted among the vulnerable groups, namely with patients of methadone therapy (ex-drug users), where I identified how many were prone to informal payments. In addition, I did semi-structured interviews with the organizations that work with the vulnerable populations such as drug users, HIV-infected people, people in need of palliative care and people with Tuberculosis ("Alternativa v Narcologii", "Ergene", "Asteria",

[22] United Nations Development Programme, "Fighting Corruption in the Health Sector: Methods, Tools and Good Practices"

"Podruga", "Tais Plus 2"), because these groups are most susceptible in accessing the health care. In-depth interviews were conducted with the founders of these organizations in order to get more detailed information about problems and issues relating vulnerable groups in accessing to health care. The more information on informal payments was obtained from face-to-face interviews with the people from international organizations present in the health care sector in the Kyrgyz Republic, who were the most informed in this phenomenon in order to fill some gaps in the research. To obtain more information on informal payments in the health care system in the Kyrgyz Republic, I relied on official documents produced by the Ministry of Health Care of the Kyrgyz Republic, analytical papers published by the World Health Organization, articles produced by outstanding researches, and the legislature of the Kyrgyz Republic. Moreover, articles and interviews published in the international and local newspapers were taken into consideration.

There were two types of interviews: semi-structured and in-depth. At first, contacts of organizations that work with vulnerable groups were obtained through Soros-Foundation Kyrgyzstan. Respondents were reached by electronic mail, after which a meeting for interviews was arranged. I had list of initial questions, which were complemented with additional questions in order to clarify the point or to extend some ideas that were useful for the work. The director of Public Health program at Soros-Foundation Kyrgyzstan was also interviewed. During the interview he gave me contacts of the people that were more familiar with the issues I was doing a research on. (Snowball sampling) Moreover, several articles have been requested from the people who had necessary articles, that were not available online. (Dr.Falkingham articles through Asel Rysali- Master of Science in Health Systems and Public Policy)

The research paper is presented in the following sequence: the first chapter presents the historical background of health system in the Kyrgyz Republic in transition period, describing health financing system and giving an overview of the reforms; the concepts of corruption and phenomenon of informal payments on the experiences of FSU and CEE countries presented in the second chapter; and the last chapter will summarize the findings on informal payments in Kyrgyzstan and give recommendations for reducing out-of–pocket payments and improving access to the health care.

Historical background, Health Financing sector and Reforms

This chapter will give you background information on the health system of the Kyrgyz Republic after the collapse of the Soviet Union. Moreover it would describe the health financing sector, and give an overview of the reforms in the health care sector that were adopted after 1990s.

Actual change to the Kyrgyz health care system happened after the collapse of a unified health care system of the Soviet Union. The health system during the Soviet time was built on Semashko model, that developed the standards for providing health care, such as the distribution of resources, doctors per population and number of beds in the hospital, according to established norms by the government. The Semashko model proclaimed the principles of universal coverage that proposed access to medical services for free for the whole population. The health care system was controlled by the state, where the state followed the system of a single-payer scheme that provided with medical services free of charge. This system had three pillars: republican, regional and oblast. Every pillar had control over its health system, where they took care of finances, provided healthcare services, collected revenues and purchased medicals. To ensure universal health coverage, the Soviet system automatically assigned every citizen to certain policlinic, where he/she would get the basic care. Moreover, people working in the government, Ministries, enterprises were assigned to clinics where medical personnel could operate them.[23] Even in the rural areas, people could get basic care by accessing policlinics, also known as *selskaya vrechebnaya ambulatoriya* or SVA, or they could receive the first aid in health posts, *feldsher accousherksi punkt* or FAPs.[24]

[23] Genevieve Gramba, "Central Asian Public Health:Transition and Transformation"
[24] Ibid p.225

However, in case if you needed specialists or specialized and better equipped hospital for certain diseases, such as tuberculosis, cancer and other infections, you should have seek to the main city of each oblast or republic's capital city. The Soviet health care system, which was mostly concentrated on certifying this principle of universal coverage, lacked enhancement in quality of represented services. Poorly maintained and equipped facilities, low paid medical personnel and poorly qualified specialists were the main drawback of the system.[25] The main causes for obscure work of the system were poorly centralized control, lack of adequate financing and lack of innovations that brought the system to the dead line. With the break-up of Soviet Union, the one centralized system of the health care collapsed, which followed up with the creation of new economic and political systems that had to design comprehensive reforms to create new health systems.

After the collapse of the Soviet Union, Kyrgyzstan experienced a major reversal in both economic and social development. The economic upheaval led country from centralized to market economy that resulted in a dramatic drop in GDP and central government expenditure. The government spending decreased by 67% between 1990 and 1996.[26] However, Kyrgyzstan has made a rapid progress in strengthening financial protection, reorganizing its system towards primary health system and improving access to health services. The government started restructuring the system by approving a number of key legislation on the health protection of the citizens, by improving equity and access to health care, improving quality of services provided and reducing inefficiencies. In addition, the health policy objectives were identified, which aimed at

[25] http://content.healthaffairs.org/content/10/3/71.full.pdf

[26] Genevieve Gramba, Central Asian Public Health:Transition and Transformation, p.226

establishing system of primary health with an emphasis on family medicine, developing the health financing system, reducing the number of beds in the hospitals which composed 14.1% from 30313 in 2001 to 26040 in 2004 and rationalizing source allocation.[27] The Kyrgyz government has prepared two national health plans that aimed to reform the system of health care.

The two national programs *Manas* (1996-2006) and *Manas Taalimi* (2006-2012) introduced internationally recognized model of health care financing. These reforms led to a shift from specialist-oriented care to family practice, implementation of health financing reform, which introduced a system of a Single-payer and Co-payment system.[28] The third program, *Den Sooluk* (2012-2016) addresses these issues, which were mentioned above; moreover it is oriented on insurance of the principle of universal coverage with high quality health, sanitation prevention services and insurance status of its citizens. The last program was launched two years ago and it is still in the process of its implementation. In order to see what impact these programs had on the heath care system, especially health financing sector, it's important to take a close look at these national programs.

Manas Program was successful in adaptation of comprehensive and structural changes of health financing system and management of main objectives of the health system defined by the World Health Organization, such as access to health care, efficiency, system responsiveness to population needs and equity in resources allocation.[29] Also it brought changes to health services delivery system, developing

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[27] Martin Mckee, Ainura Ibraimova, Bernd Rechel, Adilet-Sultan Meimanaliev, Health Care System in transition, Kyrgyzstan 2005

[28] http://www.nationalplanningcycles.org/sites/default/files/country_docs/Kyrgyzstan/nhp_kyrgyzstan.pdf

[29] Kyrgyz Republic National Health Care Reform Program «Manas Taalimi» for 2006-2010

Family Medicine, introducing new payment methods, improving the quality of provided care and strengthening the role of public health.[30] As the Family Medicine was introduced in 1997, it was designed to provide universal coverage of essential primary care. Moreover, the following objectives were undertaken by the program, such as Additional Drug Package on provision of drugs to insured population at outpatient level for improving affordability and accessibility of drugs for populations; the introduction of the State Guaranteed Benefits Package (SGBP) and co-payment for health services.[31]

Restructuring financing sector of the health care system was the main goal of *Manas Program*. The program brought significant changes to health financing sector during the reform period. The step-by-step implementation was considered as important element of the success of the Kyrgyz Republic's national health reform program. The consistent steps were undertaken. The introduction of a Mandatory Health Insurance (MHI) financed through payroll tax to complement budget funds; followed by the centralization of the purchasing function under the Mandatory Health Insurance Fund (MHIF), and citizen obligations to copay through the introduction of the State Guaranteed Benefits Package (SGBP).[32] In 2001, the SGBP was introduced in two pilot oblasts, where the local budget funds have started to be pooled at oblast level.[33] The pooling of health funds at the national level allowed the system to more equitable allocation of resources and effective distribution of health resources based on population

[30] Ibid p.6

[31] Ibid p.7

[32] Antonio Giuffrida, Melitta Jakab, Elina M. Dale, Toward Universal Coverage in Health: The Case of the State Guaranteed Benefit Package of the Kyrgyz Republic, UNICO Studies Series 17, The World Bank, Washington DC, January 2013

[33] Manas Program, 1996-2006, Kyrgyzstan

needs, thus ensuring transparency of budget formation.[34] By 2005 entire country set up oblast pooling funds.

The SGBP presented the principle of universal coverage, by ensuring access to health care services, such as primary health care, inpatient care, emergency medical care, drug and vaccine security free of charge to the whole population. Moreover, this package has identified categories of people that are eligible for accessing free inpatient care and drugs provided free of charge for the people with chronic diseases, such as Tuberculosis, HIV/AIDS, oncology patients in the terminal stage, pregnant women, people with mental diseases and etc. All these categories fall into the category of vulnerable populations that are in need of open and equal access to healthcare services for free or according to the proposed privileges of copayment. According to the Constitution of the Kyrgyz Republic of 2010, in Article 47 declares the right of its citizens to health care, which underlines that each citizen of the Kyrgyz Republic have a right to get free medical care and health services on preferential terms only to the extent of state guarantees provided by law.[35] The category of vulnerable populations mentioned above is on the list of the citizen that is eligible for accessing free medical services under the SGBP.

It is important to see the estimates of health indicators, in order to evaluate the success of programs, which were aimed at improving the well being of its citizens. According to the estimates, the incidence of diseases has increased dramatically during the introduction of reforms, for instance the incidence of tuberculosis remained high in 2000 and in 2009, it was approximately 103.7 per 100 000 people, where the incidence

[34] Ibid, p.53

[35] Constitution of the Kyrgyz Republic, 2010, Art.47

in cities was significantly higher than in rural areas, especially in Bishkek and Chui region due to the relatively high density of population and flow of internal migrants, including those at risk.[36] Moreover, the Kyrgyz Republic National Programme 'Combating and preventing HIV/AIDS', aimed to reduce number of HIV/AIDS cases, in November 2009 adopted the Law 'On Public Health', on which the existing system of vertical HIV infection should gradually be integrated into the public health system.[37] However, since 2005 the trend of steady growth of newly diagnosed cases of HIV/ AIDS continued; in 2006-2009 it was 42.9% of newly diagnosed HIV cases, which was 4 times higher than in 2005.[38] Importantly, the prevalence of HIV infection among drug users in a survey of 2009 was 14.3%, which is almost twice than it was in 2007.[39] The country is still in the early stages of HIV/AIDS, but here are some factors, which create conditions for its rise: the widespread use of a syringe for drugs, widely practiced commercial sex, marginalization of vulnerable groups and low public awareness about HIV/AIDS. These estimates were identified during the implementation of the National Programs into the health care system.

While *Manas Program* was aimed at restructuring the system, *Manas Taalimi Program (2006-2010)* used a sector-wide approach (SWAp), which focused mainly on the financial protection, increased equity, access to services and improved quality, transparency and efficiency of the system.[40] This program became successful in

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[36] Martin Mckee, Ainura Ibraimova, Bernd Rechel, Adilet-Sultan Meimanaliev, 'Health Care System in transition' Kyrgyzstan 2005

[37] Manas Taalimi Program, 2006-2010, Kyrgyzstan, Bishkek

[38] Gulgun Murzalieva,Kanat Kojokeev,Elina Manjieva, Akkazieva Baktygul,Arnol Samiev,Melitta Jakab, 'Tracking Global HIV/AIDS Initiatives and their Impact on the Health System: the Experience of the Kyrgyz Republic'

[39] Ibid p. 120

[40] Manas Taalim Program 2006-2010, Kyrgyzstan

improving previous methods of financing, which influenced the efficiency of existing resources, more rational use, and quality of medical care. Before reforming financing sector, the system had four levels of financing (republican, oblast, rayon and rural) and each had its own vertically integrated health system.[41] Today, there are two sources of funding: state and private funding. Private means of financing health care are payments for rehabilitation at the expense of household income. Households carry out formal and informal charges for medical services provided, as well as purchase of drugs at their own expense. State and private funding is the flow of domestic spending. While the external financing comes from organizations co-financing the SWAp including the World Bank, the British Department for International Development, the German Bank for Reconstruction and Development, Swedish International Development Agency (SIDA) and the external funds where financing comes from international organizations such as USAID, the United Nations Population Fund (UNFPA), UNICEF, the International Committee of the Red Cross, the World Health Organizations and the Central Asia AIDS Control Project.[42] *Manas Taalimi Program* designed financing system in such way that it managed to integrate international donors directly into the general state budget of the country.

The health financing reform has started from the introduction of the Single-Payer system, that has combined the strengths of health care reform and ensured the following: the introduction and development of state guarantees, copayment system, pooling of funds and division of the health system of buyers and suppliers of medical services. The

[41] Martin Mckee, Ainura Ibraimova, Bernd Rechel, Adilet-Sultan Meimanaliev, Health Care System in transition, Kyrgyzstan 2005

[42] Martin Mckee, Ainura Ibraimova, Bernd Rechel, Adilet-Sultan Meimanaliev, Health Care System in transition, Kyrgyzstan 2005, p.41

Single-Payer for health care providers is MHIF that is under the government of the Kyrgyz Republic, not the Ministry of Health, thus managing a budget from its own and the accumulated funds from Social Fund.[43] According to MHI, 77.6% of population under insurance, while the number of uninsured is nearly 1 million people.[44] It is considered that mostly unemployed and housewives are socially vulnerable to the uninsured population.

Moreover, limited access to the heath care remains a problem, where informal payments for treatment and costs for pharmaceuticals are the main barrier in accessing healthcare for vulnerable populations. Even though, the SGBP had the list of people who are eligible for services and medicine free of charge or have discounts, it is still hard to get a proper medical service. In order to decrease informal payments in the sector, *Manas Taalimi* was aimed to increase wages of medical personnel that would contribute to the reduction of informal payments. Even the salary was increased; it did not decrease informal payments, the informal payments are prevailing in the sector.

The third program, *Den Sooluk* (2012-2016) has started two years ago and still in the process of its implementation. The program follows the goals of two previous programs, however it extended its objectives towards the principle of universal coverage with high quality health, sanitation prevention services, insurance status of the population and gender differences.[45] Moreover, the program has four priority areas: mother and child health, cardiovascular diseases, HIV and Tuberculosis.[46] This program

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[43] Who/Manas Health Policy Project, Single Payer System of the Kyrgyz Republic, Policy Brief

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[45] Den Sooluk Program, 2012-2016, Kyrgyzstan

[46] Antonio Giuffrida, Melitta Jakab, Elina M. Dale, Towards Universal Health coverage: the case of SGBP in the Kyrgyz Republic

won't be included in discussions in the scope of this work, because it is on stage of its implementation.

The National Programs have achieved significant changes to the health care system, by restructuring and rebuilding the financing sector, making it more transparent, effective and accountable despite of economic hardships and political instability in the country. The reformation of a system brought introduction of new systems, such as the Single Payer system, copayment with the SGBP and MHIF. The system transfer to national level, with the introduction of state guarantees program and copayment system allowed to trace the distribution of resources and to create more rational budget spending. The reduction of number of beds and medical institutions during the first program also allowed the system to more equitable use of resources. The reforms were successful in decreasing governmental spending on healthcare in the first three years of its introduction. According to the Ministry of Health, the programs have been successful in reforming the system, implementing new methods of financing which created the decrease in governmental spending on the health care. However, evaluations, reports and analysis of the first program done by international researches and the health policy analysis centers found that even though estimates seem to be positive, there were objectives that the program failed to implement. The objectives such as improvement of health financing system, equitable use of resources, reduction of out-of-pocket payments, accessibility and accountability of provided services were the main issues of the second national program that ought to be addressed, but because *Manas Taalimi Program* was completed only two years ago, the comprehensive evaluation and analysis of the program has not been done yet, so it is hard to make any conclusions regarding the success of this program. Nevertheless, the National Programs for reforming the

health care system of the Kyrgyz Republic have been considered successful in restructuring the old system despite of economic turmoil, political instability and corruption in the country. However, the corruption in the health sector poses a big threat to the well being of citizens, especially vulnerable groups. Due to insufficient attention to these groups, the system violates the principle of universal coverage, violating rights of a person for getting health care services and accessing to the sector, which then creates bigger problem such as increase of infectious diseases, child mortality and overall the well being of the whole population.

Corruption in the health care system: Informal payments

The health care sector is considered to be one of the most corrupt sectors in many developing countries, FSU states and CEE.[47] Corruption in the health care sector includes different practices such as absenteeism, fraud and theft of medical supplies, informal payments, diversion of supplies in the distribution system for private gains and embezzlement of health care funds.[48] Each of these practices alone represents a major challenge in many developing countries.

Informal payments constitute a significant component of overall spending in the health care sector in Kyrgyzstan, which create obstacles to healthcare reform, violating principle of universal coverage proposed by the system. In order to discuss the phenomenon of informal payments, at first, it is reasonable to look at literature on corruption in transition countries in order to understand growth of unofficial payments in the health care system in Kyrgyzstan. Then examine relevant concepts of corruption to explain informal payments in Kyrgyzstan that creating limited access to health care services despite of reforms made to the health system. This chapter is concentrated on addressing informal payments in the Kyrgyz Republic as being a barrier that put a limited access to the health care through looking at the suggested concepts and experiences of the FSU states and CEE.

There are various definitions of corruption that are given, such as 'use of public office for private gains' or 'abuse of public functions or resources for private benefit'.[49] By its nature, corruption is a complex social, political and economic phenomenon that

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[47] Waly Wane, Informal payments and moonlighting in Tajikistan's health sector, The World Bank

[48] United Nations Development Programme, Fighting corruption in the health sector: methods, tools and good practices, 2011

[49] Vian, Corruption and the Health Sector, U.S. Agency for International Development(USAID) and Management Systems International (MSI), 2002

has various types, such as grand, bureaucratic (petty) and political corruption, and different forms such as bribery, theft and fraud.[50] Corruption in the form of informal payments is common and widespread phenomenon in former centrally planned economies.[51] From economic perspective, transition from planned to market economy led to mass privatization and liberalization of prices in post-soviet states that created economic chaos in key sectors of the country.[52] Under the Soviet system, most of the countries developed their economies with strong emphasis on one particular sector, where Kyrgyzstan's economy was concentrated mostly on agriculture. With the collapse of Soviet rule, the country had struggle dealing with all sectors in one time, lacking experience and management, which led to poorly built economy. Corruption found in the health care system is the reflection of unsustainable economic development, poor governance and mismanagement of the system. In addition, political instability and weak policy reforms could be also considered as one of the factors inducing corruption.

The theory of 'inxit' presented by Gaal and Mckee is the most substantial theory on informal payments in health care.[53] They proposed that informal payments are the results of the shortage associated with the Semashko system, which is a reaction by patients and physicians. The main argument is that providers tend to exploit their market position for gaining profit at the expense of patients' interests. The problem is that such actions deter those who cannot afford such payments in order to have access to health care. The poorest and most vulnerable need healthcare the most, but will get least access,

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[50] Moses Montesh,Conceptualising Corruption: Forms, Causes, Types and Consequences

[51] Lewis,Who is Paying for Health Care in Eastern Europe and Central Asia?, Washington, DC:World Bank, 2000

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[53] Gaal P., Mckee M., 'Informal payments for health care and the theory of 'inxi', 2004, http://www.ncbi.nlm.nih.gov/pubmed/15239210

according to ‘inxit’ theory. Moreover, the collapse of Semashko system of the health care had appeared in the irrational spending of finances, the system that was overwhelmed by the number of hospitals and beds that created inadequate maintenance of state funding, by not putting the quality of the health care on the first place.

Poor governance, political instability in the country, unsustainable economy could be reasons for corruption on macro level, while uncertainty, suggested by Kenneth Arrow, is the central feature of the health sector on micro level.[54] People are uncertain on when they get sick, when illness occur, what treatments are needed to cure, where to get needed medical care and how much should they spend on health. That is why market for health care services is very different from other markets in terms of the scope for market failure.[55] It is hard to have a control over suppliers in the health care, as it is in other markets. With the privatization of most of the pharmacies, creation of private health care, it became harder to keep track of the flow of out-of-pocket payments and formal payments in the sector. The poor functioning of market create conditions for corruption and the uncertainty inherent in delivery health care services makes difficult to detect the occurrence of informal payments.[56] However, this concept of uncertainty created the opportunity for health reforms to take place in the country. With the creation of the new system, the health care was open for any changes, but the market failure in the country became a major obstacle for pure reformation to the system.

In addition to uncertainty, the second feature is considered to be asymmetric information proposed by Arrow that basically means that the information is not shared equally among health sector actors which has significant implications for a health

54 William D. Savedoff and Karen Hussmann, Why are health systems prone to corruption?
55 Ibid p.5
56 William D. Savedoff and Karen Hussmann, Why are health systems prone to corruption?

system's efficiency and its vulnerability to corruption. [57] Providers know better about the treatment for patients, companies that produce drugs know more about their products, and some patients know about SGBP and copayment system, while others do not.[58] Such situation creates the difficulties for patients in accessing health care and getting proper treatment and services from the providers. The asymmetric information can be analyzed within the framework of 'principal-agent' relationships.[59] Basically, the principal-agent problem states that providers (doctors) act to maximize their profits at the expense of the patients' interests.[60] This kind of relationships creates the environment pleasant for informal payments, for instance, when the doctors provide patients with more expensive medicine instead of the cheap one that has the same prescription, or they could advise to go to the certain pharmacy where the doctors have informal agreements on sharing the profit, in addition the sale of different medical supplies that supposed to be free or prescription of unnecessary drugs and tests also done in order to benefit. Such actions have a direct influence on the access of vulnerable populations to the health care, especially when people are poor. Moreover, the principal-agent relationships make difficult to monitor the flow of out-of-pocket payments, because of the behavior of providers, suppliers and patients, because all of them act on behalf of their interest. The problem comes, when the patients cannot afford to get medical care and provider of health care refuses to help. (Most of the cases with vulnerable populations) In Kyrgyzstan, need to pay for health care delayed poor from seeking care, in 2009 it was almost 56%, where most of people belong to special category of people or lived in rural

[57] William D. Savedoff and Karen Hussmann, Why are health systems prone to corruption?

[58] Ibid, p.6-7

[59] Ibid, p.7-8

[60] Na Nguyen, The principal-agent problems in health care: evidence from prescribing patterns of private providers in Vietnam, http://heapol.oxfordjournals.org/content/26/suppl_1/i53.full

areas.[61] All of this established a system that is prone to corruption and in which corrupt practices is inherently difficult to elicit.

The last feature of corruption in the health care is the large number of actors involved and the complexity of their multiple forms of interaction.[62] The main actors are the government, payers, providers, consumers and suppliers.[63] The presence of so many actors creates difficulties in monitoring activities of each actor, promoting transparency in the system and identifying corruption when occurs. The involvement of many actors in the system creates a multitude of interests, which might encourage corrupt behavior.[64] The main actors may be tempted to abuse their positions for gaining profit, political influence and power. Thus, it may become difficult to attribute punishment to a certain individual when corruption case is found.

According to Hussmann, uncertainty, asymmetric information and large number of actors are one of the vivid features of the presence of corruption in the system, whereas poor governance, poor functioning of market, no regulation of laws and policies, and mismanagement are more broad and supplementary causes of corruption in the sector.[65]The research will use three main features to reveal the phenomenon of informal payments, underline the presence of informal payments in the system and explain why vulnerable populations are most susceptible in accessing healthcare services. To consider informal payments in Kyrgyzstan, the experience and lessons of FSU states and CEE on informal payments will be valued sources for the research.

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61 Martin Mckee, Ainura Ibraimova, Bernd Rechel, Adilet-Sultan Meimanaliev, "Health Care System in transition", Kyrgyzstan 2005

62 William D. Savedoff and Karen Hussmann, Why are health systems prone to corruption?

63 Ibid p.8

64 Ibid p.8

65 Hussmann, The causes of corruption in the health sector, 2006

Informal payments for health care have been a great concern of many transition economy countries.[66] During the Soviet time, the informal payments were considered as a gift or gratitude to a doctor, while today, these payments create great obstacles in accessing health care. With the corruption prevailed in the system, the rates became high and many people cannot afford to get even a first aid, without paying the minimum. Therefore, informal payments can have negative effects on the well being of citizens. However, it not only creates hardships for patients, but also makes providers to practice corruption because of the low wages and difficult working conditions.[67] In most of the cases, patients pay out-of-pocket fees to gain access to health care, which are supposed to be free, to reduce waiting time, receive treatment, hospital meals, even bed linen, as well as to get better attention and better quality of treatment. The total health expenditure of informal payments constitute up to 75-80% in transition economies. Such situation creates a significant impediment not only in accessing healthcare services, but also makes it harder to get rid of phenomenon of informal payments in the sector.

Most of the literature describing informal payments in developing countries mentions it as a fundamental aspect of health care financing[68] and major impediment to health care reforms. According to its definition, unofficial payments are those made to individuals or institutions in cash or in kind outside official channels for services that are covered by the public health-care system. In the Kyrgyz Republic, the health care system pursues the principle of universal coverage; insuring its citizens with the provision of medical help and equal access to its services. Unfortunately, when it comes to practice,

66 Balabanova, Mckee, 2002

67 Van Lerberghe et al, 2002

68 Ting Liu, Monic Sun, Informal payments in developing countries' public health sectors,pp.514-524,2012

not every citizen has access to healthcare services. One of the goals of national reforms was to reduce informal payments by increasing wages of medical personnel and creating pleasant conditions for work. However, higher wages did not prevent health workers from accepting and requiring additional payment for services. The culture of acceptance of informal payments has been deeply rooted in the system, which made it difficult to curb opportunities for corruption. Even though, with the introduction of SGBP and copayment system, patients are still required to provide payments for medical supplies, healthcare services that do not need any payment.

However, from the one side, scholars propose that informal payments can ensure the continuous supply of services, even improve the responsiveness of health care, by improving quality of provided services, because of the patients' ability to pay. But the scope of this work is in providing and ensuring universal coverage to the specific group of people that are marginalized. Well, not all of them could be socially distracted, but the diseases they have might make them vulnerable to healthcare services. Most of the times, doctors refuse to accept patients if they know that they are injecting drug users, or patients with Tuberculosis, or even pregnant women that are HIV positive or injecting drugs, referring to the fact their assistance would not help with the diseases. Moreover, medical personnel not only charge payments for the services that are ought to be provided for free for the category of people under SGBP, but also apply higher costs for these services.

The phenomenon of informal payments could differ from the legal context of the country.[69] According to researches, informal payments could be not seen as corrupt, illegal and even informal, depending on the country. Well, Kyrgyzstan and Tajikistan

[69] Gaal, 2004

are exactly the case, where informal payments are not seen as the main practices that cause corruption in the sector, they have been integrated into the national system performance and couldn't be punished. Whereas, such countries as the Czech Republic, Estonia, Slovenia, their health system has no shortage of medical supplies and salaries of medical personnel are pretty high, however the existence of informal payments prevails in the sector. It is noticeable, that the causes for corruption in the health care system could differ from country to country, where the backgrounds of existence of out-of-pocket payments could vary.

Interestingly, experiences and lessons of the FSU states and Central Eastern Europe in dealing with informal payments state that they are three types of unofficial payments. There are informal payments that are linked to the key health care actors: informal payments are results of inability of health policymakers to reform the system; informal payments are results of providers misuse of market power (principle-agent relationship); informal payments are results of patients attempt to access better treatment and services outside of SGBP.[70] Having identified the type of informal payments, which suits Kyrgyzstan the most, will help to find out the roots of informal payments. It is important, to differentiate informal payments in the form of gift or bribe. Because of the cultural tradition of gift giving in the FSU and CEE states, informal payments in form of chocolate, flowers and presents would not be considered as an act of corruption and wouldn't be taken into account. Informal payments in the form of bribes for accessing better treatment or better attention from the medical personnel neither would be taken into account, because of the patient's interest and affordability to access better services.

[70] Ensor, 2004

In the scope of this work these two types of informal payments would be ignored in the analysis of findings.

The main problem, which makes harder to reveal to what extent informal payments prevail in the sector by relying on the experience of FSU and CEE states, is difficulties with distinguishing between formal and informal payments. Sometimes, vulnerable populations lack information about copayment system or SGBP that make them to pay for the services that ought to be free. That is where the medical personnel benefit. Or there are some cases when people come from rural areas to city to seek medical care, where they give bribes willingly more than it was demanded. The question arises: Why they do so? The answer is asymmetric information and uncertainty, where people are uncertain about the system; they lack information about copayment, insurance system and state guaranteed package. Thus, people assume that there is nothing for free, and that there is a need for bribes in order to get access and proper treatment.

It is important to consider that informal payments affect people on their economic status, and there are significant indications that poor and vulnerable populations are more prone to informal payments in the sector. However, according to surveys on households and empirical evidences from the FSU and CEE countries, it is been revealed that poor people usually pay the same amount of informal payments as the rich. And mostly the poor pay more in relation to income rather than rich, and they are likely to pay more than those who are rich and employed. This tendency may vary, depending on the country, region, poverty rates and policy efficiency in the health care. The main puzzle of this research is that the mortality rates and spread of infectious diseases such as HIV/Tuberculosis/Hepatitis C are the outcomes of limited access of

vulnerable populations to health care services. Thus, it is important to look at the main reasons of limited access to healthcare services from the patients' side. The next chapter concentrates on the findings of the survey and interviews, moreover it presents the recommendations for the reduction of out-of-pocket payments in the sector.

Findings of the research on informal payments in Kyrgyzstan

Informal payments influence vulnerable populations at most in accessing to health care. In order to find out what were the reasons for a limited access to healthcare services among vulnerable populations (drug users, HIV-infected people, people in need of palliative care and people with Tuberculosis) I conducted the survey in order to reveal how the patients of methadone therapy were prone to informal payments in the hospitals. Before looking at the results of the survey, it is important to know what is the methadone therapy and who are its patients.

Methadone substitution therapy or methadone maintenance treatment is the therapy, which is aimed at the reduction of heroin use and has been an alternative to the opioid on which the patient is dependent.[71] This therapy helps injecting drug users to switch from heroine or other opioids to methadone. Methadone is a synthetic opioid, which is one of the types of drugs, however, the effect that it has on the health of a person is less harmful than from other opioids.[72] It is more likely that you get off from the drugs at all, if you start taking methadone therapy. Most of the people stay on methadone for a long-term, however with the time, they could decrease the dose and come off it altogether. Methadone therapy allows people to live a normal life, to work, to participate in social life, decrease the spread of infectious diseases and overall to improve the health status of drug users with HIV and other diseases.

The methadone therapy was introduced in 2002 in Bishkek and Osh city. The programme was successful it its implementation, and today it has more than 20 sites in

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[71] Country example: methadone substitution therapy in Kyrgyzstan, http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/activities/drugs/country-example-methadone-substitution-therapy-in-kyrgyzstan

[72] Methadone Replacement for Heroin, http://www.patient.co.uk/health/methadone-replacement-for-heroin

the primary health centers in the whole country. Moreover, in 2006 there were several penitentiary institutions such as #3, 10, 16, 47 and other, where the methadone therapy has been introduced for the prisoners.[73] Methadone therapy was a part of harm reduction programme on HIV/AIDS which main orientation was to prevent spread of HIV in the country. The therapy is available for those who want to stop taking drugs; moreover HIV positive injecting drug users are accepted to receive methadone therapy as well as others. The methadone treatment programme continues working with non-governmental organizations, civil societies that are concerned with the problems of vulnerable populations. NGOs provide services such as legal support, psychosocial help, legal counseling, support in obtaining passport, job opportunities, social services that are necessary for patients of methadone therapy, positive HIV injecting drug users, and pregnant women with positive HIV status. Moreover, medical personnel are specially trained to identify and implement certain measures towards the needs of methadone therapy patients. They are also taught to avoid stigma and discrimination, and develop human attitude towards patients.[74]

The hypothesis of this research is that the informal payments cause a major impediment in accessing healthcare services of vulnerable populations, which poses a threat to the well being of its citizens, having effect on health indicators such as infant and child mortality, increase of dangerous infections such as HIV/Tuberculosis, and irrational health spending. Thus, in order to prove or to reject this hypothesis, the following should be done:

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[73] Dr. Emilis Subata, Dr. Giorgi Pkhakadze, 'Evaluation of pilot methadone maintenance treatment in the Kyrgyz Republic', November 2006

[74] Interview with Irina Pugacheva, March, 2014, PA "Alternativa v Narcologii"

1) to present findings of the survey and overall the percentage of those who had difficulties and were required to pay informal payment to access healthcare services;
2) to analyze responses and evaluate the problems that injecting drug users faced while accessing healthcare services;
3) to compare the percentage of newly diagnosed cases of HIV before and during the implementation of health care reforms;
4) to look at the child and infant mortality rates from the beginning of reformation programs and evaluate whether there have been any changes;
5) to compare overall health expenditures of the health care sector, differentiating informal and official payments;
6) to look at the expenditures of MHIF and SGBP during the reforms;
7) to look at the rates and spread of Tuberculosis during the implementation of health care reforms;
8) to look at the health indicators for the last 6-7 years;
9) to identify what problems people in need of palliative care and people with Tuberculosis/Hepatitis C and pregnant women injecting drugs faced;
10) to make recommendations for reducing informal payments and ensuring access to vulnerable population in the health care system.

The survey included 78 patients of methadone therapy, people who were ex-injecting drugs users. It was done with the help of Public Association 'Alternativa v Narcologii' which provided useful information about the patients of methadone therapy and helped with conducting a survey with patients. The questions (see the list in the appendix III)

were drawn up taking into account the specificity of this category of people to perceive information. The findings of the survey are shown in the following table:

Patients of methadone therapy (age group, employment status, presence of documents)					
Age of respondents	F (%)	M (%)	Working Full-time (%)	Unemployed (%)	Presence of documents (%)
18-30	5	6	6	5	8
30-45	11	54	47	18	55
45-55	6	8	8	6	8
55 -older	1	8	1	5	5

Source: own survey

This table is divided into several columns, by the age of respondent, sex, employment status and presence of documents (passports). It can be observed, that overall the highest proportion of people are from the age 30-45, also this age group has the highest percentage in the employment status and presence of documents. Well, according to this table, it can be revealed that most of the patients from 30-45 are able to work and make money. 23% of all respondents are females, while males are 76 % of all respondents. Moreover, it's been revealed that 63% of respondents have jobs and 76% of people have ID documents.

The next step was to reveal the reasons for having a limited access to health care services. Analyzing answers of respondents, I have underlined the main reasons for the difficulties in accessing to medical care. Half of the respondents were either stigmatized or discriminated, which led to inability to get medical help. Almost 90% of the

respondents were asked for informal payments while accessing the healthcare sector. Moreover, some doctors refused to provide services unless the patient showed ID documents, where 24% of respondents that had no IDs had problems in getting medical service. In addition, almost 34% of respondents could not access healthcare services, because they couldn't afford paying for the treatment and medical supplies. When a patient had a chance to get healthcare service, he/she was asked to buy medical supplies such as syringes, wadding, bandages and medicine. More than half of respondents were not satisfied with provided services, referring to the medical personnel disaffection and dislike. That's why some of them were not seeking for a medical care at all and were engaged in self-treatment. However, in extreme cases they contacted the ambulance, where they also had to pay. Costly services, expensive medicine, stigma and discrimination, inability to access health services has a direct affect on the health of people.

Not only patients of methadone therapy are vulnerable to informal payments in the sector. Other groups, such as pregnant women with positive HIV status or injecting drugs, people in need of palliative care and people with Tuberculosis have similar problems in accessing to health care services. For instance, people in need of palliative care has the right for accessing medical services for free, such as diagnostics, consultations with the doctors and etc. However, due to the fact that there are too many people, medical personnel started practicing informal payments.[75] It is important to note, that the palliative care services (oncological diseases on its last stage) are the most expensive services in the health care. Thus, providers and patients perceive illegal payments as a social norm, creating barrier for those who are not able to pay for the

[75] Interview with Taalaigul Sabyrbekova, PF "Ergene", March, 2014

services. In this sphere, providers refer to the lack of financial resources, lack of chemotherapy drugs and supplies that creating the situation 'first paid, first served'. Interestingly, when the evaluation process of newly diagnosed cases of oncological diseases were taking place throughout the country, there was no single case in Batken oblast.[76] The assumptions were made that either people revealed the disease on its last stage or they did not seek for medical help, because they could not afford it. Mainly, patients pay because they want to get better attention from medical personnel, or to avoid waiting list and get the treatment faster. In such cases the more you pay, the more services you'll be able to have access on, while those who have no money will depend on informal payments. Those, who have ability to access to health care services, are forced to act this way and participate in unofficial payments, whereas the poor and vulnerable populations has no way to access to services. The same situation could be prescribed to people with Tuberculosis/Hepatitis C and pregnant women injecting drugs or HIV positive people.[77]

According to the National Center for AIDS in 2011 it's been revealed 599 HIV-infected, of which 358 were injecting drug users. In total, from 1987 to 2011 it has been identified 3887 cases of HIV positive people, where AIDS was diagnosed in 437. During this same period, 539 people living with HIV died and 194 people died from AIDS. Kyrgyzstan and other CIS states are among the countries with the highest growth rate of HIV infected people. For the last 4 years, the newly diagnosed cases of HIV were 4

[76] Interview with Taalaigul Sabyrbekova, PF "Ergene", March, 2014
[77] Interview with organizations, March, 2014

times higher than it was in 2005. Moreover, transmission of HIV from mother (mostly pregnant women injecting drugs) to child increased to 2.1% in 2010.[78]

Overall, if to compare with the introduction of reforms, there have been a gradual and steady growth of HIV/Tuberculosis diseases; moreover there are slightly changes in infant mortality. It can be observed in the following table:

	2003	2005	2006	2010	2011	2012
Infant mortality per 1,000 births	20.9	29.7	29.2	31.2	21.4	-
Number of newly detected case of HIV/AIDS	132	171	244	545	567	-
Tuberculosis incidence rate per year per 100,000 – estimated	128.3	123.9	122.7	129.3	131.1	-

Source: numbers are taken from different reports (Kyrgyzstan)

Having observed the estimates on child mortality, HIV/AIDS cases, Tuberculosis, it can be concluded that there have been slightly changes, however if the measures are not going to be taken, it could pose a visible threat to the health of citizens.

[78] Interview with PA "Podruga", March, 2014

In the conclusion, recommendations will be given on how to reduce informal payments and what measures should be taken, in order to ensure vulnerable groups with equal access to healthcare services.

Conclusion

Actual change to Kyrgyzstan came after the collapse of the Soviet Union, when the county has experienced significant changes in all key sectors in the country. Transition of the country from planned to market economy led to the mass privatization and liberalization of prices in post-soviet states, which opened a path for informal market. Slow economic development, poor governance, and mismanagement of the system, political instability, and weak policy reforms were the causes for corruption that has prevailed in the country.

The health care sector is considered to be one of the most corrupt sectors in low-income countries. It has been considered that the most successful and comprehensive reformation of the health care system has taken place in Kyrgyzstan. The country presented two national programs that were aimed at restructuring the financing sector, reforming the health care delivery system, improving quality of health care and providing universal coverage to the population. However, due to the rise of informal markets in the system and inability of reforms to fight with it has created barriers to population in accessing to healthcare services.

Informal payments were not seen as corrupt practices by policymakers. They have been built into policy dialogues, constituting a significant component of overall spending in the health care system in Kyrgyzstan. In addition, it has been considered that they became a major obstacle to healthcare reforms. The poor and vulnerable populations are most susceptible to informal payments in the sector. The survey was conducted in order to reveal the extent of informal payments among patients of methadone therapy. The results have proved that informal payments are one of the main barriers in accessing to medical care. Moreover, different causes of limited access were

identified. Stigma and discrimination, high costs for the services, lack of supplies, medicine, poverty, employment status, presence of documents, status in society played role when vulnerable populations were seeking for medical care.

First of all, in order to reduce informal payments in the sector, it is important to rethink the phenomenon of informal payments and create policies that will work at their elimination from the system. Moreover, the government should take an active part in promotion accountability of health reforms, ensuring that these reforms created in order to meet the needs of its citizens rather than those in 'white robes'. With the introduction of Single payer system, copayment system, MHIF and SGBP, it is vitally important to create an organ, which will monitor the financial sector and will be engaged in proper distribution of finances within the system. In addition, it is important to make reports annually, where the overall work can be demonstrated, evaluating minuses and pluses of certain actions. In order to do that, the Ministry of Health should involve international experts and specialists from partner countries, even from the FSU countries and CEE, where they could exchange with experience and knowledge.

There are number of international organizations working on the problems of vulnerable groups, however, in order to ensure the equal access to healthcare services, the more should be done. Medical personnel should be trained working with the specific category of people, avoiding stigma and discrimination and other reasons, in order to provide medical care. The phenomenon of informal payments should be reduced in the sector, and increasing the wages of medical personnel is not the way. It was suggested, that formalizing informal payments is the way to reduce informal payments in the system. By doing that, people would be more informed about the formal payments, the SGBP and copayment system would start properly working, providing services free of

charge for the categories of people that are on the list. The active participation of civil society organizations in the dialogue with the Ministry of Health, with the government and other international organizations on certain issues, understanding each others positions, findings solutions and starting implementation would be one of the ways in the improving the health system. The main issues that needed to be addressed are HIV/AIDS, Tuberculosis, child mortality, rational health spending, reduction of informal payments and sanitation services. All these goals are the main objectives of *Den Sooluk* program, which is on the stage of its implementation. So it would be interesting for further research to investigate whether these objectives were reached, what were the results of the third program and how the situation with informal payments has changed.

Appendix I

A study on informal payments in the health care system in Kyrgyzstan

Mini-survey to identify the extent of informal payments among clients of MTT

Bishkek 2014

1. Age_____

2. Gender: Male Female

3. Do you have a passport? Yes No

4. Do you have a job? Yes No

5. When was your last time you visited a doctor?

o 1 week ago

o 2 weeks ago

o month ago

o I do not remember

o your answer_____

6. Which hospital / polyclinic do you usually go?

7. For what reasons do you usually go to the hospital? Do you get to access to health care services? If not, explain.

8. What does doctor do? Is doctor friendly to you? Does the doctor provide required help? Please, describe it in details.

9. Have you ever been asked to pay for the healthcare services? Yes No

If yes, please describe for what services you have been asked and why? Did the doctor give you a receipt?

10. If yes, how much did you pay? _____som

11. Did doctor give you prescription to medicine? Yes No

12. Has the doctor written any referral to the different hospital or another specialist? Provide details.

13. Do you pay for each visit to the doctor? Yes No

If yes, how much? _____som

14. How often do you go to the doctor?

o Rarely

o Often

o Every month

o Once a year

o Once a week

o Your answer_____

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