HEALTHCARE REFORMS IN KYRGYZSTAN:
ROLE OF THE CIVIL SOCIETY

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Abstract

During the transition from the socialist past the window of opportunity allowed the state and the donors to undertake the reform of the healthcare system in Kyrgyzstan. After the reforms, the healthcare system transformed into a system with limited affordability and accessibility of care in spite of the official proclamations of universality expressed by the state and the donors as the goals of the reforms. The main questions the current works attempts to answer are: Why has intended socialized healthcare system evolved into a system regulated by informal market? and Why is there a dichotomy between universalist declarations of the government and the real situation in the healthcare system? This paper looks at the health policy change from the perspective of group and process theories of public policy analysis. Different factors could contribute to limited effectiveness of the reforms intended at building socialized healthcare; however, for the purposes of narrowing the research area and focusing the analysis on one specific factor of the policy change this paper will examine civil society influence on the healthcare reforms process. Specifically it is assumed that the reforms that intended to preserve universal healthcare were not comprehensively followed through and led to emergence of informal markets partly due to the fact that health civil society organizations emerged after the commencement of the reforms, became more active after the first reforms program finished and had limited influence during the implementation process of the second reforms program.
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Introduction

Ill-health of a nation poses a direct threat to its national economic and political viability; therefore, investing into healthcare is investing into national security.\(^1\) The health of the nation begins to deteriorate, life expectancy decreases, maternal and premature mortality rates increase and the rates of communicable and non-communicable diseases grow when people do not have access to adequate healthcare. Health of the nation is important for development of the country, it is therefore reasonable to see why the healthcare system in Kyrgyzstan transformed into a system with limited affordability and accessibility of care in spite of the official proclamations of universality. The main questions arise: Why has intended socialized healthcare system evolved into a system regulated by informal market? and Why is there a dichotomy between universalist declarations of the government and the real situation in the healthcare system?

During the Soviet Union the healthcare system was built according to the Semashko model, which focused on provision of universal healthcare coverage with health services being free at the point of delivery.\(^2\) The Soviet system managed to cover most of the population; even remote villages had specialized doctors and hospitals with several beds for in-patient treatment.\(^3\) The scheme of the system funding and services delivery was cumbersome and complicated. The system was divided into three administrative levels: republican, regional and district. Each administrative tier managed their own “mini-system of healthcare”: collected revenues, pooled funds, provided

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\(^3\) Ibid.
medical care and purchased health services.\(^4\) Besides, there were specialized hospitals (e.g. tuberculosis, oncology hospitals) which had their own vertical system; moreover, different state bodies (Ministries, large factories) ran their own health system – there were specialized hospitals for workers of these bodies and their families.\(^5\) Such a system required substantial funding which the Soviet state provided; however, the breakup of the Soviet Union meant automatic breakup of the healthcare system in the republics because they could not manage to finance such a system under the conditions of failing economy. The new economic and political systems were created after the dissolution of the previous systems and ideals; moreover, social welfare programs and policies were rethought and reshaped due to major changes in the structure and financing schemes.

Kyrgyzstan was one of the first states in Central Asia to reform its healthcare system; moreover, it appeared to be one of the most progressive in the implementation of the reforms: it launched the preparatory stage in the early 1990s, and then implemented the first reforms program Manas, which was followed by the second reforms program Manas-Taalimi. The third reforms program Den-Sooluk has recently been approved; however, it is still in the initial stages of implementation and reconsideration. Therefore, the latter program will only briefly appear in the analysis. The goals of the reforms proclaimed by the government in official speeches and interviews and written as goals of the reforms in the reforms documents were to preserve a system of state-provided healthcare with universal coverage of the population.\(^6\) According to the official

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\(^5\) Ibid.

proclamations everybody in the republic has a right for healthcare; therefore, the reforms were supposed to result in an accessible healthcare system. However, a dichotomy appeared between what was being said and what was being done. Principle of universal healthcare coverage was undermined by the transition from state-provided healthcare to healthcare financed partly from the budget and partly from insurance and copayments. Also, a governmental decree in 2009 combined both proclamation of the need for universal healthcare coverage and expansion of accessibility for vulnerable groups with the need to let market mechanisms into the state hospitals. Interestingly, this decree became the only document which sought to present market in healthcare and universal healthcare coverage as compatible concepts.

In addition to the attempts to incorporate market mechanisms into the healthcare system, which was first purported to be state-provided and universal, an informal market emerged in the state medical institutions. Informal market relationships between doctors and patients are built on the principle of service-provider-client interaction where a service-provider seeks to maximize his/her profit. Examples of informal market mechanisms unofficially regulating the system of state-provided health care include voluntary and involuntary gifts to the workers of medical institutions; initial informal pay to a doctor, so he/she takes some action when the patient is first seen; unjustified hospitalizations, surgeries and caesarian sections for the purpose of making money; sale of different utensils which are supposed to be free; prescription of unnecessary drugs and


7 Ministry of Healthcare of the Kyrgyz Republic, "Programma vnedreniya rinochnih mehanizmov v sistemu zdravoohraneniya a Kyrgyzskoi Respubliki na 2009-2013 gody."
tests and referral to specific pharmacies or laboratories because the doctors have informal agreements on sharing the profit; and prescriptions of more expensive versions of the same drug. Such activities are aimed at profit making and compromise the concept of universal healthcare coverage, because many poor people cannot afford receiving needed medical help.  

Assuming that public policy making is a complex process with many actors involved it is helpful to study health policy change through looking at the factors which could influence the trajectory of the reforms and their final destination. Different factors could contribute to limited effectiveness of the reforms intended at building socialized healthcare; however, for the purposes of narrowing the research area and focusing the analysis on one specific factor of the policy change this paper will examine civil society influence on the healthcare reforms process. Specifically it is assumed that the reforms that intended to preserve universal healthcare were not comprehensively followed through and led to emergence of informal markets partly due to the fact that health civil society organizations emerged after the commencement of the reforms, became more active after the first reforms program finished and had limited influence during the implementation process of the second reforms program.

Focusing on the health CSOs’ input in health policy change in Kyrgyzstan this paper uncovers a new approach to analyzing healthcare reforms in transition countries, through looking at civil society activity and its policy influence. The area of health CSOs activities in Kyrgyzstan is relatively unexplored and therefore, appears as potentially interesting for further research.

In order to analyze how civil society involvement may have influenced the reforms process, first, it is important to understand what the reforms aimed to achieve and what was actually achieved. For that I looked at the reforms documents which are available at the website of the Ministry of Healthcare of the Kyrgyz Republic, at the statistical data on health status of the population from the website of the National Statistical Committee, at the analytical papers produced by Health Policy Analysis Center located in Bishkek, at the analytical papers published by the World Health Organization, and at the legislature, specifically the Constitution and the Programs of State Guarantees.

For obtaining information on civil society activities during the reforms I turned to the secondary data: articles published in the international and local newspapers as well as to the abovementioned analytical papers. Also, I conducted semi-structured interviews with the representatives of civil society organizations (CSO) and international organizations present in the healthcare sector in Kyrgyzstan which became a major source of information with regards to the activities undertaken by the CSOs (see the list of organizations’, whose representatives were interviewed, in the appendix I) because the area of CSOs activities in healthcare in the Kyrgyz Republic is relatively unexplored it was difficult to find extensive and comprehensive secondary sources. Some information regarding the initial goals and progress in implementation of the reforms was deduced from the interviews as well (see the list of the core questions asked during the semi-structured interviews in the appendix II).

Overall, 20 interviews were conducted, for each organization only one representative was interviewed, who was the founder, the director or the most knowledgeable person to answer the questions. The organizations received the list of
preliminary questions by electronic mail and then arranged a meeting for the actual interview. Besides the questions which were written down as the core of the interview, there were also follow-up questions asked in order to clarify some information or to make more implicit connections of ideas. The contacts of civil society organizations active in healthcare sector were obtained from the Soros Foundation in Kyrgyzstan and the Country Office of the World Health Organization which are the most active international organizations working in the sector. These two international organizations were also interviewed. Then during the interviews the representatives of the CSOs also gave contact information of the people working in the same sphere who may be relevant to the present work (snowball sampling). Therefore, there are limitations to the research in terms of validity of its sampling; however, the information from the secondary sources was used to fill possible gaps resulted from the sampling.

The results of the research are presented in the following sequence: the first chapter discusses literature relevant to the analysis of the role of civil society in health policy change in the context of post-socialist states in transition; the second chapter offers overview of the reforms and their results; actor analysis and the description of the results on the health CSOs activities, their policy influence and input into healthcare system reforms are presented in the third chapter. The last chapter summarizes the findings and their significance for reformers of healthcare in transition countries; furthermore, it presents limitations of the current paper and recommendations for further research.

**Context, Factors and Actors in Policy Reforms during Post-Socialist Transition**

To understand why the reforms of the healthcare system in Kyrgyzstan did not fully succeed and declaratively socialized healthcare system allowed some informal
market mechanisms to intervene, one needs to look closer at the process of the reforms which resulted in the current healthcare system. In order to comprehend how the reforms were taking place and what were the factors influencing the course of the reforms it is reasonable to look first at the transition literature in general and the literature on post-socialist transition specifically because the reforms of the healthcare system in Kyrgyzstan were undertaken in the context of the larger political, economic and social reforms during the transition from the Soviet past towards the independent future. Once the context of the reforms commencement is set, literature on public policy analysis is crucial for identifying the tools for analysis of health policy change and for pointing out important actors and their input into the health policy making.

Much of the literature focusing on transition talks about violent overthrow of authoritarian regime and democratization.\textsuperscript{10} It discusses structure and composition of society,\textsuperscript{11} economic performance,\textsuperscript{12} geographic location, history of democratic governance\textsuperscript{13}, share of power between hardliners and soft-liners,\textsuperscript{14} presence of strong elites and united opposition\textsuperscript{15} and other aspects of the system at the edge of the transition from an authoritarian regime. However, unlike the Baltic States, Kyrgyzstan did not struggle for its independence from the Soviet Union: there was no popular mobilization or uprisings against the previous authoritarian regime. Therefore, not all the transition

\begin{footnotesize}
\begin{enumerate}
\item \textsuperscript{14} McFaul.
\item \textsuperscript{15} Valerie Bunce, \textit{Rethinking Recent Democratization: Lessons from the Post-Communist Experience.}, n.d., http://www.clas.ufl.edu/users/bmoraski/Democratization/Bunce03_WP.pdf; McFaul.
\end{enumerate}
\end{footnotesize}
literature applies for the Kyrgyzstan’s case. Although, transitologists argue that post-soviet transitions cannot be considered within the framework of the traditional transition paradigm\textsuperscript{16}, the model does present useful insights about the transition that are relevant to the post-socialist transition as well. Specifically, the authors of the transition paradigm introduce a concept of “uncertainty”\textsuperscript{17} during the transition: uncertainty of the direction of the transition with its numerous dilemmas, and difficult political and economic decisions. Moreover, since the previous regime is dismantled “structural indeterminacy”\textsuperscript{18} takes over political realm: the future is open and the decisions about the structure of the state and its institutions need to be made.

Uncertainty during the transition creates a window of opportunity for reformers. Structural and institutional indeterminacy, uncertainty of the direction of the transition and uncertainty about power distribution are conditions under which, according to the theory of resources mobilization, there is political opportunity for policy change.\textsuperscript{19} Through the lens of this theory, one can explain why actors in the healthcare sector became more active and pushed for reform during the period of uncertainty of the 1990s transition.

In the beginning of the 1990s the decision makers in Kyrgyzstan were uncertain about future political, social and economic system. The social safety nets existing during the Soviet Union were not viable any more. First, the system used to be centralized and ruled from Moscow; therefore, once out of the Moscow’s control the system had to be

\textsuperscript{18} Ibid, p 19.
reformed. Furthermore, extensive welfare state that had been supported during the Soviet
Union had required substantial financial resources which were limited when the republics
became independent. Hence, the transition with its uncertainty and institutional
indeterminacy created a political opportunity for reforms including health policy
change.\textsuperscript{20} Uncertainty of transition, described by Guillermo and O’Donnell, and relative
openness of the new government allowed the reforms to take place.

It is also important to look at the insights offered by the authors writing on post-
socialist transitions because the nature of these transitions is different from the nature of
the third wave transitions that served as empirical evidence for traditional transition
theorists. Unlike the theory of resource mobilization, some authors argue that transition
economies saw rapid decline of their industrial production, decrease in the size of the
government sector and “low rates of tax collection,”\textsuperscript{21} which in turn severely limited
government’s ability to support extensive healthcare system inherited from the Soviet
Union\textsuperscript{22} and the reforms became a necessity and not only a result of political opportunity
and openness of the government. Although many post-soviet states still had the right to
free state-provided healthcare stipulated in their Constitutions, in reality healthcare
spending decreased and patients’ were charged for the services they previously received
for free, because otherwise the system could not be supported.\textsuperscript{23} Moreover, unofficial

\textsuperscript{20} Ibid, p 1460.
\textsuperscript{23} Ibid.
out-of-pocket expenses became a commonplace.\textsuperscript{24} Hence, the reforms of the healthcare system in post-socialist countries were not only conditioned by uncertainty and political opportunity, but were provoked by the economic hardship and need to cut public expenditure.

Dismantling of the Soviet system meant transition to a market economy and withdrawal of the state from different spheres of social life. Shock therapy and rapid transition without preparedness of the institutions led to increased poverty rates and incapability of the state to support the welfare system.\textsuperscript{25} Privatization schemes, rising unemployment and state desertion led to increased inequality and poverty.\textsuperscript{26} These resulted in abandoned welfare system, including healthcare and as a result dropping longevity and deteriorated health.\textsuperscript{27} Hence, post-socialist transition, including transition in Kyrgyzstan, is associated with mishandled economic reforms that resulted in high poverty rates and deteriorated welfare services system. The governments in post-soviet states failed to design proper institutions, which resulted in prevalence of market failures.\textsuperscript{28} The scholars argue that the healthcare reforms were a logical outcome of the economic reforms because the deteriorated economic situation in the country required a change in welfare policies and decrease of the extensive state presence in the healthcare sector.


\textsuperscript{26}Mishtal.

\textsuperscript{27}Ibid; Varese.

Welfare systems across the post-socialist states differ due to “diverse histories of actors, policies and policy-making in different welfare fields.”\textsuperscript{29} The context of the post-socialist transitions matters. Furthermore, it is argued that transition years were crucial in the formation of the welfare systems in the post-socialist states: the systems formed after the initial years of transition appear to be resilient to changes.\textsuperscript{30} The changes that took place after the breakup of the previous regime were immense: during the transition the conditions of the political and economic system allowed rapid and substantive transformation of the welfare state; however, understanding of the forces that stood behind the welfare system reforms is crucial for understanding of the post-socialist welfare state.\textsuperscript{31} The first reforms took place in the first half of the 1990s, the following rounds of reforms were built on the achievements of the initial reforms, and the system built during this initial years proved to be resilient to changes. For better understanding of the forces involved in the building of post-socialist healthcare system and its further development actor analysis will provide some useful insight.

During the transition the new state government attempts to find sources of legitimacy; the decisions and policies made during this time are aimed at obtaining legitimacy. According to some scholars, such search for legitimacy leads to institutional isomorphism, when institutions are modeled after similar institutions that are perceived more legitimate and successful.\textsuperscript{32} During the post-socialist transition, the reforms, which took place, strongly correlate with the isomorphic positions that the countries had with

\textsuperscript{30} Ibid, p 5.
\textsuperscript{31} Ibid.
respect to the West and each other.\textsuperscript{33} In the atmosphere of uncertainty and institutional indeterminacy, the states do not have clear goals and mechanisms of their achievement; they seek legitimacy and tend to model their institutions after more successful states or institutions in order to legitimate their actions.\textsuperscript{34} The models adopted are not necessarily good for the adopting states; however, the reforms that take place are believed to be based on more efficient and successful examples.\textsuperscript{35} Uncertainty, brought by transition and ambiguity of the goals,\textsuperscript{36} forced reformers to model after western institutions or allow western experts to lead in the reforms process. Kyrgyzstan’s case did not escape from falling for obtaining legitimacy through copying institutions from abroad and through allowing western experts to define what the reforms of healthcare will touch upon.

The reforms of the healthcare system meant a change of the health policy, particularly, the change of the policy that affects “the set of institutions, organizations, services, and funding arrangements of health system.”\textsuperscript{37} In order to understand what type of healthcare system emerged after the reforms and why, one needs to understand how the process of the reforms took place and what played role in the policy change. Health policy is a public policy; therefore, one should apply analysis of public policy making for the analysis of the health policy change. There are several models used for public policy analysis. Those include: institutionalism, rational choice, incrementalism, elite theory, public choice theory, game theory, group theory, and process model.

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{33} Ibid, p 3.
\item \textsuperscript{34} Ibid, p 6
\item \textsuperscript{35} Ibid.
\item \textsuperscript{36} Ibid, p 7.
\end{itemize}
\end{footnotesize}
Institutional model implies that the structure and arrangement of government institutions influence the outcomes of the policy.\textsuperscript{38} State bodies undoubtedly played important role in the healthcare reforms in Kyrgyzstan; however, influence of international donors, especially at the commencement of the reforms, and of the civil society later in the process should not be underestimated. Other theories explain public policy as a rational choice of the governments,\textsuperscript{39} as “a continuation of past government activities with only incremental changes,”\textsuperscript{40} as a preference of the elites in power\textsuperscript{41}, as a result of collective decision-making process by self-interested individuals\textsuperscript{42}, or as an outcome of the rational choice in the competitive situation.\textsuperscript{43} However, these theories provide limited explanation of the reforms of healthcare sector in Kyrgyzstan, because there either were no actors that the theories assume to have in their analysis, or the situation on the moment of the reforms commencement was different from the one provided in the theories. Two remaining theories of public policy making will be the


most helpful in the analysis of the healthcare reforms in Kyrgyzstan: group theory and process theory, because both consider public policy as a complex process involving multiple actors.

The group theory purports to look at the public policy and decision making as an activity resultant from the group struggle. It states that individuals with the same interests gather together into formal or informal groups and push for the fulfillment of their needs and interests. Public policy becomes equilibrium in the interest groups struggle. Change of power distribution among interest groups is expected to cause change in public policy. According to the theory policymakers are “constantly responding to group pressure – bargaining, negotiating, and compromising among competing demands of influential groups.” This theory is relevant for explanation of the later period of the reforms, when other actors besides the state and the international donors emerged; however, the extent to which these newly emerged civil society groups could influence the state policies is still to be identified.

Process model views policy making as political activity involving multiple actors. The model encourages studying the processes of public policy making and not the substance of the policies. It stresses the importance of understanding how public policy decisions are made: the processes of policy development, implementation and

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45 Dye, p 21.
46 Ibid, p 22.
48 Dye, p 15.
Looking at the health policy change in Kyrgyzstan through the lens of the process model will help us understand how the policy was made, which actors were involved at which phases of the reforms. However, in the current paper we will look at the process of health policy making, groups and actors involved in it and will include the policy content analysis, because without looking at who gets what (content) it will be difficult to understand what was the process of policy making, why certain actors were involved or excluded from this process and why the process resulted in certain policy preferences.

Analysts of public policy employ policy networks as an analytical tool. Similar to group and process theorists of public policy they view public policy making as a complex process with involvement of a range of actors representing private, non-governmental and governmental institutions who are dependent on each other for resources and support.\(^{50}\) Today policy decisions are often made in a “decentralized and informal manner.”\(^{51}\) Therefore, multiple scholars expressed ideas where concept of public policy network was present; however, they gave it a different name: policy sector,\(^{52}\) policy domain,\(^{53}\) policy

\(^{49}\) Ibid.


\(^{51}\) Kenis and Schneider, p 27; Kenis, p 10.


topic’s organization set,\textsuperscript{54} the policy actor system,\textsuperscript{55} and the policy community.\textsuperscript{56} For the purpose of simplification the term policy network will be used in this work.

Policy networks are “clusters of actors, each with an interest, or “stake” in a given policy sector and the capacity to help determine policy successes or failures.”\textsuperscript{57} Policy networks are not necessarily based on official “hierarchical authority patterns but also include informal relationships such as interpersonal communication.”\textsuperscript{58} This concept helps us understand the relationships between the actors interacting on a given issue.\textsuperscript{59} Numerous works have been written on the importance of policy networks in the public policy decision-making; however, it was not clearly elaborated what types of networks influence policy making process and how, and what policies result from what types of policy networks at place.

Healthcare in Kyrgyzstan has been reformed and during the reforms multiple actors were involved. In order to analyze the process of reforms and why they resulted in certain outcomes it is useful to look at the policy process applying the concept of policy networks. Scholars stated that “partnerships between organizations have become a popular technique of participation and have been posed as solutions to many health problems.”\textsuperscript{60} Therefore, since the state did not have resources for or experience in policy

making on its own, without direction from Moscow, it is interesting to see what actors were involved and how they influenced the trajectory of the healthcare reforms.

Specifically civil society influence will be studied in the present work because the scholars noted that the growth of the civil society in recent years has played significant role in changing public policy agendas and in participating in public policy making. Health civil society organizations were marked as an influential factor in the course of the healthcare reforms, delivery of the health services and monitoring of the healthcare provision in the world. To be clear what is meant by civil society the definition from the Lancet Journal will be taken: civil society is “a sphere of social interaction between economy and State, composed above all of the intimate sphere (especially family), the sphere of associations (especially voluntary associations), social movements, and forms of public communication.” Civil society is a realm which lies between the State and an Individual. It does not have the authority to make policies, implement and enforce them because it does not have regulatory and coercive power of the state; however, it “provides social power of influence of ordinary people.”

Many scholars writing about healthcare and civil society involvement acknowledge the important role civil society organizations (CSOs) play in this sector:

1) civil society in healthcare is sometimes referred to as the Third Sector because it provides health services alongside the state and private-for-profit health providers; 2)

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63 Ibid, p 819.
66 Ibid.
they are increasingly grouping and uniting to form health networks and advocate or campaign for/against particular health actions and policies, 3) growing political power of the NGOs and CSOs allows them to be “an alternative voice when the opposition parties are weak or absent.”

The sphere of influence of the CSO in healthcare also depends on its specialization. There are different sources which provide categorization of the health CSOs specialization. In the Journal of Sociology of Health and Illness three rough categories of the health social movements/CSOs are provided: those that address 1) access to health services; 2) inequality of health provision and access for marginalized groups; and 3) “disease, illness experience, disability and contested illness.” Civil Society Initiative of the World Health Organization works with the CSOs in healthcare and categorizes them according to the function of the health system that they perform: health services provision, health promotion and information exchange, policy setting, resource mobilization and allocation, and monitoring quality of care and responsiveness. These categories are helpful in looking at the CSOs in healthcare in Kyrgyzstan because they help analyze the scope of action of a specific organization, its possible networks and spheres and degrees of influence.

The vast literature on transition, on theories of policy change and public policy making, on public policy networks, and on the civil society in public policy making and, more specifically, in health policy making prepares a well-formed ground for further research on the influence of civil society on health policy in Kyrgyzstan during the years

\[67\] Ibid.
\[68\] Jareg, p 821.
\[70\] Civil Society Initiative, p 6.
of reforms. The research will concentrate on the role of the civil society in the reforms; however, other actors will be taken into account since the civil society policy influence will be assessed through the set of indicators and the framework of policy networks which requires the actor analysis. Such a research will provide one of the explanations of the current situation in healthcare and its possible developments in the future.
Extensive Reforms in the Healthcare Sector: The Timeline

Reforms of the healthcare system intended to preserve the system of state provided healthcare with its benefits of universal coverage and accessibility at the same time optimizing the spending. The reforms started in 1992 and were successful in cutting the amount of hospitals and decreasing the amount of specialized doctors by closing or merging the hospitals and retraining medical specialists into general practitioners. Throughout the reforms period major changes of service delivery and financing mechanisms were undertaken; also, the legislature change compromised the right of each citizen for free health care in the public hospitals; and ultimately, the informal market intruded into the system of public medical institutions decreasing accessibility and affordability of health services.

“The Second World War until the mid-1980s, the Soviet Semashko model of health care focuses on increasing the health system’s capacity to deliver universally accessible health services funded and managed by the state and free at the point of delivery.” 71 Such a system involved large amount of hospitals with different medical specialists; specialized doctors worked even in the remote villages’ hospitals. The system provided large number of beds for hospital stays and average hospital stay lasted 15-20 days. The system was divided into three administrative tiers: district, region and republican level; cities had their own structure of health services provision and different ministries also had their specialized hospitals. 72 In spite of its seeming inefficiencies the system managed to provide universal coverage to its population.

71 Ainura Ibraimova, Baktygul Akkazieva, Gulgun Murzalieva, and Dina Balabanova, p 127.
72 B. Rechel, p 282.
After the disintegration of the Soviet Union, Kyrgyzstan pursued economic policy of free-market, mismanagement of which led to further collapse of the economy. As the economy was failing, the health sector resources were also depleting; the state could not afford to support an extensive healthcare system that existed during the soviet times. At the beginning of the 1990s, when Kyrgyzstan pursued active foreign policy, it entered different international organizations in order to establish its international status as an independent country. In 1992 Kyrgyzstan became a member of the European Regional Bureau of the World Health Organization, then in 1993 the WHO Information Center was opened in Bishkek, and in 1994 the WHO Bureau on Coordination and Relations with Kyrgyzstan was opened, which was later renamed into the WHO Country Office in Kyrgyzstan. With the assistance of the WHO, Kyrgyzstan commenced the reforms of the healthcare sector which included four phases: 1) the preparation state which entailed capacity building and program development; 2) the state program on the reforms of healthcare Manas (1996-2005), which completely restructured the system; 3) continuation of the state program on healthcare reforms Manas-Taalimi (2006-2010) intended to improve quality of services; another state program on reforms Den Sooluk (intended to start in 2012) is currently at the initial stages of implementation.

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74 Emil Omuraliev, e-mail message with an attachment to author, March 28, 2013.
The main purpose of Manas reforms was to optimize healthcare without compromising accessibility and universality of coverage. Extensive system of hospitals inherited from the Soviet Union was not viable anymore; financing of healthcare system was not sufficient to support cumbersome infrastructure, large amount of hospitals and pay to a large number of medical workers. So, the Kyrgyz state together with specialists from the WHO developed a program aimed at decreasing the number of hospitals and optimizing the system. The main focus was shifted on the primary healthcare. The main donor, who provided funding for the reforms, was the World Bank. The main features of the reforms involved structural changes and reforms of the financing scheme and decreasing the number of hospitals. The statistics shows that there were 331 hospitals in 1991; by the end of Manas program this number was reduced to 169. The number of medical institutions in 1991 amounted to 618, which was decreased to 205 in 2006. In the villages Family Doctors’ Groups or Centers were established; in the cities on the base of former polyclinics Centers of Family Medicine were organized. Also the number of days, allowed by the medical protocols for hospital stays, was decreased. The burden on the state budget was also reduced due to the measures taken for the decreasing of the amount of specialized doctors and training/retraining of general practitioners, who were

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77 National Statistical Committee.
renamed into Family Doctors. Besides, structural changes in the sector, there were also changes in the way the system is financed: Mandatory Health Insurance Fund was established (2003) and co-payment for medical services was introduced; also, the State Program of Guarantees which provides legislative base for minimum health services and medications benefit package is developed and approved annually starting from 2001. Manas allowed to preserve the state provided healthcare in spite of the economic collapse and to decrease public spending on the healthcare sector.78

Whereas Manas program was about restructuring of the system of service delivery and financing; in Manas-Taalimi a sector-wide approach was used, which was focused on improvement of the system indicators: financial protection, increased equity, access to services and efficiency, improved quality, responsiveness and transparency.79 Manas-Taalimi was successful in pooling funding; healthcare became the only sector so far which managed to harmonize donors’ efforts and manage external money centrally.80 However, the statistical indicators and survey results regarding effectiveness of Manas-Taalimi in achieving its objectives vary: according to the Ministry of Healthcare information the indicators were improved81; however, the effect of the reform is less positive in the analysis provided by the health policy analysis centers82 and the situation is even less optimistic about the reforms’ results in the view of the civil society representatives83. Since Manas-Taalimi program was completed only in 2012, comprehensive analysis of the results and effectiveness of the program has not been done.

78 Interview with the head of the Family Group Practitioners Association, April 2, 2013
79 Ibraimova, slide 6.
80 Interview with Burul Makenbaeva, April 10, 2013.
81 Ibraimova and Akkazieva, p 125.
83 Interviews with Civil Society Organizations.
Unlike the first program of reforms, civil society became more active during the implementation and monitoring of the Manas-Taalimi program.

The focus of the current program Den-Sooluk is preventive care and health promotion. However, after discussion some new changes of financing system of four branches of healthcare have recently been approved (mental health, tuberculosis/HIV/AIDS, oncology and hemophilia). Since the process of the program approval is still going on, this program will not be included in the analysis of this paper, because the goal is to analyze proclamations (declared goals) and real outcomes and actions undertaken during the reforms.

Over the course of the reforms the legislature has been changed several times. First, the Programs of State Guarantees were introduced in 2001. With time certain services guaranteed by the state for beneficiaries changed: for example, in 2006 such expensive procedures as hearing aid, prescribed glasses and dental prosthetics were excluded from the program; however, there was a new source of financing for complex procedures involving high technologies. In 2003 the list of beneficiaries in the State Program of Guarantees, who were eligible for free care almost doubled comparing to the 2002 Program; however, in 2004 the list was shrunk again and those who were no longer eligible for free health care became eligible for discounts. This could be possibly explained by the 2003 Constitution reform, when the right to free healthcare in state hospitals was excluded from the Constitution. The article 34.1 in the Constitution before the 2003 reform said that the “Citizens of the Kyrgyz Republic shall have the right to health protection and to benefit from free care provided by the network of state public health institutions.” While the article 47.2 and 47.3 on the right to healthcare after the
reforms stated that “The state creates conditions for medical care of each citizen and takes measures on development of state, municipal and private healthcare,” while “free medical care, as well as medical care with discounts for eligible persons, should be provided in accordance with the State Programs of Guarantees.” Therefore, explicit right for free healthcare was excluded from the Constitution and only those eligible according to the Programs of State Guarantees could receive health services for free or at the discounted rate.

In 2006, under some pressure from the NGOs for Elderly Care, pensioners of 75 years and older were added to the list of beneficiaries receiving services mentioned in the Program for free, and pensioners under 75 years of age were added to the list of patients who can receive health services with discounts.84 Also in 2006 HIV/AIDS patients were given a special status.85 The lists of categories of people who were eligible for free care were altered several times during the existence of the Programs of State Guarantees. Those who were excluded from the list of people eligible for free care were usually moved to the category of people who were eligible for discounted prices for care in public hospitals.

So, according to the Program of State Guarantees only certain types of health services and medicines are available free of charge for certain groups of beneficiaries. Other patients have to pay according to the price lists or according to the tables of copayment rates. However, independently from the rights for discounts or free care,
patients have to pay in full for MRI, tomography, hemodialysis and other costly procedures.\footnote{State Program of Guarantees Attachment, 2012.}

Although state provided medicine has been preserved during the reforms, private clinics were also established and allowed; moreover, market intruded into the system of state hospitals negatively influencing equitability and accessibility of care. The official prices for health services and drugs grew. For example, the growth of prices for outpatient health services in the period from 2000 until 2003 is 36.06%, for in-patient – 59.23%, for drugs – 181.37\%.\footnote{Melitta, Jacob, and Abdyl Temirov, \textit{Trends in State and Private Expenditure on Healthcare in Kyrgyz Republic 2000-2003}, Policy Analysis #28, Bishkek: Health Policy Analysis Center, 2005, \url{http://www.hpac.kg/index.php?option=com_content&view=article&id=19&Itemid=4&lang=ru}, p 9.} Such an increase can be seen as a gradual tendency throughout the years of the reforms. Due to closing of the village hospitals and increased prices for services, accessibility for villagers was compromised and hospital visit now was associated with additional time and financial expenses.\footnote{Gulgun Murzalieva, Kanat Kozhokkeev, Kubanychbek Dzhemuratov, Svetlana Nasirova, and Ulan Tursunbaev, eds., \textit{The Effects of Restructurization on Rural Accessibility to Health Care and Its Economic Efficiency}, Policy Analysis #25, Health Policy Analysis Center, 2003, \url{http://www.hpac.kg/index.php?option=com_content&view=article&id=19&Itemid=4&lang=ru}, p 12.} Lack of state hospitals in the remote regions promoted establishment of private medical institutions starting from 2001.\footnote{Murzalieva, p 13-16.} However, private medicine became more popular and demanded only in 2006.\footnote{Aleshkina, p 13.}

The reforms were successful in that they managed to decrease governmental spending on healthcare even in the first three years after introduction of copayment and Mandatory Health Insurance Fund. For the period from 2000 until 2003 the state spending decreased from 83.1\% to 71.0\% of the whole healthcare budget.\footnote{Murzalieva, p 16.} For the period from 2000 until 2009 private financing of healthcare prevails over the state

\begin{thebibliography}{99}
\item State Program of Guarantees Attachment, 2012.
\item Murzalieva, p 13-16.
\item Aleshkina, p 13.
\item Murzalieva, p 16.
\end{thebibliography}
contribution.\textsuperscript{92} Also, the reform aimed at promotion of primary healthcare and cutting of the secondary healthcare institutions visits. This goal was also successfully achieved: the percentage of patients going straight to the secondary healthcare institutions decreased from 16\% in 2003 to 3\% in 2009.\textsuperscript{93}

The system of informal market existing in state hospitals resulted in decreased number of patients with chronic diseases coming to the hospitals and increased financial burden on the vulnerable social groups. The statistics shows that often poor households spent more than 20\% of their income on health services or drugs.\textsuperscript{94} Although introduction of copayment aimed at reducing of informal out-of-pocket expenses, these expenses did not decrease; moreover, out-of-pocket expenses have a tendency of growth (analysis of 2004-2009 years).\textsuperscript{95} Such situation led to a phenomenon when people who need healthcare do not seek medical help because they do not have enough money – in 2006 it was 53\% and in 2009 – 56\%.\textsuperscript{96}

Market in public healthcare institutions exists in following forms: 1) out-of-pocket expenses for voluntary and involuntary gifts to medical workers; 2) bribes to the doctors, so that they take an action when a patient needs medical help (especially relevant with regard to marginalized groups); 3) increased amount of hospitalizations, often unjustified, so that the doctors and nurses can profit more; 4) increased amount of surgeries and caesarian sections, often unjustified (because patients and their relatives/friends perceive a surgery as a more serious medical procedure and usually are prepared to pay informal payments requested by the doctors), therefore doctors and other

\begin{flushright}
\textsuperscript{92} Aleshkina, p 40. \\
\textsuperscript{93} Ibid, p 12. \\
\textsuperscript{94} Ibid, p 21. \\
\textsuperscript{95} Ibid, p 33. \\
\textsuperscript{96} Aleshkina, p 43.
\end{flushright}
medical workers have an opportunity to make more money; 5) sale of different utensils necessary for hospital stay such as boot covers, surgical gauze, syringes, sterile gloves etc., which should, otherwise, legally be free of charge; 6) prescription of unnecessary drugs; 7) prescription of more expensive drugs, when there is the same substitute of a cheaper price because doctors have informal agreements with pharmacies and receive certain percent of the profit; 8) referral to a specific laboratory or diagnostics center because doctors have informal agreements with these private organizations and profit more if their patients become clients of these laboratories or diagnostics centers. These are just some of the most vivid examples of informal market relationships existing in the state-provided healthcare.

Hence, the reforms were partially successful because they managed to preserve the system of state medical institutions and optimize the spending. However, the aim of preserving accessibility and affordability was not fully achieved because of the reforms of service delivery and financing. The number of hospitals was reduced and people living in remote areas, or in the areas where the hospital was closed faced more difficulties receiving needed medical help. Furthermore, introduction of copayment and full payment for more expensive procedures (MRI, hemodialysis etc.) compromised affordability of the services. Besides, intrusion of the informal market undermined the Program of State Guarantees and created further barriers for population. The main question to answer is why the reforms led to decreased accessibility and affordability in spite of official declarations of the opposite aims of the reforms. Since in the current situation the interests of the population are hurt it is reasonable to look at those who represented these

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97 Interviews with CSOs; email to author, February 15, 2013; interview with pharmacists, February 13-20, 2013.
interests throughout the reforms process and whether they were effective in their endeavors.
Health Civil Society: Defining the Health Policy or Playing according to the Pre-Existing Rules

The group and process theories of public policy analysis suggest that a policy change is a complex process which involves multiple actors and state is not the only player influencing the outcome of the policy. Hence, a comprehensive picture of the reforms development can be obtained through actor analysis during which interests of different actors involved in the policy making process are determined and actors’ policy influence is assessed. To put it simply, there were three main actor camps in the reforms of the healthcare system in Kyrgyzstan: state and donors; the Family Group Practice Association, and Hospital Association; and other health CSOs independent from the state. The moment of political opportunity in the beginning of the 1990s allowed the state and the donors to mobilize the resources and push for reforms in the healthcare sector as well as in other sectors. The state and the donors were making policies and decisions and implementing them. Their main interest was to optimize the system decreasing the spending without fully giving up state-provided healthcare. The Associations, which were created as civil society organizations, represented medical workers and medical institutions. From one hand, they were lobbying for increased salaries and improved working conditions for the workers, and increased financing for medical institutions; from another hand, having close contact with the Ministry of Healthcare, the associations shared the state interest in optimizing the system; therefore, they pushed for increase of copayments and reduction of the lists of categories of people eligible for free and discounted health care. Other health CSOs represented the population. Usually such CSOs concentrated their activity on marginalized groups (rural women, HIV/AIDS...
patients, drug and alcohol abusers etc.) or special categories of patients (e.g. diabetics); only one organization, Alliance of Patients’ Rights Advocates (created in 2004), focused on the rights of patients in general without concentration on specific groups of patients. These health CSOs tend to be independent from the state unlike the associations of doctors, and hospitals, and their main goals are information exchange, service delivery, promotion of patients’ rights, monitoring of health care provision and advocating policy change. From the section on the background of the reforms it is concluded that the reforms were successful in achieving goals of the state and donors, which were optimization and rationalization; however, were not fully successful in achieving proclaimed goals of universal affordability and accessibility of medical care.

Worldwide, civil society is acknowledged as an important actor, contributing to healthcare reforms. In Kyrgyzstan healthcare system was not analyzed from the political perspective of the interplay between the actors. Most of the analysis done in the healthcare sector was cost-benefit analysis, economic analysis of efficiency and analysis of effectiveness of the reforms. No overall exploration of the reforms results was done; moreover, dichotomy between declared goals and real situation in healthcare sector was not studied closely, if some analysis has been done it concentrated on economic resources and political will of the state. Hence, previous research mostly focused on analyzing the activities of providers of care (the ministry, hospitals, doctors etc.). Policy input of health CSOs representing the consumers has not been studied carefully. Therefore, it may be useful to look at the activities of independent health CSOs to see how effective or ineffective they were in promoting rights of the health care service consumers and what policy influence these CSOs had in order to explain why the system of healthcare
disproportionately fulfilled the goals of the providers without fulfilling the needs of the consumers.

**Timeline of civil society involvement in healthcare sector**

During the first years of transition from the socialist system the state was uncontested in its policymaking power. Specifically to the healthcare sector, in the first years of independence the Kyrgyz government realized that the state will not be able to support the Soviet system of healthcare and the main goal was optimization of the system in order to cut the expenditure. The state was the only actor who started the preparatory program of the reforms in 1992. Then, as Kyrgyzstan became a member of the World Health Organization, more actors appeared in the sphere of healthcare which assisted the state in development and implementation of the reforms program. In 1993-1995 those were the WHO and the World Bank, which was the main donor providing funding for the reforms. Then, closer to the launch of the first reform program in 1996, other donors such as Dfid, Swiss Red Cross, Swiss International Development Agency, later USAID, SOROS Foundation, the Global Fund and other minor donor contributors such as Carhab and others joined. The main donors remained in the healthcare system throughout the two reforms programs.

Civil society organizations did not appear on the theater of actions until 1997. In 1997 the first health civil society organizations were created by the initiative of the donors (World Bank and DFID): they were the Family Group Practice Association (FGPA) which united family doctors and nurses of Kyrgyzstan, and the Hospital Association (HA). These organizations played a major role in restructuring of the system of health services provision, retraining of medical specialists and contributed greatly to
the development of the legislative and normative base for new mechanisms of healthcare system financing. However, taking a closer look at the two associations, one will see that they are not fully independent from the state: these associations are closely related formally and informally to the Ministry of Healthcare. For example, the FGPA took active part in reorganization of the system because the state was still weak and the Ministry of Healthcare could not fulfill its functions with regards to the reforms implementation. Although the core mission of the association is promotion of the interests of its members (the family doctors and nurses), the association did the most share in the development of new normative acts, protocols and documents. It is in the competence of the Association to approve new clinical protocols used in primary care, to approve and introduce changes to the curriculum of the medical educational institutions and to certify primary care specialists. Also, the Association conducts monitoring of the care provision on the primary healthcare level. Interestingly, the Ministry of Healthcare does not even have the department responsible for the primary healthcare and all of the functions of the Ministry in this regard are unofficially transferred to the FGPA, and HA. As was noticed during the interview with the head of the FGPA, the Association works very closely with the Ministry and there are no major conflicts or confrontations with the state body. The only issues that are not agreed upon are the salary of the doctors and the amount of funding provided for the hospitals. The associations ask for the increased pay and the increased budget for the hospitals and the centers of family medicine, and the Ministry of Healthcare is reluctant to change its policy on these two issues. When asked about lobbying and change of the overall health policy, the head of the FGPA answered that their organization is overloaded with routine work of developing standards of
education for nurses and general practitioners, clinical protocols for treatment and other daily tasks that they do not have enough time even for representation of the interests of their members. Lobbying for change of health policy requires time, which the FGPA, and HA do not have because they are ultimately the only agencies that are responsible for everything related to primary healthcare.

According to the WHO definition, civil society does not have the authority to make policies, implement and enforce them because it does not have the regulatory and coercive power of the state. However, these Associations have the authority to make policies, approve them and implement. Therefore, these organizations are not pure “bridges between the population and the state,” because they are closely related to the state, represent interests of the state workers (family doctors and nurses) and state institutions (state hospitals) and fulfill some of the Ministry’s functions; moreover, the workers in these associations used to work in the Ministry of Healthcare or in the hospitals and have close informal ties with the state representatives while such close ties with the population are not observed.

The CSOs, which are independent from the state started to emerge in the beginning of the 2000s and the majority of the organizations were opened in the period between 2003 and 2007. These data is based on the interviews and the information found on the websites of the CSOs. Specifically, the date of official registration was taken as the date of opening, because tracing the dates of the creation of the initiative groups which had functioned before the official state registration was not feasible. Hence, most health CSOs, besides the two associations in the primary healthcare, were opened when the first round of the reforms “Manas” was coming to an end in 2006. Therefore, they

98 Civil Society Initiative, p 3-10.
could not influence the policy or even monitor the implementation of the reforms policy, because they were either just registered or still too weak and disorganized to have any meaningful policy influence.

In 2006-2012 reforms program “Manas-Taalimi” the FGPA, and the HA were active participants both during the development stage and throughout the implementation stage. However, other health CSOs at the moment of the reforms start were still newly opened organizations and did not have reputation of qualified professional organizations which could contribute to the development of the national program on healthcare system reforms. Also, their relations with the Ministry of Healthcare for the most parts were not well developed; therefore, these CSOs were rarely allowed to monitor the process taking place in the Ministry and its departments. The state bodies, the Country Office of World Health Organization and the FGPA, and the HA did not take other health CSOs seriously; most of the CSOs were not well known and the Ministry of Healthcare together with its main partners in the reforms did not consider including these newly emerged CSOs into the policy making process. Therefore, the policy networks during the development of the second reforms process were composed of the same old actors involved in the first reforms program.

Only by the end of the second reforms program in 2012 did the health CSOs realize some of their advocacy plans. The CSOs which were opened in the period 2000-2006 had considerable experience in working with healthcare institutions, had relatively long time to study the situation in the healthcare sector and learn the techniques of effective presentation and lobbying of its interests. Moreover, cooperation of health CSOs with the rights advocating organizations allowed the CSOs to win several court
cases against the state. For instance, Mental Health and Society together with other smaller mental health CSOs and numerous legal advocating organizations such as Golos Svobody, Precedent and others, managed to win several court cases against the state and state system of mental healthcare as well as managed to lobby for the inclusion of mental health sector of the healthcare system in the reforms program Den-Sooluk (2012-2016). Moreover, owing to the activity of Mental Health and Society and its partners, hemophilia, oncology and tuberculosis sectors were also included in the project of the reforms Den-Sooluk (which initially did not include these four branches of healthcare). Other CSOs which work in healthcare only as part of their activity, for example HIV/AIDS and reproductive health CSOs, started cooperating closely with the state; therefore, earning reputation and advocating some of their goals to the state with the following adoption of their suggestions by the Ministry of Healthcare or other state bodies in the sector. Therefore, the CSOs activity, their cooperation with the state, their involvement in monitoring, and projects aimed at advocacy and policy change in the healthcare system became more visible and achieved some results with regards to bringing change into legislature or common medical practice only by 2008-2012.

**Timeline of CSOs Involvement in Reforms Process**

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<tr>
<td>WHO, state, WB, SIDA</td>
<td>1997 – the first real NGOs: the Association of Family Doctors and Nurses and the Association of Hospitals</td>
<td>Majority of the health NGOs started to form in the beginning of 2000s and became active by 2008-2012.</td>
<td>HIV/AIDS, Mental Health organizations became especially active and influential.</td>
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Although, civil society organizations marked their achievements and stressed increased influence of the health CSOs by 2008-2012, the Country Office of WHO, the
FGPA, and HA do not recognize the input of other health CSOs beside themselves. As, the head of the FGPA put it: “The other health CSOs are too small and invisible in the sector. I have not seen their input and their activity. Possibly HIV/AIDS CSOs could be marked for some activity; however, most of them are working from one grant to another competing for funds without considerable contribution to the healthcare sector as such.”

Also, the list of civil society organizations that the Country Office of the WHO provided did not include any smaller CSOs besides the Family Group Practitioners Association, the Association of Hospitals, several international organizations, the National Red Crescent Society and the independent CSO Mental Health and Society. At the meeting, the WHO representative also doubted policy influence of other CSOs, saying that the Associations which were founded in 1997, and the Mental Health and Society are the organizations the WHO cooperates with; whereas, other smaller and less influential CSOs mostly work on small scale projects and do not have influence on the larger policy making process. Moreover, he could not name other CSOs in the healthcare sector besides those which were on the list the Country Office of the WHO had provided.

However, Roza Otunbaeva’s decision to create Public Advisory Council under each state body promoted CSOs influence in healthcare policy. In 2010 the Public Advisory Council was organized under the Ministry of Healthcare. According to the Statute on the Public Advisory Council, the Council is entirely composed of the civil society representatives and the main functions of the Council among others include

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99 Interview with a representative of the Family Group Practitioners Association.


participation in the discussions and decision making, representation and promotion of the civil society interests and fostering cooperation between the civil society and the Ministry.\textsuperscript{101} Although, such a unit under the Ministry of Healthcare created a platform for the health CSOs to be directly involved in the discussions and policy making under the Ministry of Healthcare, the independence of the Council is doubtful. For instance, the chairperson of the Council, Uchkempirova Rosa is also an officially hired consultant for the Ministry of Healthcare, which creates a conflict of interests and potentially compromises independence of the whole Council. Thus, the Council increased possibility for policy influence exercised by the independent health CSOs; however, the influence these CSOs can have through the Council is also limited.

The timeline shows that the CSOs were not involved at the critical moment of the transition from socialized healthcare, as it used to be in the Soviet period, to partly market-regulated system with copayments and insurance, which later brought about informal markets in public hospitals. As it was discovered in literature review, favorable times for mobilization of social movements are times of political opportunity at the period of uncertainty and indeterminacy caused by transition. The independent health CSOs did not emerge until 10 years after the favorable moment of political opportunity. Moreover, the welfare systems formed after the initial years of transition appear to be resilient to changes.\textsuperscript{102} Therefore, the health CSOs could not influence the course of the reforms at the initial stages when the principal mechanisms of service delivery and financing were determined and reformed. When the CSOs emerged, they could only bring about incremental changes because the core of the system was already resilient to

\textsuperscript{101} Ibid.  
\textsuperscript{102} Beblavy, p 5.
change and the newly emerged CSOs did not have significant policy influence to push for new drastic reorganization of the system. Hence, the CSOs did not participate in determining the basics of the healthcare system in Kyrgyzstan and therefore, did not represent consumers of health services at the critical moment in the reforms. Then, they could only initiate incremental changes depending on their policy influence.

Civil Society Organizations’ Policy Influence

Since the main puzzle is why the healthcare system meant to be affordable and accessible, therefore consumer friendly, did not become one, but encouraged formal and informal market interventions in the state medical institutions which undermined the universality of the healthcare coverage, it is helpful to look at the activities of those who represented the consumers’ interests – the health CSOs. It is notoriously difficult to operationalize the measure for “policy influence” of the CSOs; however, based on the history of the health CSOs in Kyrgyzstan and interviews with the CSOs, the WHO Country Office, and Soros, policy influence of the CSOs during the healthcare reforms in Kyrgyzstan will be assessed. Information aggregated from the previous literature and the interviews allows us to compile a list of criteria for assessment of CSOs influence. The criteria include: the date of registration, specialization of a health CSO, framing, financial sustainability, professional knowledge (education, practical knowledge, context knowledge), informal networks, and policy networks (cooperation between each other and with a state).

The date of registration in the context of reforms in Kyrgyzstan matters because of the chronology of the reforms. The earlier during the reforms the CSO was registered the more opportunity it had to influence the reforms and the more influence it gained by
today. As the timelines showed the reforms preparation took place in 1992-1995, if health CSOs had appeared at that time, they may have had a political opportunity to mobilize their resources, because the state was also weak at that time, and impact the model of healthcare which was then developed. However, most health CSOs were registered in the period of 2000-2007, which made it impossible to have a say in the development of the first program and significantly impaired their ability to matter in the development of the second program. However, the earlier the health CSO was registered the more influence it obtained by today. For example, Mental Health and Society is one of the earliest independent health CSOs, it was registered in 2000, and one of the most influential, recognized by the Ministry, the FGPA, the HA and the WHO Country Office. Longer existence on the healthcare arena gave the CSO a chance to gain knowledge, reputation and experience which increased its policy influence. Therefore, the strength of a health CSO’s policy influence is partly determined by the chronology of its involvement. Generally, most CSOs were not opened until later during the course of the reforms, therefore overall capacity of the health civil society to influence the reforms trajectory was weak.

Health CSOs perform different types of healthcare system functions. The same health CSO may perform multiple functions; however, in most cases a health CSO is more active in one or few of the directions. The following table present categorization of health CSOs by Civil Society Initiative of the WHO, and the third column presents examples of the interviewed Kyrgyz health CSOs which perform respective functions (Kyrgyz CSOs are put in the respective line on the base of their implemented projects and performed activities and not on the bases of their proclaimed missions and goals):

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103 Civil Society Initiative, p 6.
<table>
<thead>
<tr>
<th>Health System Function</th>
<th>Examples of Role of CSOs</th>
<th>Examples of CSOs in Kyrgyzstan</th>
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<tr>
<td>Health Services</td>
<td>Service provision;</td>
<td>Rans Plus (facilitating</td>
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<td>Facilitating community</td>
<td>marginalized community</td>
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<td>interactions with</td>
<td>interaction with services;</td>
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<td>services;</td>
<td>distribution of syringes);</td>
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<td>Distributing health</td>
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<td>resources such as</td>
<td>medicine provision);</td>
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<td>condoms, bed nets, or</td>
<td>Ranar; New Perspective on</td>
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<td>cement for toilets;</td>
<td>Mental Health; Asteria;</td>
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<td></td>
<td>and</td>
<td>Podruga; Tais Plus2; Network</td>
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<td></td>
<td>Building health</td>
<td>on Harm Reduction; Aman Plus;</td>
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<td></td>
<td>worker moral and</td>
<td>Family and Society; Community</td>
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<td></td>
<td>support.</td>
<td>Action for Help; Partner</td>
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<td></td>
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<td>Network; Plus Center (13</td>
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<td></td>
<td></td>
<td>organizations)</td>
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<tr>
<td>Health Promotion and Information Exchange</td>
<td>Obtaining and disseminating health information; Building informed public choice on health; Implementing and using health research; Helping to shift social attitudes; and Mobilizing and organizing for health.</td>
<td>Alliance of Patients’ Rights Advocates (Information Exchange); Ransar; Independent Legal Advocacy Group; Asteria; Podruga; Tais Plus2; Network on Harm Reduction; Aman Plus; Family and Society; Community Action for Help; Partner Network; Plus Center (12 organizations)</td>
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<tr>
<td>Policy Setting</td>
<td>Representing public</td>
<td>Rans Plus (promotion of HIV/AIDS patients’ rights, Den Sooluk development); Independent Legal Advocacy Group; Mental Health and Society; Asteria; Network on Harm Reduction; Aman Plus; Family and Society; Partner Network (8 organizations)</td>
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<td>and community interests in policy; Promoting equity and pro-poor policies; Negotiating public health standards and approaches; Building policy consensus, disseminating policy positions; and Enhancing public support for policies.</td>
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<tr>
<td>Resource Mobilization and Allocation</td>
<td>Raising community preferences in resource allocation; Mobilizing and organizing community co-financing of services; Promoting pro-poor</td>
<td>Rans Plus (struggle for transparency in allocation of resources); Mental Health and Society (2 organizations)</td>
</tr>
</tbody>
</table>
and equity concerns in resource allocation; and
Building public accountability and transparency in raising, allocating and managing resources.

| Monitoring Quality of Care and Responsiveness | Monitoring responsiveness and quality of health services; Giving voice to marginalized groups, promoting equity; Representing patient rights in quality of care issues; and Channelling and negotiating patient complaints and claims. | Rans Plus; Independent Legal Advocacy Group; Mental Health and Society; Asteria (4 organizations) |

From the interviewed organizations there were more organizations that provided health services, gave out condoms or syringes, promoted healthy lifestyle, produced and distributed informative brochures than those involved in advocacy, monitoring and policy setting. Obviously, the health CSOs which are not involved in the latter do not have considerable policy influence, because they do not get involved in processes which can potentially change state health policies. Therefore, the former constitute category#1 of CSOs whose policy influence is minor or non-existent and the latter constitute the category#2 of health CSOs which have ability to influence state policy making. Although the sampling for the interviews may not be fully representative, the information obtained from the CSOs during the interviews and from the analysis of the secondary literature presents overall health civil society in Kyrgyzstan as one dominated mostly by the organizations from the category#1 which undermines overall policy influence of the
health civil society in the country. Further, the analysis will concentrate on the category#2, since they have potential for influencing the health policy.

Besides specialization, a health CSO policy influence depends on its “meaning work – the struggle over the production of mobilizing and countermobilizing ideas and meanings.” Scholars named such production of ideological base of actions – framing. For comprehending what frames the health CSOs have/had their statements of the mission and the reasons for action were used. The most prevalent frame was that of social justice and human rights. Interestingly, the framing of the CSO Mental Health and Society has changed over time. If in the beginning the main message was human rights, equality of rights of people with mental disorders or disabilities, opportunity for social integration for people with mental disorders and similar ethical and moral appeals; then in 2007-2008 the necessity of actions was justified by efforts of saving state budget’s money. Specifically, the framing changed when the organization completed Budget Transparency Project in 2008; the new appeal to the state authorities and the donors was that the organization’s activity actually saves the states’ money and that the CSO’s suggestions are also based on the optimization goal, therefore, the state needs to listen and take into account the policy suggestions of the organization. Hence, the interests of the state coincided with the framing of the organization’s actions which increased the probability of successful cooperation with the state. Whereas, other health CSOs did not change their frames so drastically and still continued to use the frames of justice and morality. The fact that the Mental Health and Society’s policy influence is recognized by the WHO, the Ministry of Healthcare and other CSOs, produces an assumption that their

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framing process and resultant frames were more successful. Therefore, the CSOs’ policy influence increases when their frames coincide with the interests and frames of other powerful actors in the policymaking arena.

Financial sustainability was marked by all the interviewees as one of the most important factors of the policy influence. All the health CSOs in Kyrgyzstan function on the money received from donors (members or constituencies do not contribute), who have their own budget limits, agenda and specific goals they allocate funds for. The CSOs’ representatives referred to many occasions when the money did not come in time, or in a full promised amount, due to changes in the donors’ policies or budget; which restrained the CSOs activities. Moreover, current funding mechanism of the health CSOs frequently promotes competition among the health CSOs and inhibits their ability to cooperate for the common goal. The health CSOs live from grant to grant and when there is a period of time between the grants – some health CSOs have to transfer their activities to the stand-by mode and wait until the next grant is available. Therefore, financial unsustainability presently observed among the health CSOs undermines their overall ability to have meaningful input into health policy making. Such a conclusion is valid for all the health CSOs in Kyrgyzstan: regarding this criterion, the level of health CSOs unsustainability may vary; however, all the CSOs are unsustainable.

Professional knowledge was pointed out during the interviews as a powerful tool for increase of health CSOs’ policy input. Specifically, professional knowledge incorporates three areas: education, practical knowledge and knowledge of the context.

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105 Interviews with the CSOs.
Many representatives of the health CSOs lacked formal higher education or admitted that their diplomas were bought. The need for higher education was conditioned by the need for research skills, analytical thinking and proper use and understanding of terminology and statistics.\textsuperscript{107} One of the interviewees elaborated on the criterion of professional knowledge in the following way: “In order to lobby for some policy we have to present strong arguments in support of this policy based on the prior research, solid cost-benefit analysis and professionally elaborated suggestions.”\textsuperscript{108} “Often at the meetings with the state officials, when we tried to promote some change in policy, we faced questions about our suggestions that we could not answer. It was obvious that we needed to increase our capacity and professional knowledge of the sphere.”\textsuperscript{109} The lack of higher education among the workers and leaders of the health CSOs was somewhat compensated by the numerous trainings and seminars organized by the donors. However, few of these seminars contained a practical component. The knowledge of different research methods, budget allocation techniques, time management and other necessary skills, received at the trainings was often insufficient due to its theoretical base. Also, the health CSOs, workers or leaders of which came from the background closely related to the area of the CSOs’ expertise tend to be more successful in their policy influence because they have more insight into the core of the problem. Hence, the higher the degree of professional knowledge possessed by the organizations’ leaders and workers, the higher there is probability of these organizations having an influence on policymaking process.

Besides more conventionally accepted indicators of policy influence, the health CSOs occasionally have to use some informal connections and relationships in order to

\textsuperscript{107} Interviews with CSOs.
\textsuperscript{108} Interview with Sergei Bessonov, Attica representative.
\textsuperscript{109} Ibid.
influence policy. For instance, the head of Rans Plus pointed out that “sometimes we have to ask our relatives or acquaintances to help in some processes. For example, there may be a friend of a friend, a relative or a neighbor who works in the Ministry of Healthcare or in the hospital or in some other state institution and when the solution of the issue is long postponed by this institution we sometimes ask this person to assist in speeding up the process.”\(^{110}\) As was also mentioned during the interviews, most of the time these informal schemes are avoided; however, from time to time the CSOs do use informal networks for promotion of their interests and for increasing the policy influence. However, the informal networks are not determinants of the policy influence; they are just a convenient tool that can be used for easing the process.\(^{111}\) Thus, the interviews confirmed existence of the informal networks and their sometimes positive impact on the policy input of the health CSOs; however, this factor is not determining and the previous indicators of the policy influence are more important.

Unlike informal connections, policy networks play crucial role in determining a health CSO’s policy influence. Policy networks are “clusters of actors, each with an interest, or “stake” in a given policy sector and the capacity to help determine policy successes or failures.”\(^{112}\) In Kyrgyzstan there are two principal types of networks existing in healthcare: *sector-specific* and *issue-specific*. Sector-specific networks are involved in overall health policy change making general decisions about the way the system functions: financing, responsiveness, monitoring, health promotion and etc. Issue-specific networks are those focused on policymaking and policy change in a specific branch of the

\(^{110}\) Interview with Ibragim Lebuzov.  
\(^{111}\) Interview with Burul Makenbaeva.  
\(^{112}\) Peterson, p 1.
healthcare system, for example, policy change in the sphere of HIV/AIDS, oncology, mental health or reproductive health.

One sector-specific network in healthcare sector (Graph 1) involves the Ministry of Healthcare, Donors, the Country Office of the WHO, the FGPA, the HA, State Center on HIV/AIDS, and the National Red Crescent Society, which are all interconnected and cooperate closely on the policymaking in the sector in general. As seen on the graph Alliance on Reproductive Health and Mental Health and Society are the civil society organizations which are involved in a sector-specific network. However, they are located further from the other actors because their influence is lesser than the state actors’ and the donors’ policy influence. The pharmacies also contribute to the formation of the general health policy; however, they are not represented officially in the network through working groups, committees and other ministry organized groups for involvement of non-state actors. Pharmacies also do not lobby openly and do not create networks of their own to promote their interests. Frequently, they have bilateral agreements with the ministry or
individual hospitals and do not have formal presence in the decision making bodies. Within the sector-specific network all the actors cooperate or collaborate with each other. The health CSOs involved in this network have stronger policy influence than other CSOs because they have a say in general health policy. From the graph one may conclude that the health civil society overall policy influence is weak because only two CSOs are represented in the network and both of the CSOs are further away from the main decision-making body – the Ministry of Healthcare.

Issue-specific networks concentrate on one field in healthcare. The first type of issue-specific network is shown on the Graph 2 and is based on the example of HIV/AIDS network; however, mental health issue-specific network is similar. The health CSOs in these two healthcare spheres (HIV/AIDS & mental health) appear the strongest. They managed to be involved in working groups and committees under the Ministry and their numerous policy suggestions were taken into account and often adopted by the state. Moreover, both HIV/AIDS and mental health CSOs managed to influence new reforms program Den-Sooluk and policy changes they were lobbying for were included in the program. The first type of issue-specific network involves state bodies, donors, law clinics which cooperate closely with the HIV/AIDS CSOs, individual HIV/AIDS CSOs and HIV/AIDS CSOs united into associations (Network on Harm Reduction and Partner Network). Actors united in this network have influence over HIV/AIDS policies due to their close cooperation with the state. However, within this network health CSOs united into associations have more policy input than those lobbying individually.  

Other types of issue-specific networks (graphs 3, 4, and 5) also exist in the HIV/AIDS sphere, however, they are present in other healthcare areas as well. The CSOs

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113 Interviews with CSOs.
involved in this networks have limited or no policy influence because 1) they do not cooperate closely with the state while cooperating between each other by uniting into associations (Graph 3) 2) they do not cooperate closely with either the state and cooperate with each other when they need to without uniting into associations (Graph 4) and 3) they do not cooperate with the state or between each other (Graph 5).

The less cooperation there is between the CSOs the less serious they are taken by the state bodies and the donors, therefore, the less policy input they may bring into health policymaking. Consequently, the CSOs united into associations have increased policy influence in comparison to the CSOs cooperating without uniting into one strong actor in the eyes of the state and the donors. The CSOs which do not cooperate between each other or the state have no policy influence because they do not interact with the decision-making body and other actors. Such organizations usually have advocacy, monitoring and policy-setting as their goals declared through their official mission and charter (if they have one); however, in practice they mostly perform such functions as provision of health services, promotion of health and information exchange,\textsuperscript{114} which do not strictly require cooperation with the state or between each other.

The type of policy network a health CSO is involved in partly determines its policy influence. Involvement in sector-specific policy networks opens horizons for

\textsuperscript{114} Interview with the head of Alliance of Patients’ Rights Advocates.
influencing overall health policy; participation in issue-specific networks which include state actors, other CSOs, law clinics and donors (type#1, graph 2) allows the health CSOs to influence policy of a specific branch of the healthcare sector; and participation in the issue-specific networks (type#2, 3, 4; graphs 3,4,5) which do not cooperate or rarely cooperate with the state and with various degrees of inter-organization cooperation limits policy influence of the health CSOs. Hence, keeping in mind that only two independent health CSOs are in the sector-specific network and CSOs from only two branches of healthcare (HIV/AIDS and mental health) participate in issue-specific networks of the type#1, with the rest CSOs composing issue-specific networks of types #2, 3, and 4, it is relatively easy to come to a conclusion that overall health civil society is weak and its influence on the health policy is limited.

From all of the above indicators the HIV/AIDS and mental health sectors of the healthcare emerge as somewhat influential while other CSOs appear to be weak and exposing no policy influence. Therefore, overall health civil society can be ranked as weak. Thus, the health civil society had no influence at the beginning of the reforms because the health CSOs formed only after the reforms had been launched. The civil society policy influence during the second reforms program was limited due to its overall poor score on the above-mentioned indicators of policy influence. Consequently, the health civil society could not meaningfully represent the interests of the population which could lead to disproportionate results of the reforms benefiting the state and the medical workers more than the patients. However, presence of the civil society in the healthcare sector could play the role of the barrier for further privatization and further spread of informal market relationships in the public hospitals. Therefore, the health civil society
may not have had determining influence on the overall health policy; however, it did not allow the situation to get worse for the patients and now is gradually working on the improvement of the situation in healthcare and elimination of the emerged dichotomy between the proclamations of universality and reality of profit-making in state hospitals.\textsuperscript{115}

\textsuperscript{115} Interview with the WHO representative.
Conclusion

The study of the healthcare reforms in Kyrgyzstan is a study representative of the social welfare reforms in post-socialist transition countries. It was importantly mentioned that the period of transition created a moment of political opportunity for undertaking the reforms. The group and process models of public policy making offered a useful framework for the analysis of health policy making by looking at the healthcare system reforms as a health policy change which happened in the context of multiple actors interplay. Actor analysis and special emphasis on the role of the health civil society involvement and its policy input during the reforms provided helpful insights about possible reasons for incomplete reforms implementation, emergence of the formal and informal markets in the state medical institutions and compromised affordability and accessibility of the healthcare in spite of the official proclamations of universality.

The fact that the health CSOs emerged closer to the completion of the first reforms program explains why they could not influence the reforms at their start when the system was defined and therefore, could not represent the interests of the population at the commencement of the reforms process. Moreover, due to their limited influence on the policymaking process during the second reforms program the health CSOs could not meaningfully lobby for a change of health policy in favor of affordability and accessibility for the common people. The health CSOs’ activities could not drastically reorganize the healthcare system because it has already been formed and resilient to change by the time the CSOs were founded. However, health civil society’s increased policy influence by the end of the second reforms program may explain why the situation in healthcare did not deteriorate for the patients; specifically, their input into specific
branches of the healthcare or small scale projects could be one of the factors preventing the system from further “marketization.”

The current research provides an overview of the health CSOs involvement in the healthcare system reforms. Since it covers a period of time from 1990 until 2012, the scope of the research had to be narrowed to analyzing only one possible factor which could explain the emergence of a dichotomy between the official proclamations of the reforms’ goals and the real situation in the healthcare. Also, the policy networks and the actor analysis had to be simplified in order not to overload the work with the detailed analysis of the actor relationships emerging and changing during the 22 years of the reforms.

The analysis of the dichotomy between the proclamations and reality through the lens of the health civil society activities provides only one part of the bigger picture. In order to complete the jigsaw, further research may focus closely on other economic (e.g. committed resources) or political factors (e.g. political will) which could add more explanations of the current situation in the healthcare system. Additionally, to test conclusions suggested in this paper, further research may concentrate on several specific health policies (preferably, one - heavily influenced by the CSOs and another – adopted without meaningful involvement of the health CSOs) which were adopted by the Ministry of Healthcare or Parliament and trace the history of these policies in details: who was involved, how much resources were available and what were the specific steps and actions taken by the civil society. Such a case study will 1) test the validity of the indicators worked out for the assessment of the health CSOs influence, and 2) find
whether there are significant differences between the health policies depending on presence or absence of the health CSOs’ policy influence.
Appendix I

List of organizations interviewed:

1. Alliance of Patients’ Rights Advocates
2. Aman +
3. Association of Family Doctors and Nurses of Kyrgyzstan
4. Asteria
5. Attica
6. Community Action for Health
7. Country Office of World Health Organization
8. Family and Society
9. Hospitals Association
10. Independent Legal Advocacy Group
11. Mental Health and Society
12. New Perspective on Mental Health
13. Network on Harm Reduction
14. Partner Network
15. Plus Center (Osh oblast)
16. Podruga (Osh oblast)
17. Ranar
18. Rans Plus
19. Tais +
20. Tais +2 (Jalalabad oblast)
Appendix II

Core Questions Asked During the Semi-Structured Interviews

About the organization:

1. When was your organization founded/or when did you start working in the healthcare sector in Kyrgyzstan?
2. What is your stated mission and goals?
3. Why did you choose to achieve these specific goals?

The organization’s activity:

4. What were the most important activities you undertook in order to achieve your goals? When? (timeline)
5. How did you frame the necessity of your actions?
6. What are the most important mechanisms and instruments you use in order to achieve your objectives?
7. What partners do you work with?
   a. Do you cooperate with governmental bodies? Which? In what way?
   b. Do you cooperate with civil society organizations? Which ones? In what way?
   c. Do you cooperate with donors? Which? In what way?
8. Which of the goals were successfully achieved?
   a. Why some of the goals were not successfully achieved (if any)?

About the healthcare system in Kyrgyzstan:

9. Do you think Kyrgyz healthcare is socialized or market-regulated (in declarations, in reality)?
10. Were the healthcare reforms successful? Why yes, or why not?
11. What is the role of the civil society organizations in the reforms process?
12. Is there a need to change approaches that civil society organizations use in order to participate in healthcare reforms? How should their activity be changed?
Bibliography


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Ibraimova, Ainura, Baktygul Akkazieva, Gulgun Murzalieva, and Dina Balabanova. "Kyrgyzstan: A Regional Leader in Health System Reform." In *'Good Health at Low Costs' 25 Years on. What Makes a Successful Health System?*, by Martin McKee, Anne Mills Dina Balabanova, London. 117-157: The London School of


Murzalieva, Gulgun, Kanat Kozhokeev, Kubanychbek Dzhemuratov, Svetlana Nasirova, and Ulan Tursunbaev, eds. The Effects of Restructurization on Rural Accessibility to Health Care and Its Economic Efficiency. Policy Analysis #25, Health Policy
Analysis Center, 2003,


