Can the Transition to Compulsory Medical Insurance Reform the Country's Health Care System?

written by Azer Mehtiyev

The phased introduction of compulsory medical insurance in Azerbaijan, which began in early 2020, has finally ended: since April 1, 2021, the entire population has been covered by compulsory medical insurance. Two other events in April also sparked interest in rethinking the country's health care system:

1. First, there were the arrests of the heads of two large medical facilities treating patients with a new type of coronavirus (COVID-19) – the chief physician of Zigh Modular Hospital of the Ministry of Emergency Situations' Medical Center and the director of New Clinic Public Legal Entity – and some employees. At that time, there was an interesting controversy between the Ministry of Emergency Situations (MES) and the Medical Territorial Units Management Association (MTUMA) over the appointment and subordination of the chief physician of Zigh Modular Hospital: local media reported that the arrested Chief Physician and staff of the well-known MES hospital were not employees of the MES Medical Center and that they were under contract to MTUMA. MTUMA reacted immediately, stating that that information did not reflect the truth and that no contract had been signed between MTUMA and MES or its hospital. In fact, these statements can be seen as attempts by these agencies *to evade responsibility or share it partially*;
2. Second, there was the firing of the health minister Ogtay Shiraliyev, who did not appear in public during the pandemic and seemed to abnegate any responsibility.

Over the past year, against the backdrop of public dissatisfaction with the organization of the treatment of coronavirus patients, some media outlets in Azerbaijan have voiced opinions on the need to remove state medical institutions from subordination to MTUMA and return them to the ministry. However, it is no accident that such opinions have increased and intensified in the media after these recent events.

As someone who has been constantly monitoring and observing the country's health reform attempts and efforts over the past 15-20 years, I can say that the problems in Azerbaijan's health system and the public's dissatisfaction are not new, they have taken root in the health system and have been gradually deepening for years. It would be naive to expect that these problems will suddenly be resolved and eliminated after the transition to compulsory medical insurance (especially when this takes place during a pandemic).

There is no research or systematic evidence to suggest that the problems in medical institutions have increased since the transition to MTUMA. It is too early to assess the consequences of the transition to compulsory medical insurance, as we are still in the early stages. Therefore, in the current situation, it is only possible to evaluate the progress of compulsory medical insurance reform, as well as to assess how radical the changes are that this process could lead to in the health care system as a whole. In this article, I will comment on precisely these two issues.

Preparatory stage for reforms in Azerbaijan's health system

The issue of reforms in Azerbaijan's health system began to be discussed in the late 90s and early 2000s. The Semashko model of health care, inherited from the former USSR and intended to provide free services to the public, no longer worked. With limited economic and financial resources, the government could not allocate enough funds for the normal functioning of the

health system, even the limited funds allocated from the state budget became fodder for corruption, the provision of supplies and equipment for medical institutions gradually deteriorated, and the public's out-of-pocket payments for medical services increased.

According to the World Bank, in Azerbaijan in 2002, only 20-25% of total annual health expenditures came from the state budget, and the remaining 75-80% were out-of-pocket payments (World Bank 2005). According to the State Statistics Committee (SSC), the amount of funds allocated from the state budget to the health sector in 2002 amounted to AZN 44.8 million (about USD 50.2 million), which is 4.8% of annual state budget expenditures and 0.7% of annual GDP. The amount of funds allocated for health care from the state budget was about AZN 5.50 (USD 5.70) per capita. According to Transparency International's 2002 Corruption Perceptions Index, Azerbaijan ranked 95th out of 102 countries with 2 points.

The State Commission on Health Reforms was established by the Order of the President of the Republic of Azerbaijan #760 of March 13, 1998 in order to determine the kind of reforms needed in the health care system, to prepare a reform program, to organize and carry out the reforms. The commission's charter was approved on December 29 of that year by Decree #49.

In October 1999, the Law of the Republic of Azerbaijan on Medical Insurance 28 (#725-IQ) was adopted. The Presidential Decree of December 30, 1999 (#241) on the implementation of the law instructed the Cabinet of Ministers to determine the amount and procedure for payment of compulsory medical insurance premiums within 2 months, and the tariffs for medical services in the compulsory medical insurance system, as well as to approve the compulsory medical insurance program. However, there has been no official statement or official document on the implementation of these tasks.

The Health Reform Project, worth USD 5 million, was signed with the World Bank in 2001 to support the development of health reform. The project, which ran from 2001 to 2006, included components for strengthening primary health care, as well as capacity building and optimization of the ministry in five pilot areas. In 2005-2006, with the active participation of the World Bank, the World Health Organization, USAID, and several other international organizations, discussions on health reform in Azerbaijan expanded, and an expanded concept of health sector reform was developed and submitted to the government. However, this document was not approved as a program, remaining merely a working document [Azerbaijan HiT, 2010].

In 2006, an agreement was signed with the World Bank for a USD 50 million Health Sector Reform Project. This project, which was implemented in 2006-2013 and covered 5 pilot regions (Absheron, Aghdash, Ismayilli, Gakh, and Shaki), envisaged structural and management reforms in the health system. A report from the Ministry of Health stated that the Azerbaijani government would provide an additional USD 28.3 million, the United States Agency for International Development (USAID) – USD 8.0 million, UNICEF – USD 470,000, and the World Health Organization – USD 35,000. As part of the project, a report was prepared in 2009 to assess the performance of the Azerbaijani health care system, fully reflecting its problems.

In 2005-2006, the government developed and adopted 9 programs for a group of diseases (diabetes, oncology, chronic kidney failure, blood diseases, etc.), and began to allocate funds from the state budget to finance these programs.

On February 6, 2007, a Decree of the President of the Republic of Azerbaijan (#523) repealed the above-mentioned order and decree on the State Commission for Health Reforms.

The first attempt to reform the health financing system

On December 7, 2007, amendments and additions were made to the

Law of the Republic of Azerbaijan on Medical Insurance in order to establish compulsory medical insurance. On December 27, the Order of the President of the Republic of Azerbaijan (#2592) on the Establishment of a State Agency for Compulsory Medical Insurance under the aegis of the Cabinet of Ministers of the Republic of Azerbaijan was signed. The order states that the agency was established "to improve the management of the health system of the Republic of Azerbaijan, to further improve the quality of health services by adapting the mechanism of medical care to modern requirements, and to launch a compulsory medical insurance system."

On January 10, 2008, a decree of the President of the Republic of Azerbaijan (#2620) approved a concept paper for the reform of the health financing system and the implementation of compulsory medical insurance. The concept paper stressed that the introduction of compulsory medical insurance will create a new economic basis for financing Azerbaijan's health system, provide all citizens with free basic medical services, improve the quality of medical services, and improve the health system management.

On August 11, 2008, Resolution #179 of the Cabinet of Ministers of the Republic of Azerbaijan approved the Action Plan on the Implementation of the Concept Paper on Reforming the Health Financing System and Implementation of Compulsory Medical Insurance in the Republic of Azerbaijan for 2008-2012. The Action Plan included a list of measures to be taken by the end of 2012 to implement the concept paper on the introduction of compulsory medical insurance, the names of the agencies responsible for their implementation, and the deadlines for the implementation of each measure.

Included in the 2008 state budget package, the program document entitled "Concept paper and forecast indicators for the economic and social development of the Republic of Azerbaijan for 2008 and the following three years" also set concrete goals to be achieved by the end of that period as a

result of health financing reforms the creation of the medical insurance system (State Budget Package of the Republic of Azerbaijan for 2008. Volume II. Baku, 2007, pp. 82-83).

Although the annual state budget for 2008-2011 envisaged expenditures related to the introduction of compulsory medical insurance (AZN 30.0 million in 2008, AZN 51.0 million in 2009, AZN 30.0 million annually in 2010 and 2011), those expenditures were never made. This is because the establishment of the main body to implement compulsory medical insurance – the State Agency for Compulsory Medical Insurance under the aegis of the Cabinet of Ministers – did not take place until the end of 2015.

As part of a study conducted in 2012 with the support of Oxfam International on the state of health financing reform in Azerbaijan, I investigated the reasons for the failure to establish the State Agency. My conclusion was that the main reason was the conflict between interested parties in controlling the large financial and other resources circulating in the health sector. At that time, the appointment of the heads of public health facilities in Azerbaijan and the state funds allocated to these facilities were sources of corruption.

Although the vast majority of public health facilities in Azerbaijan were subordinated to the Ministry of Health, there were also health facilities subordinated to a number of other government agencies. In addition to the Ministry of Health and its subordinate bodies, the Ministry of Finance, heads of district (city) executive authorities, district finance and health departments, and others were directly and indirectly involved in the allocation of funds from the state budget. In other words, the planned reforms in the field of health financing affected many different interests. The Ministry of Health wanted the State Agency for CMI to be subordinated to the ministry and tried to achieve that.

Public health becomes less accessible as funding increases

Due to large oil revenues, starting from 2007, the amount of funds allocated to the *Health* section of the state budget, as well as state investments in the health sector, were increasing year by year. Expenditures in the *Health* section of the state budget amounted to AZN 162.0 million in 2006 and AZN 618.9 million in 2013, a fourfold increase. At the same time, the amount of state investments in the health sector in 2007-2013 amounted to AZN 1.0477 billion.[1] (these funds were allocated to the construction of new health facilities and the overhaul of existing health facilities).

Another example: according to the Ministry of Finance, the 2007 state budget allocated AZN 12.1 million for supplying hospitals with medicines, bandages, and materials, and AZN 5.0 million (actual expenditures) for the purchase of food products.[2] In 2012, these expenditures amounted to AZN 37.3 million and AZN 18.5 million,[3] i.e. they increased by 3.1 and 3.7 times, respectively. However, it was no secret at the time that all medicines and food for hospitalized patients were provided by the patients themselves or by relatives (whereas in 2005 the Ministry of Health approved a list of drugs to be provided to inpatients at the expense of the state.). approved a list of drugs). The increase in state funding for this sector has intensified the struggle between interested parties.

At the same time, despite the increase in public funding for health, the share of out-of-pocket payments in health expenditures has increased again. According to the World Bank, the share of out-of-pocket payments in total annual health expenditures in Azerbaijan fell from 72.3% in 2002 to 52.7% in 2007. Although the amount of funds allocated by the state to the health sector has increased significantly since 2007, the share of out-of-pocket payments has also started to increase again, reaching 60% in 2012.

However, by the order of the Minister of Health, services provided to the population for a fee were abolished on February 1, 2008 at treatment and prevention facilities included in the structure of the ministry and financed from the state budget.[4] Along with corruption in public health, I must note that the increase in the share of out-of-pocket payments is due to factors such as the rapid increase in the number of private clinics in Azerbaijan's health sector and the increase in incomes and solvency due to the economic recovery.

At the same time, monitoring revealed that during this period, the number of citizens going abroad for treatment (Iran, Russia, Turkey and other countries) was growing rapidly from year to year. For example, according to the SSC, the number of citizens traveling abroad for medical tourism increased from 20,600 in 2007 to 169,000 in 2013, an eightfold increase. This could be considered an indicator of the public's dissatisfaction with the high prices and low quality of medical services provided in Azerbaijan. It can be concluded that despite the significant increase in both the public's demand for medical services and the government's spending on health care, there has been no progress in the level of access to quality health care, which has actually deteriorated. This situation is known in health care as the Inverse Care Law.

This situation could not fail to attract the attention of the government, especially just prior to the 2013 presidential election. Thus, in the development concept paper Azerbaijan 2020: Vision of the Future, approved by the Decree of the President of the Republic of Azerbaijan dated December 29, 2012 (#800), the issue of the transition to compulsory medical insurance was highlighted as an important reform area. And immediately after the election, some efforts were made in this area. However, the economic crisis in Azerbaijan in 2015 played a decisive role in taking real steps towards the transition to compulsory medical insurance.

The second attempt to reform the health care system: The transition to compulsory medical insurance

According to experts who have studied the experience of health reform in different countries, the existing institutions and ruling special interest groups operating in each country are often actively opposed to radical change, and are often even able to find grounds for their opposition. Therefore, radical reform of the system requires a certain political or economic upheaval (Marc J. Roberts et al. 2003).

The economic crisis that Azerbaijan faced in 2015 was such a shock, launching radical reforms in the financing of the health system in Azerbaijan. At the same time, the government faced severe budget constraints due to the sharp decline in oil revenues. It was clear that if oil prices remained low in the long run, the government would find it difficult to adequately finance many sectors. Health care is an area where funding needs to be constantly increased. At the same time, it may not be possible for the state alone to meet this growing demand only at the expense of the state. Under the then-current financing mechanism, it became clear that no matter how much the state allocated for health care, it would not be possible to bring the population's access to quality health care to the desired level. The introduction of compulsory medical insurance could allow the government to mobilize additional financial resources in the health sector, as well as to introduce mechanisms for a more efficient use of funds. In any case, this time the government demonstrated a more consistent political will in the transition to compulsory medical insurance.

By the Order of the President of the Republic of Azerbaijan dated October 27, 2015 (#1474) the Director of the State Agency for Compulsory Medical Insurance under the aegis of the Cabinet of Ministers was appointed. Then, the charter and structure of the State Agency were approved by Presidential Decree #765 dated February 15, 2016.

According to the Decree of the President of the Republic of Azerbaijan dated November 24, 2016 (#1125) "On some measures to improve public administration in the Republic of Azerbaijan," the State Agency for Compulsory Medical Insurance under the aegis of the Cabinet of Ministers of the Republic of Azerbaijan (SACMI) was established as a public legal entity. Then, by the Decree of the President dated September 6, 2017 (#1592), SACMI's charter was approved.

The charter states that "the State Agency for Compulsory Medical Insurance ensures the implementation of compulsory medical insurance, concentrates funds for financing medical services within the service package in the compulsory medical insurance fund, acts as a centralized buyer of medical services on behalf of the state, and is a public legal entity that provides the reimbursement of necessary expenses in this regard." The Chairman of the Board of the agency was appointed by the Presidential Decree dated September 11, 2017 (#3222). Thus, the process of creating the agency was completed.

The pilot introduction of compulsory medical insurance in Azerbaijan had already begun earlier. In accordance with the Decree of the President dated November 29, 2016, the introduction of compulsory medical insurance was launched on January 1, 2017 in the administrative territories of Mingachevir and the Yevlakh region. Later, the Aghdash region was added to the list of pilot areas (Decree of May 10, 2018 [#53]) and beginning February 17, 2018, the population living in that territory was covered by compulsory medical insurance. In parallel with the pilot introduction of compulsory medical insurance, the process of creating the necessary legal and institutional framework was underway in preparation for the implementation of the reform throughout the country.

Amendments and additions were made to the Law of the Republic of Azerbaijan "On Medical Insurance" (Law of December 28, 2018 (1441-VQD); Law of December 3, 2019 (1718-VQD), etc.), and the legal bases of the following issues were clarified: those

insured by compulsory medical insurance; insurance premiums under compulsory health insurance; calculation and payment of insurance premiums and submission of reports; scope and structure of service package; amount of co-financing; right of subrogation; compulsory medical insurance fund; prices for medical services under compulsory medical insurance; oversight over the amount, duration, quality, and conditions of medical services; implementation period of medical insurance in the territory of Azerbaijan; etc. Prices for insurance and insurance payments were set separately for different segments of the population.

By Presidential Decree #418 of December 20, 2018, SACMI was authorized to establish the Medical Territorial Units Management Association (MTUMA), a public legal entity. According to the decree, MTUMA was established "in order to increase the level of medical services provided to the population, to improve the mechanisms of oversight over the quality of medical care and the protection of patients' rights, and to ensure the reliable protection of public health." The decree also mentioned the names of public health facilities that would not be subordinated to MTUMA. According to the MTUMA charter, approved by the Agency Board, the main purpose of MTUMA's activities is to ensure the organization of medical services to protect the health of the population in subordinate medical institutions and to take measures to improve the quality of medical services.

The list of medical institutions subordinated to MEDICINE was approved by Resolution of the Cabinet of Ministers #163 dated April 12, 2019. The resolution came into force on January 1, 2020. Medical Territorial Units (MTUs) are created by the Agency, taking into account the size of the population, the geographical area, the transport infrastructure, the network of medical institutions and their potential, as well as the number of doctors and nurses in the administrative-territorial units at medical institutions included in the state health system and subordinate to MTUMA. By Resolution #03 of the

Agency Board dated January 21, 2020, a total of 14 MTUs were identified.

The government's Resolution #5 of January 10, 2020 approved the Package of Compulsory Medical Insurance Services. There are 2,550 medical services included in the Service Package and the number is expected to grow. Beginning January 1, 2020, compulsory medical insurance was introduced in stages across the country, and since April 1, 2021, compulsory medical insurance has covered the entire territory of the country and all citizens. Compulsory medical insurance premiums began to be collected on January 1, 2021.

What will change in the health system with the introduction of compulsory medical insurance, and what won't

Based on studies of health systems in various countries, it can be said that the level of access to quality medical services and public health depends not only on the introduction of compulsory medical insurance, but also on the structure, capacity, and potential of the health system.

The World Health Report : 2000 : Health Systems : Improving Performance from the WHO defines a health system as "comprising all the organizations, institutions and resources that are devoted to producing health actions." A health system is considered effective if it is able to provide all of a country's citizens with the necessary amount of quality medical services at the needed place and time. The main pillars of an effective health care system are as follows:

1) A sustainable financing mechanism;
2) Properly compensated, highly professional human resources;
3) The availability of reliable information for political and managerial decision-making;
4) A smoothly functioning logistics system that allows the delivery of medicines, vaccines, and technologies to wherever they are needed;
5) The maintenance of medical facilities in the appropriate

condition and the proper organization of their operation;
6) And management capable of setting and enforcing the rules of the game within the sector, directing the activities of sector participants in a comprehensible way, and using the potential of all stakeholders.

Health system reform is a purposeful and systematic effort to improve the performance of the system (Marc J. Roberts et al. 2003). The performance of the health system is assessed by the level at which the goals of the system are reached. The goals of the health system are health (level and equality), adequacy (meeting people's expectations), accessibility and risk sharing, and efficiency (effectiveness).

The impact of the reforms is reflected in the changes in the system's evaluation indicators for the listed goals, but this requires the completion of the reforms and a serious database. Therefore, let's look at which of the above pillars of the health care system can be changed by the introduction of compulsory medical insurance.

It is known that the objectives of the health financing mechanism are: i) to attract sufficient and sustainable resources for the health system; ii) to use these resources optimally (proper incentives and good management); iii) to ensure everyone's financial access to health care. Accordingly, the health financing mechanism performs three functions: revenue collection, pooling, and purchasing (Charles Normand, Axel Weber 2009).

Compulsory medical insurance is one of the most widely used health financing mechanisms in the world. Compulsory medical insurance (CMI) is formally based on the principle of universal access to health care and is perceived as a fair financing mechanism. Fair financing means that every household must pay a fair share of the cost of health care. Their fair share is based on the ability of households to pay.

There are also two aspects to fair funding: healthy people

support sick people; more affluent families support low-income families. As a result of this pooling of risks, healthy people support the medical care provided to the sick through their insurance payments (Charles Normand, Axel Weber 2009). Thus, the introduction of CMI, first of all, creates changes in the mechanism of health financing. I would like to draw special attention to a few issues in this regard.

Will the introduction of CMI lead to an increase in public funds for health financing?

The Law on Medical Insurance defines insured persons under CMI (Article 15-2) and insurance premiums under CMI (Article 15-10). According to the law, all citizens of Azerbaijan, foreigners with refugee status, and stateless persons are insured at the expense of the state budget for AZN 90 per person for a full calendar year. This amount will be indexed once a year in accordance with the annual level of the consumer price index in the country.

At the same time, the following insurance premiums are provided for different categories of the population:

• Compulsory medical insurance premiums are levied on employers and employees working in the public sector and the oil sector in the amount of 2% of the monthly salary fund up to AZN 8,000 and 0.5% after AZN 8,000;
• Employers and employees working in the non-state and non-oil sector are subject to compulsory medical insurance in the amount of 1% of the monthly salary fund up to AZN 8,000 in 2021, 2% from 2022, and 0.5% after AZN 8,000;
• Individuals performing work (services) on the basis of civil-law contracts will pay compulsory medical insurance in the amount of 2% of their monthly income up to AZN 8,000 and 1% of their monthly income after AZN 8,000;
• Individuals registered as taxpayers will pay a compulsory medical insurance premium of 4% of the minimum monthly wage each month (currently the minimum wage is AZN 250, which is

AZN 10 per month);
• Citizens who are of working age and unemployed or self-employed are insured and pay a compulsory medical insurance premium of 48% of the minimum monthly wage per year (according to the transitional provisions of the law, these individuals will start paying insurance premiums from January 1, 2024).

In addition, a percentage will be transferred to the CMI fund at established rates for each liter of gasoline, diesel fuel, or liquefied gas consumed in Azerbaijan, and from excise taxes on alcohol, energy drinks, and some tobacco products (cigarettes).

Insurance premiums for CMI are collected by the State Tax Service under the aegis of the Ministry of the Economy. For this purpose, changes were made to the classification of budget revenues in the unified budget classification (Resolution #494) and an auxiliary section entitled "Compulsory Medical Insurance Premiums" (Budget Classification Code – 124000) and some articles were added. Although the prices and payers of CMI fees are known, the government has not officially announced the forecasts of the total payments to be received from CMI payers in 2021. The amount to be paid from the 2021 state budget for the payment of compulsory medical insurance premiums only to employees of organizations financed from the state budget was announced in the 2021 state budget package: For this purpose, AZN 105.9 million is to be provided by the state (including AZN 4.8 million from the budget of the Nakhchivan Autonomous Republic).[5]

Based on our calculations, I can say that the total amount of CMI fees that can be collected from all sources in 2021 may be around AZN 450.0 million. According to the Ministry of the Economy, in the first quarter of 2021, revenues from compulsory medical insurance premiums amounted to AZN 112.3 million. The amount of funds collected in the first quarter of the year gives us reason to say that the total funds collected during the year will be close to our estimates.

In connection with the transition to CMI, the amount spent by the state to finance health care has been increased. Thus, in 2021, the state budget envisages the allocation of AZN 1.4090 billion to the Health Expenditures section (4.9% of all state expenditures). Of this amount, 1.0447 billion (74.1%) is earmarked for compulsory health insurance for the country's population to be paid by the state.

Thus, in 2021, the total funding for the CMI goals may be about AZN 1.5 billion. To give an idea of the scale of the increase in health expenditures, I would like to note that in 2019, the total amount of actual expenditures from the state budget to polyclinics, dispensaries, and hospitals under the aegis of the Ministry of Health amounted to AZN 408.3 million. If we take into account that, in the framework of the introduction of CMI, the medical institutions subordinated to MTUMA were previously subordinated to the Ministry of Health, then in 2021 the funds to be paid for the services provided by these institutions may be 3.6 times higher than in 2019. We also noted above that not all funds allocated from the state budget to finance health care are earmarked for CMI – about 400.0 million manat is to be used for health care through other channels. Taking this into account, the amount of public funds earmarked for the health sector in 2021 is expected to be more than AZN 1.9 billion (or up to 2.5% of projected GDP for the year).

Thus, we see a significant increase in public funds for the financing of medical services provided to the population through the introduction of CMI. As sustainable and high-income jobs increase in the country, opportunities to finance health care through CMI will also increase.

Will the distribution of CMI funds be transparent and correct?

According to the Law on Medical Insurance, the funds received from the financial sources of compulsory medical insurance (excluding co-financing) are to be concentrated in the

compulsory medical insurance fund. Articles 15-21 of the law, entitled "The Compulsory Medical Insurance Fund," specify how the fund is to be used. According to the Regulations for Recordkeeping and Submitting Reports on Compulsory Medical Insurance Funds, approved by the Cabinet of Ministers in December 2020 (Resolution #495), the funds received by the compulsory medical insurance fund are collected in SACMI's bank account. According to the regulations, the agency must prepare an annual report (covering the period from January 1 to December 31) on the income and expenditures of the Compulsory Medical Insurance Fund and submit it to the President of the Republic of Azerbaijan by June 30 of the following year.

It is clear that the CMI Fund will not have a separate account, and the report on the movement of funds will be submitted only to the president, without making it public. There are no regulations on how the information on the movement of funds of the Fund will be reflected in SACMI's financial statements.

This indicates that there will be problems with transparency in the collection and use of the CMI Fund. However, ensuring the transparency of public funds earmarked for the health sector (i.e. from the state budget and CMI fees) should be one of the key components of health financing reforms and the implementation of CMI. In order to ensure good governance, it would be expedient to include the draft budget forecast for the next year and budget execution reports of the CMI Fund (respectively) in the state budget package submitted by the government to the parliament, as well as to publish them on the SACMI website. At the same time, it is important to ensure the oversight of the Chamber of Accounts over the collection and use of the CMI Fund.

Will SACMI be the only institution that can be a purchaser (payer) of medical services using state funds?

Not all polyclinics and hospitals included in the state health system are subordinated to MTUMA. In the functional section of the 2021 state budget for *Health*, AZN 85.0 million is allocated to hospitals remaining subordinated to the Ministry of Health and, although they are also subordinated to the ministry, AZN 7.2 million to the Academician Zarifa Aliyeva National Ophthalmology Center and AZN 44.4 million to the National Oncology Center, both of which administer state funds independently. In addition, a number of government agencies in Azerbaijan still have their own health departments, which are also funded from the state budget. The *Health* section of the state budget for 2021 allocates funds to the Special Medical Service of the Republic of Azerbaijan, the Ministry of Internal Affairs, the Ministry of Emergency Situations, the Ministry of Youth and Sports, the State Customs Committee and the hospitals of Azerbaijan Railways. It is not clear whether this approach, inherited from the former USSR, will be maintained even after the introduction of CMI. In the context of the introduction of CMI, the maintenance of these departmental health facilities creates additional benefits for employees of these institutions: they will benefit from both CMI and departmental health services financed from the state budget.

Another issue here is payment for medical services and medicines within the framework of state programs for the treatment of certain diseases (diabetes, tuberculosis, kidney failure, blood diseases, etc.). These are not included in the CMI services package. Funding for these programs is provided to the Ministry of Health and its subordinate hospitals. However, the existence of special state programs for the treatment of these diseases means that such patients are insured by the state. Therefore, it would be expedient to group these diseases as an additional (or privileged) service package of CMI, and to transfer the function of purchasing services to SACMI.

It is necessary to eliminate this diversification in the

procurement of medical services using state funds, both to increase the efficiency of the use of public funds and to create a sustainable system of public funding of health.

SACMI is not mentioned among the organizations that are to receive funds in the *Health* section of the state budget for 2021. It might be more appropriate to change the functional classification of state budget expenditures, add to the *Health* section a subsection (and the necessary articles) called the "Compulsory Medical Insurance Fund," and record the funds allocated by the state for medical insurance in accordance with their functional purpose, additionally indicating SACMI as the budget administrator of these funds.

Will the introduction of CMI create an effective mechanism for the quality control of health services?

The concept of quality in health care is approached in terms of both clinical quality (examination and treatment) and service quality (in terms of organizational conditions) quality. Therefore, in answering this question, we must pay attention to several aspects:

i) The elimination of the doctor's monopoly position in the doctor-patient relationship. With the introduction of CMI, there is a separation between the consumer of medical services and the purchaser of those services (in the sense of the payer). All necessary information to pay for the cost of examination and treatment services provided to the patient will be provided to SACMI. The agency will check the adequacy of examination and treatment procedures on the basis of clinical protocols and decide on their payment. (The clinical protocols approved by the Ministry of Health are posted on the website of the Center for Public Health and Reforms. In November 2019, the Minister of Health issued an order on the implementation of clinical protocols in primary health care.) In March 2020, the Cabinet of Ministers approved Regulations for Conducting Medical and Economic Expert Assessments

(Resolution #93) and Regulations for Conducting Expert Assessments in the Quality of Medical Services (Resolution #94). In the current environment where health facilities are equipped with digital technologies, the necessary software and staffing further strengthens clinical quality control capabilities;
ii) The quality of the organization of services (comfort, cleanliness, food supply, etc.) or the issue of conflict of interest. This can also be approached as a matter of the independence of the providers of medical services or their subordination to the institution that pays for these services. As is known, until now, in Azerbaijan the functions of developing and implementing health policy, providing medical services, controlling their quality, and paying for them were concentrated in the hands of one body – the Ministry of Health. The transition to CMI involves changing this system. The removal of medical facilities from subordination to the Ministry of Health also serves this purpose. However, as is known, at present, the medical service facilities taken from subordination to the ministry have been transferred to the subordination of MTUMA established under the auspices of SACMI. This means that at present, a single institution will be both the provider and the purchaser (payer) of medical services. Of course, this also creates a conflict of interest. It is desirable that medical institutions providing medical services be independent. SACMI says that MTUMA is a temporary institution for the transition period, and that it will be abolished after the state medical institutions are transformed into public legal entities and they gain independent management skills. Keeping medical facilities under the auspices of the Ministry of Health during the transition period could create problems such as dual subordination, obstruction of reforms, the creation of an image of formal change, etc.;
iii) Apart from the quality of medical services (i.e. apart from CMI and medical institutions), the issue of the organization of state (public) control – two particularly

important mechanisms should be in place: a) proper organization of the certification of medical institutions and medical staff – currently done through the Ministry of Health (in countries with successful experiences, the certification of doctors is carried out by independent professional associations); b) monitoring and assessment of the level of satisfaction of the public with medical services – the Ministry of Health, as the body responsible for the development and implementation of health policy, can ensure this by conducting regular surveys among the population. In addition, periodic public health reports (for example, for a period of 5 years) may be prepared;
iv) The issue of the protection of patients' rights – On the one hand, this refers to the right of the patient to choose a medical institution and a doctor. The introduction of CMI opens the door to this, but it will take time to make it actually work; on the other hand, it refers to the settlement in court of any disputes between the patient and the medical service or CMI institution;
v) The organization of an independent public assessment of the quality of medical services and the work of the CMI mechanism – this is an important tool for the successful implementation of the CMI mechanism and the organization of the quality control of medical services. This is also extremely important in terms of gaining public support for reforms. Opportunities should be provided for independent civil society organizations and independent experts to periodically assess the level of public satisfaction with health services at the local, regional, and national levels.

As can be seen, the introduction of CMI opens up new opportunities to eliminate the doctor's monopoly and control the quality of medical services. However, a number of other mechanisms need to be put in place in order to bring the quality of medical services to the desired level.

Won't the introduction of CMI lead to a drain of highly qualified personnel from state medical institutions into the

private sector?

From the above calculations, it is clear that the amount of funds collected for the purchase of medical services under CMI has increased significantly compared to previous years. As CMI is implemented, optimization is also carried out, and there is a reduction in the *inflated* number of staff in medical institutions. This will significantly increase the funds allocated for the payment of medical workers.

By Resolution #02 of the Board of SACMI dated January 21, 2020, the Regulations for the Remuneration of Health Workers Working in Medical Institutions Subordinated to MTUMA were approved. According to the regulations, health workers' compensation will consist of their official salaries, bonuses for working conditions, incentive bonuses, and other payments. Only time will tell to what extent this regulation can provide significant incentives for professional health workers (data for analysis is extremely limited at this time).

Another issue to be clarified here is whether doctors working in medical institutions subordinated to MTUMA will be allowed to work in private medical institutions as well. It is known that until now, most doctors working in public hospitals also worked in private hospitals, and there was a certain conflict of interest. Therefore, proper incentivization of professional health workers is a crucial issue for the introduction of CMI.

Will medical facilities and patients be provided with medicines of sufficient quality?

The issue of drug supply to medical institutions and patients, as well as the quality and price of the drugs, are in fact broad topics that require special research. Despite the fact that the prices of medicines and medical supplies in Azerbaijan are regulated by the state, the constant increase in the price of medicines, as well as the decline in the quality of drug treatments (experts explain this by changes in

the molecular composition of the drugs) are currently a concern. The solution to this problem is not eliminated by the introduction of CMI. This is because the Ministry of Health and other relevant government agencies are responsible for regulating the drug market, eliminating monopolies, and monitoring the safety and compliance of imported drugs and the risks of corruption in procurement. There is uncertainty about the provision of medicines and medical supplies to medical facilities. Because MTUMA's charter includes the duty to "provide treatment and prevention facilities under the aegis of compulsory medical insurance with drugs, bacteriological and viral agents, and other medical products." At the same time, the statute of the Ministry of Health stipulates the task of "providing the population and treatment and prevention facilities with drugs, bacteriological and viral agents, and other medical products." At present, the Innovation and Procurement Center of the Ministry of Health purchases medicines and medical supplies with state funds (including for the provision of medical facilities under the auspices of MTUMA). The ministry also controls the quality of medicines imported into the country. It is necessary to resolve this situation, which creates a complex conflict of interests.

Will it be possible to ensure effective coordination of the activities and interests of all participants in the health system in the context of the introduction of CMI?

The fate of health financing reforms, as well as that of the reform of the country's health system in general, depend to a large extent on the answer to this question. Unfortunately, monitoring of the processes that have taken place so far provides very few arguments for an affirmative answer. Most participants in the health care system see the transition to CMI as a task for SACMI. However, the issue of reforming and improving the health care system will largely depend on the ability and capacity of the Ministry of Health to be a leader and play the role of an *organization of organizations*. At the same time, the solution depends not only on the relationship

between the Ministry of Health and SACMI, but also on other institutions involved in the health system and the proper organization of the government as a whole. Even in the fight against a new type of coronavirus (COVID-19) infection, it is clear that there are problems in coordinating the activities of these agencies. For instance, the Resolution of the Cabinet of Ministers #231 dated June 30, 2020 is an example of this). Clarification of issues related to the role and participation of private medical institutions in the implementation of CMI remains one of the most important topics in the coordination of interests within the system and the solution of health care reforms.

Conclusion

The first attempt at health financing reform failed due to the intensification of the struggle of competing interests within the system in the context of expanding the government's financial capacity and increasing resources allocated to the system. In the second attempt, after health care reform and the introduction of compulsory medical insurance after the 2015 crisis, the government appears to have demonstrated a more consistent political will.

The process of preparing the necessary legal and institutional framework for the introduction of CMI is almost complete. Compulsory medical insurance has already been introduced throughout the country. With the introduction of compulsory medical insurance, there is an increase in public funds for health care. The introduction of CMI will lead to a number of changes in the health system. However, a change in the funding mechanism and the introduction of CMI will not be enough for a complete reform of the country's health system as a whole.

There is also an intensification of conflicts of interest within the system in the context of the introduction of CMI and the increase of resources circulating in the health system. The lack of a unified strategy and program of reform

in the health care system, among other factors, seems to play a major role in the poor coordination of the activities and interests of health system participants in the process of health financing and the implementation of CMI.

The differences in the values, interests, political philosophy, and institutional responsibilities of the participants in the health system inevitably have an impact on the process. Therefore, I consider it necessary to develop a clear strategy and program of systemic reforms, to provide clear and concrete goals to all interest groups and society in terms of gaining greater support for reforms and achieving success.

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[1] The total amount of state investments in the health sector for 2007-2013 was calculated by the author on the basis of the Ministry of Finance's reports on the implementation of the state budget for those years.

[2] *Azərbaycan Respublikasının 2009-cu il dövlət büdcəsinin zərfi, V kitab*. Baku, 2008. p. 338

[3] *Azərbaycan Respublikasının 2014-cü il dövlət büdcəsinin zərfi, V kitab*. Baku, 2013. p. 442

[4] *Azərbaycan Respublikası Nazirlər Kabinetinin 2008-ci ildə fəaliyyəti haqqında Hesabat*. Baku, 2009, p. 193. Note: Detailed information about the health system of Azerbaijan at that time can be obtained from the source *Azerbaijan: HiT, 2010*.

[5] *Azərbaycan Respublikasının 2021-ci il dövlət büdcəsi haqqında* Azərbaycan Respublikasının Qanun layihəsinə dair izahat, p. 30.