Baku Research Institute

The Implementation of Mandatory Health Insurance:

Visible and Invisible Dimensions of the Process

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CONTENTS

OVERVIEW

The introduction of a mandatory (or compulsory) health insurance (MHI) mechanism across the Azerbaijan last year was undoubtedly one of the most important events in the socio-economic life of the country. The recent transition from the post-Soviet-based universal health care system to a health care system based on mandatory health insurance is one of several large-scale, complex and somewhat painful socio-economic reforms affecting the interests and well-being of almost all segments of society. The fate and outcome of such large-scale changes will depend decisively on how well the systematic roadmap of the reform is prepared and implemented, how well the medical staff directly involved in the process understand and support the changes, and the expectations and confidence of its ultimate beneficiaries.

The Baku Research Institute (BRI) has conducted research in order to assess the progress of MHI's implementation, as well as to study the attitude of the population and health workers towards the process, and their expectations. The research is based on an online public survey, interviews with healthcare workers, and an analysis of data obtained from inquiries to public offices directly involved in the implementation of the reform. We found that: i) public expectations that the accessibility and quality of medical services will improve as a result of the introduction of compulsory health insurance are still low; ii) there is a lack of understanding and uncertainty in the attitudes of health workers at various levels towards the nature, course and expected outcomes of the reforms; iii) institutions responsible for the implementation of the reform and the effective organization of the health system in the country lack a systematic roadmap for the completion of reforms and development prospects for the healthcare system.

INTRODUCTION

The healthcare financing reform and the implementation of mandatory health insurance (MHI) in Azerbaijan were launched in January 2017. At that time, the government began to implement MHI as a pilot project in the administrative territory of Mingachevir city and Yevlakh district. The following year, Agdash district was included in the pilot areas. Starting in early 2020, MHI was introduced in stages throughout the country, and in April 2021, the entire country was covered by MHI. Back in June last year, BRI posted a large article chronicling the healthcare reform in Azerbaijan, the content and course of the process, the formation of the legal and institutional framework for reform and the main trends in the process.

I would like to mention a few important points related to the introduction of the MHI reforms:

Firstly, although the initial decisions on the move of healthcare financing to a compulsory health insurance mechanism in Azerbaijan were made in late 2007-early 2008, no real steps had been taken in this direction by the end of 2015. It should be noted that on 27 December 2007, the President of Azerbaijan signed an Order on *Establishing the State Agency on Mandatory Health Insurance under the Cabinet of Ministers of the Republic of Azerbaijan*. That was then followed with the further approval of the "Concept for Health Financing Reform and Introduction of Mandatory Health Insurance" by the Presidential Order dated 10 January 2008. On 11 August 2008, the Cabinet of Ministers approved the *Action plan for the implementation of the Concept for Health Financing Reform and Introduction of Mandatory Health Insurance for 2008-2012* by Decision No. 179;

Secondly, the actual formation of the State Agency on Mandatory Health Insurance (SAMHI) under the Cabinet of Ministers of the Republic of Azerbaijan was launched only at the end of 2015: a Director was appointed to the Agency by the Presidential Order dated 27 October 2015 (Order 1474), then the "Statute of the State Agency for Mandatory Health Insurance" was approved by Decree (765) of the President of the Republic of Azerbaijan dated 6 September 2017. Under Presidential Decree (1125), the SAMHI, a public legal entity with the legal status of an "executive authority," was established on the basis of this Agency. By the Presidential Decree dated 6 September 2017 (№1592), the Statute of SAMHI was approved. Following the appointment of the Chairman of the Board of the Agency by another presidential decree, the process of forming the Agency was largely completed; the *Statute of the Agency* was approved by presidential Order 1592 dated 6 September 2017. Following the appointment of the Board Chairman of the Agency by another Presidential Order, the process of forming the agency was largely completed;

Thirdly, in accordance with the Presidential Decree dated 29 November 2016, the implementation of MHI was launched on 1 January 2017 as a pilot project in the administrative regions of Yevlakh, Mingachevir. The following year, the Agdash district was added to the pilot areas;

Fourthly, under Presidential Decree 418 dated 20 December 2018, the Administration of the Regional Medical Divisions (TABIB[1]), a public legal entity, was established under the

[1] TABIB (*TƏBİB* in original) is also a backronym for the traditional word for doctor (*təbib*) in Azerbaijani.

SAMHI. The list of state medical facilities to be supervised by the TABIB from 1 January 2020 was approved by Resolution 163 of the Cabinet of Ministers dated 12 April 2019;

Fifthly, with numerous amendments and additions to the *Law of the Republic of Azerbaijan On Medical Insurance* in 2018-2020, many legal aspects of the application of mandatory health insurance have been clarified (including: insured and insurer, mandatory health insurance premiums, calculation and payment of insurance premiums, reporting, the scope and structure of services package, amounts of co-financing, subrogation right, mandatory health insurance fund, mandatory health insurance rates, control over the size, duration, quality and conditions of medical services, the period of the implementation of health insurance by the country's regions, etc.).

Sixthly, the Benefit Package of MHI was approved by Resolution 5 of the Cabinet of Ministers dated 10 January 2020. The number of medical services included in the Benefit Package of MHI is 2,550. Citizens can use these medical services only in state medical facilities supervised by the TABIB. In cases in which is it is not possible to provide relevant services in state medical facilities supervised by the TABIB, a referral is issued to another medical facility that has a contract with the TABIB, and on the basis of such a referral the citizen can use the medical services mentioned there free of charge. As of the end of 2021, such medical facilities that had concluded a contract with the TABIB numbered 27. Note that the list includes both public and private medical facilities;

Seventhly, mandatory health insurance was introduced in stages across the country from 1 January 2020, and MHI has been covering the entire territory of the country and all citizens since 1 April 2021;

Finally, on 1 January 2021, Azerbaijan started to collect mandatory health insurance premiums. MHI contributions must be paid to the Mandatory Health Insurance Fund (MHIF). According to the Law on Health Insurance, the state budget subsidizes the health insurance premiums for all citizens of Azerbaijan, foreigners with refugee status, and stateless persons with a payment of 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.

The remainder of the premium to be paid by Azerbaijani citizens and residents is calculated according to the following for different categories of the population:

- Mandatory health 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 mandatory health 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 mandatory health 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 mandatory health insurance premium of 4% of the minimum monthly wage each month (currently the minimum wage is AZN 250, 4% of which is AZN 10 per month);

- Citizens who are of working age and unemployed or self-employed are insured and pay a mandatory health 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 1 January 2024).
- In addition, a percentage will be transferred to the MHI 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).

As can be seen from this brief summary of the moves towards the introduction of MHI in the country, the process covers a rather long period (about 12 years).

The goals and objectives of this healthcare financing reform were reflected in the *Concept for Health Financing Reform and Introduction of Mandatory Health Insurance* approved by the above-mentioned Order of the President of the Republic of Azerbaijan of 10 January 2008. The Concept identified the following main goals for health financing reform in the country: i) to create new economic principles for financing the health care system and improving the population's access to health care; ii) to increase the quality of healthcare services through the more efficient use of public funds allocated to the health sector; and iii) to improve the population's health and increase average life expectancy.

At a time when only two years have passed since the introduction of MHI across the country, it may seem premature to assess the results of reforms in terms of achieving the above goals and objectives. However, based on the lessons learned from the experience of countries implementing reforms in the healthcare system based on the Soviet model of health care we believe that the fate and outcome of such large-scale socio-economic reforms may depend on many factors. However, we consider the following three factors to be especially important: 1) full understanding by the institutions responsible for reforms of the changes and that they have a detailed systematic roadmap for the reforms; 2) support for the reforms by health workers in health facilities involved in the reforms; 3) participation of population groups and citizens in the process of change and support for the reforms.

In our opinion, the importance and necessity of the first out of these three factors should not be in doubt. An important requirement for the organization of management is that the agencies responsible for the implementation of reforms have a well-developed strategy, as well as a detailed roadmap that reflects the sequence, timing and expected results of the reform. Lack of this strategy makes it difficult for decision-makers and executives at different levels to understand reforms; creates problems in assessing the results of each stage of the reform process and determining the next step; increases uncertainty over time; and prolongs processes unnecessarily, increasing costs and other negative consequences. The availability of a detailed roadmap for the reforms is also necessary and important in terms of two other factors.

The medical staff working in the health facilities covered by the reform are both active participants in the changes and beneficiaries of these changes. Timely and adequate information on the nature and importance of the reforms as a whole, the sequence and timing of the changes, and the expected effects and outcomes, especially in the interests of medical staff, is crucial for both their active involvement in the process and their support for the reforms. Otherwise, the medical staff may behave in a way that is detrimental to the change by various means, out of concern for uncertainties that arise from time to time.

Finally, it is clear that the main goal and ultimate beneficiary of this reform is the health and well-being of individuals and communities. The outcome of the reforms will also depend on the level of public confidence in these processes and their active participation in them. In

addition to awareness-raising activities on MHI, sensitive mechanisms should be put in place to ensure timely and fair solutions to the problems faced by patients in the process of change, so that the changes are properly understood and accepted by the individuals and communities. Patients' continued "out-of-pocket payments" for the services covered by the MHI Services Package, on the one hand, may increase citizens' indifference to the reforms, and on the other hand, lead to a new source of dissatisfaction with the additional costs besides MHI fees.

In this research, we have tried to assess the status of the reform process on the above three factors. To do this, we sought to answer the following questions during our research:

1) Do the responsible agencies have a detailed roadmap outlining the sequence, timing and expected outcomes of all reform phases and steps, as well as of the timing and outcomes of the reforms as a whole?

2) What are the opinions of healthcare workers in the reformed healthcare facilities on the reforms and to what extent do they support them?

3) How much are the final beneficiaries (citizens) aware of the reforms and what are their expectations?

The methodology of the research is first described below, and findings and outcomes are presented. This study utilized three sets of data collection: 1) a set of questions was developed and then asked of SAMHI and the Ministry of Health; 2) a set of interview questions was developed and then healthcare workers were interviewed about their experience and attitudes on the MHI reforms; and 3) a survey was developed and then distributed online to the public, asking about their knowledge of and attitudes towards the MHI reform.

METHODOLOGY

The survey, the results of which are presented in this piece, was conducted in October-December 2021 with the participation of experts from the Center For Support For Economic Initiatives. In the research process, data were collected using both quantitative and qualitative methods. The collection and processing of data on research questions are performed as follows:

In order to clarify the situation with the detailed roadmap for the reforms and the development strategy of the health system, the research first looked at the electronic resources of the official bodies responsible for reform (Cabinet of Ministers, TABIB, Ministry of Health, etc.) and other open sources (including http://www.e-qanun.az/). Then we prepared research questions and applied to the Ministry of Health and SAMHI for an interview. They said that the questions asked during our initial verbal appeal to the Ministry of Health did not concern them. In response to a request sent to the ministry's official website, the ministry said that "a number of medical facilities supervised by the Ministry of Health have been transferred to the subordination of SAMHI." In addition, it was noted that the Ministry "performs its functions and responsibilities in accordance with the Regulations approved by the Decree of the President of the Republic of Azerbaijan." In other words, the Ministry refused to answer our questions about healthcare policy and the development strategy of the healthcare system in the country. Unlike the Ministry of Health, SAMHI answered the questions in our electronic application in a timely manner. In addition to these answers, the information provided on the Agency's website was used in the research process.

It should be noted that in the questions to SAMHI, there was also a question about how the agency educated the medical staff and the public about the implementation of MHI. We used the answers to this question to clarify issues related to the other two research questions.

In order to clarify the second part of the research—the opinions of healthcare staff working for the reformed healthcare facilities and the extent to which they support the reforms—we selected for interviews 20 healthcare workers in Baku and different regions across the country. Due to limited resources, we were not able to involve more interviewees. We contacted the people we selected for the interview by telephone, direct communication, and social networks. Among the medical staff we contacted, there were people represented in the management of the institutions (such as the head of a polyclinic, the deputy chief physician, the head of a medical center, etc.), as well as doctors and nurses. We explained the purpose of the survey to them and stated that if they participated in the interview, their names would be kept anonymous, and their names would not be disclosed in the research report. We also said that if there were any questions they were unwilling to answer during the interview, they may not answer them. Some of them we had contacted were randomly selected, and some were based on personal relationships. Five of them refused to participate in the interview. Interviews were conducted with the remaining 15 people. In the end, we summarized the information on the questions collected in the form of interviews.

Additionally, we conducted an online survey through Freeonlinesurveys.com to assess the public's awareness of the move to the MHI reform and changes in access to health care following the reforms. The survey questions covered the following areas: i) general information about the respondents (age, sex, education, marital status, etc.); ii) assessment of respondents' level of awareness of MHI; iii) assessment of changes in respondents' access to medical services

included in the MHI Services Package. The online survey was conducted between 21 October and 8 November 2021. We disseminated information about the survey through social networks and appealed to citizens to participate in the survey. Given the site's data analysis capabilities, we decided to stop the survey when 1,550 respondents had participated. The information on the composition of the respondents was as follows:

- 75.9 percent of respondents were men and 22.8 percent women;
- 63.4 percent of those surveyed belonged to the 26-40 age group. Respondents under the age of 25 accounted for 8.3 percent, those in the 41-50 age group for 17.9 percent, those in the 51-60 age group for 6.6 percent, and those over the age of 60 for 2.7 percent;
- According to the level of education, respondents with higher education made up the great majority (86 percent) among respondents. 4.1 percent of respondents had secondary education and 3.7 percent had specialized secondary or vocational education;
- 85.5 percent of respondents reported living in urban areas, 7.2 percent in settlements, and 5.1 percent in rural areas;
- Regarding the regional distribution of the survey participants, the survey involved respondents representing almost all economic regions, excluding the East Zangezur Economic Region. The main participants were from the capital Baku (64.1 percent);
- 65.9 percent of respondents were married and 32.8 percent were single;
- In terms of employment structure, 69 percent of respondents worked under an employment contract. 8.4 percent of respondents said that they worked as private entrepreneurs. 5.4 percent of respondents are informally employed, 13.2 percent are unemployed, and 0.7 percent are students. 1.2 percent of respondents (pensioners, the disabled) indicated the "other" for employment status.

As can be seen from the information on the composition of the respondents, the vast majority of participants were residents of cities and towns. Our ability to interview citizens in rural areas, who face more problems with access to healthcare services and awareness of the MHI move agenda, has been limited. We believe that the increase in the number of rural residents among the respondents would not have changed for the better in terms of awareness, changes in access to health care services, or expectations.

RESEARCH FINDINGS AND OUTCOMES

1. Reform Strategy and Roadmaps: A Review of the Prospective Model of the Country's Healthcare System

The country's healthcare system endeavors to improve health and ensure access to quality medical services for all ages, as well as meet public expectations for healthcare. This is to be done while sharing expected risks and efficiently allocating resources. A healthcare system is considered effective if it is able to provide all citizens of the country with the necessary quality medical services when needed. The World Health Organization defines a healthcare system as "a set of all organizations, individuals and activities whose primary purpose is to promote, restore and/or maintain health." Building an effective healthcare system requires the proper mobilization of tasks and functions, as well as resources among the elements that make up the system, and the proper coordination and direction of work, while taking into account the contribution of each element to the goals of the system.

Healthcare reforms are purposeful and systematic efforts to improve the performance of the system. As noted above, reforms in Azerbaijan's healthcare system encompass a change in health financing mechanisms and a move to health care based on compulsory health insurance, which is a participatory financing of the state-funded health care system. The experience of healthcare reform in many post-Soviet countries (e.g., Georgia, Moldova, Kazakhstan, Russia, to name a few) has made it clear that the reform of post-Soviet healthcare systems, which were in deep crisis even before the Soviet Union fell apart, made it impossible to advance the system as a whole by reforming only some elements.

An article on the preparation and implementation of MHI reforms in the country, published on the BRI website in June last year, noted a number of problems observed in the organization and implementation of these reforms. Among the concerns for the fate of the reforms were: i) the failure to present to the public both roadmaps for the reforms and their development strategy and plans for development of the country's healthcare system as a whole; (ii) the roles, functions and responsibilities of individual *players* in the healthcare system are not clearly defined; iii) conflicts of interest in interagency coordination; iv) the transfer of functions such as the development and implementation of healthcare policy, the provision of medical services and the payment for services (financing) from one party to another instead of being distributed among separate entities; v) completion of the reforms i.e., uncertainty over the duration of the full implementation of the MHI-based financing mechanism, etc. In fact, all of these problems stem from a fundamental problem: the lack of a unified strategy and roadmaps for healthcare reforms. Therefore, this particular research aimed to study this issue specifically.

As already mentioned above, the implantation of MHI in the country is carried out on the basis of the *Concept for Health Financing Reform and Introduction of Mandatory Health Insurance.* We did not find any other official document on the websites of the Ministry of Health, TABIB, or other open sources that outlined the strategy and roadmaps for the reform, nor for the health care system as a whole. Therefore, as part of the research, we asked the Ministry of Health and SAMHI whether there were such documents available with them.

Interestingly, the Ministry of Health generally acts as if it has nothing to do with this reform. Their response to our inquiry confirms this (we have provided information on the Ministry's response in the Methodology). Some of the questions to the Ministry were as follows:

1. As it is known, the country is currently implementing healthcare financing reforms. What is the role of the Ministry of Health in this process?
2. What changes has the implementation of MHI created in the country's health system and healthcare policy?
3. How is interagency coordination (Ministry of Health, SAMHI, state medical facilities, etc.) ensured in the process of implementing MHI?
4. To what extent can the introduction of MHI improve the situation in the field of public health financing?
5. How do you explain that a number of large state hospitals are not supervised by SAMHI?
6. How will the need for medical facilities (hospitals, clinics) in any city or region be determined and who will be in charge of this work?
7. How will competition between medical facilities be ensured?
8. Is the healthcare system development program being elaborated in the country?

As we can see, the questions are not related to the process of implementing MHI, but to the organization of healthcare policy. These are issues related to the Ministry of Health. The main central executive body responsible for the development and implementation of healthcare policy in the country is the Ministry of Health. This is reflected in the *Statute of the Ministry of Health of the Republic of Azerbaijan* approved by the Decree of the President of the Republic of Azerbaijan dated 25 May 2006. According to the statute, the Ministry of Health is the central executive body designed to implement state policy and regulation in the field of public health (hereinafter - the relevant field). One of the main activities of the ministry is to participate in the formation of a unified state policy within the healthcare system and to ensure the implementation of this policy. It is the ministry's responsibility to identify areas for healthcare development and improve the organization of medical care.

The Statute of SAMHI (approved by the Decree of the President of the Republic of Azerbaijan dated 6 September 2017) states that the Agency "is a public legal entity that acts as a centralized recipient of premiums for the country's mandatory health insurance on behalf of the state and pays for healthcare services with the money collected." According to the Statute, the Agency's activities are related to the introduction and development of mandatory health insurance. Additionally, the Agency participates in the formation of state policy in the field of MHI and ensures the implementation of this policy.

As we can see, the Statutes and Charters of these bodies clearly indicate the duties and functions of each of them in the field of health care. In this case, it is not clear that the Ministry of Health "dissociated itself," as it told us, from the development of healthcare policy and healthcare reforms. Even from the experience of countries implementing healthcare reforms, we can say that the reforms and improvement of the healthcare system will directly depend on the ability of the local Ministry of Health to lead and organize other interagency cooperation.

It is clear from the SAMHI's response to our question regarding the reform strategy and the existence of a roadmap that there are no such documents related to the reforms. Thus, the answer to our question is not about the reform strategy, but about the Strategic Plan of the Agency: "The Agency has developed a Strategic Plan for 2022-2024. The Strategic Plan includes a long-term and comprehensive plan set out to ensure that the Agency's objectives are met and that it achieves its objectives. The strategic plan for 2022-2024 is aimed at ensuring access to healthcare services, reforms to increase the efficiency of the healthcare system and the efficient use of funds allocated to this area."

Another question to the Agency to clarify the reform roadmaps was how to establish a system of accountability for the progress of the reforms: "Have you created a system of monitoring and evaluating of the progress of the reforms?" The Agency responded in a statement that "all reforms must be monitored and held accountable. Citizens' appeals to medical facilities by the Agency are monitored daily through the registration system. Reports on medical services are prepared. The public is provided with information on monthly statistics on the use of the Services Package of MHI throughout the country. The progress of the reform is reviewed and evaluated by the working group, both in the short term and in general. Problems arising in medical facilities are investigated and resolved by working groups." Apparently, this response does not refer to the monitoring of the implementation of the reform strategy (roadmaps), but to the monitoring of medical services provided in medical facilities where MHI is applied (similar information is published in the annual reports on the Agency's website). Monitoring and evaluation of strategies or roadmaps are usually based on pre-defined targets and indicators for the stages and outcomes of the reform, and monitoring and evaluation reports are prepared accordingly. Such reports are intended to assess the progress of reforms, to identify the reasons for deviations, and to make necessary adjustments. Such monitoring and evaluation are not possible without a well-developed reform strategy, plan or roadmap.

One of our arguments for the lack of a reform strategy and roadmap is the lack of a clear vision of the new system to be established as a result of the reforms and the timing of the completion of the reforms. As it is suggested by the WHO, one of the main goals of the MHI mechanism is to develop and implement healthcare policy in the healthcare system; to prevent the centralization of the functions of providing medical services, quality control and reimbursement; to achieve an effective mutual control mechanism by dividing these functions between different institutions. Before the reforms, all these functions were performed by the Ministry of Health, but now with MHI, medical facilities supervised by the Ministry have been transferred to the TABIB under SAMHI. In other words, in the present case, SAMHI now provides medical services, controls their quality, and pays for them. In fact, it was expected that the TABIB would be abolished after serving as a temporary institution for the transition period, once state medical facilities were transformed into public legal entities capable of independent management. However, in the survey we sent to the Agency, the answers to the questions related to the organization of the activities of the state medical facilities involved in the reforms show that there is serious uncertainty in this area.

Thus, in response to *questions about SAMHI's organization of independent activities of medical facilities involved in the reforms (hospitals, clinics, doctor's offices, etc.), the completion of such work and the timing of the transfer of medical facilities to independent management*, the Agency said: "By Resolution 163 of the Cabinet dated 12 April 2019, state medical facilities were transferred to the supervision of the TABIB. Medical facilities are

managed by the TABIB. Under the Resolution, state medical facilities are not intended to operate independently. It should be noted that appropriate measures are being taken to effectively organize the activities of state medical facilities in the country, centralize management and optimize the network of medical facilities."

In response to the question about *the selection of management and recruitment of employees in the reformed medical facilities,* the Agency said, "issues, such as recruitment of staff in medical facilities, the creation of structural and staff units, etc are also implemented by the TABIB in coordination with the Agency."

The answer to the question "How will healthcare centers in the villages be managed?" was as follows: "Healthcare centers and posts in villages and settlements are supervised by the directors of central hospitals in the regions and are managed by central hospitals."

Finally, in response to the question "How will the system of transparency and accountability of medical facilities be established?" the Agency said: "In order to control the activities of state medical facilities supervised by the TABIB, the Agency and TABIB staff periodically carry out monitoring. At the same time, medical statistical reports are periodically prepared and presented to the public."

From the answers we received from the Agency (including the TABIB) to our questions about the organization of the future activities of the state medical facilities involved in MHI, we can say that either the representatives of SAMHI have limited ideas and views about the goals of the reformand how it will make things better, or they believe that the outcome of the process will be the creation of an additional source of funding for the healthcare system in the form of MHI payments and the transfer of financial resources from the Ministry of Health to SAMHI, or, certainly, both.

Among the questions to SAMHI were those related to the organization of competition in the field of medical services. The Agency's answers to the questions "How will competition between medical facilities be ensured?" and "The exclusion of the majority of private clinics from the MHI system represents a restriction of competition, doesn't it?" did not correspond to the essence of the issue.

Among the questions to SAMHI we had sent as part of this research, there were also questions related to the prospective development of the country's healthcare system, in addition to questions related to the implementation of MHI. We had sent the following questions to both the Ministry of Health and SAMHI:

- *How do you explain that a number of large public hospitals are not supervised by the TABIB?*
- *What would be the fate of medical units and hospitals included in the structure of various government agencies after the introduction of MHI?*
- *Is there a healthcare system development program in the country?*

As mentioned above, the Ministry of Health did not answer these questions. SAMHI did not specifically give their view on these issues, emphasizing that these issues do not fall within the competence of the Agency and recommended that we address a relevant agency or ministry. Although these issues are not under the authority of the State Agency, the Agency's inability to answer those questions speaks to the fact that its representatives see the ongoing MHI implementation reforms as a separate reform, and not as part of an overall strategy or roadmap to improve the country's healthcare system.

2. Attitudes and Expectations of Healthcare personnel from the Reforms

We believe that it is extremely important to study the views of both key players and physicians as impact groups involved in the process in order to assess the steps taken in the implementation of MHI and the results achieved at the initial stage.

The first thing we wanted to learn from these groups was how SAMHI and other implementing bodies communicated with doctors and healthcare workers on the implementation of MHI. This was similar to our question to SAMHI: "How have education and awareness-raising on the introduction of MHI been organized among the population and healthcare workers?" SAMHI's response contained extensive statistics on all training, education and public awareness events, television and radio broadcasts organized by the agency in 2019 and 2020, as well as in the first nine months of 2021: "In 2020, 470 programs / storylines were broadcast on 23 different television, radio and internet television channels, and in 9 months of 2021, 393 programs / storylines were broadcast on 28 channels. During the first 9 months of this year, a total of 31 hours and 10 minutes of airtime on various TV channels were connected with the compulsory health insurance system." It also provided information on education and awareness-raising activities carried out through the Agency's website and social networks. The response emphasized that trainings for medical and non-medical staff of medical facilities on the organization of both medical services and the organization of work as part of MHI are regularly organized. "This year, we also provided information regarding trainings held for healthcare workers in state medical facilities on the conduct of medical examinations and referrals. The training focused on the MHI system, medical services covered by the Services Package, service rates and payment calculation procedures, types of consignment notes, procedures for urgent and scheduled dispatches, procedures for consignment note registration, documents required for dispatch letters and the technical features of the electronic hospital management system."

The answers of medical staff to the question "What kind of activities were carried out with doctors in connection with the implementation of MHI in the country?" can be summarized as follows: "The work carried out is mostly related to the documentation work in accordance with the requirements of the new system, and instructions are sent in this regard. Based on the instructions received from higher organizations, the chief physician and department heads give explanations to employees. There may have been some training for hospital officials on the reforms, but there was no training or other training or awareness-raising for doctors and healthcare workers."

According to the interviewees, after the introduction of MHI, work in terms of documentation has increased significantly. They said that the main change to patient admissions is in registration. Unlike before, all patients who come to a hospital can visit the doctor they choose by asking for a registration card from the receptionist at the entrance to the medical institution. The patient is registered on the basis of the code reflected in the coupon.

The impact of the use of MHI on the growth of physicians' incomes is also one of the key issues in our research. In this regard, we sent this question to SAMHI: "Will the doctors and health workers be concerned with the current mechanism, stimulating their (especially doctors') work?" The Agency in its response said that "in order to ensure a decent standard of living for healthcare workers at medical facilities supervised by the TABIB, to increase their interest in

improving their professionalism and skills, to regulate the remuneration system based on the assessment and measurement of healthcare workers, the Agency has approved the Rules for Remuneration of Healthcare Workers, according to which, the salaries of medical staff include official (tariff) salaries, bonuses paid for working conditions, incentive bonuses and other payments provided for in the Labor Code. Incentive supplements for medical workers are provided in the form of fixed or monthly incentive supplements, depending on the position and the nature of the work performed."

In response to the question "How has the move to the MHI system affected doctors' salaries?", the healthcare workers interviewed said there have not been any changes in the salaries of healthcare workers not impacted by the MHI system: these include doctors, health workers of rural health centers. There are some increases in the salaries of all doctors impacted by the MHI system, but so far the system of remuneration of doctors and the incentives applied are rather weak. Therefore, there is dissatisfaction among doctors with the promised increases. According to some respondents, "at this stage, the new salary system is mainly for the benefit of hospital managers and officials, as well as administrative staff." Most of the interviewees believe that "doctors will be able to feel the increase in salaries more in 2022 and beyond."

Doctors in their answers to the question "What are your expectations (both positive and negative) from the introduction of MHI?" suggested a cautious approach. According to them, the process has just begun, and it is too early to say that significant changes have taken place, both in terms of funding and logistics. According to their observations, it seems that both the medical staff and the current infrastructure of the institutions are not yet ready to implement MHI on their end. There are especially many problems for polyclinics and regional doctor's offices. They cannot send patients directly for analyses, but only to district centers.[2]

The interviewees noted that the quality of the existing medical infrastructure, especially at medical facilities in the regions, suggests that the already extant problem of referrals from the regions to regional and country-level capitals might not be alleviated under MHI. Due to the lack of medical infrastructure in the regions, patients are mainly referred to Ganja or Baku. And this is not even for complex operations such as heart surgery, stent placement, angiography; referring patients to the cities for such diseases should be considered normal. Rather, our interviewees note, patients are often referred for issues of far less seriousness: "But now patients are referred to large cities not only for such complex and difficult operations, but also for most medical examinations and analyses. In those cities, people in need of urgent medical examinations sometimes have to wait in line for days." This means that the existing material and technical capabilities of the healthcare system are not able to meet the influx in case of MHI.

According to the doctors, there are certainly changes for patients: they have access to a large number of services, and even a number of expensive operations under MHI. "In a positive sense, this expectation was met and can be considered reasonably justifiable."

[2] We deem it important that after these interviews, the Board of the State Agency on Mandatory Health Insurance in its decision on 22 December 2021 stated that "In order to increase the accessibility of medical services for the insured, protect the health of the population, ensure early detection of diseases and prevent complications, as well as to ensure citizen satisfaction, changes have been made to the "Rules of issuing referrals for provision of specialized medical services (Rules)." According to the amendment, insured citizens are now able to apply for specialized outpatient care (medical examination by a qualified doctor at any state medical facility supervised by the Administration of Regional Medical Divisions (TABIB) without a referral.

It was also noted in the interviews, "our main expectation from the introduction of MHI is to improve the quality of services and increase the salaries of doctors. It is too early to wait for a quality result. However, the expectation of a sufficient increase in wages has not yet materialized in the past year." Another expectation of doctors is that the doctor-patient relationship will become more orderly organized and transparent. Expectations that people's health will improve will be emphasized: "Often patients did not go to the doctor on time due to financial difficulties, and then their treatment was not possible. Insurance allows these people to be examined and treated."

We asked the doctors, "Have there been any changes in the healthcare system, organization of medical services, provision of medicines, management of medical facilities, establishment of patient-doctor relations since the implementation of MHI?" Answering the question, the doctors said that they observed the most positive change in the field of technical support: "Medicines, gloves, disinfectants are delivered on time. The situation in this area is much better than before."

At the same time, several doctors who answered the question said that they observed an increase in tension in the doctor-patient relationship. "In many cases, patients blame doctors and argue with doctors for services they could or could not get at the level they wanted because of legal constraints or infrastructure problems."

Another issue mentioned by doctors in connection with the changes in the doctor-patient relationship was related to out-of-pocket payments. Doctors noted that "although out-of-pocket payments have not been completely eliminated, there has been a decrease in the amount paid."

The next question we asked of doctors was related to their attitude to the MHI process: "How precisely and correctly do you think the MHI activities are organized? What problems can you see?" Almost all interviewees began by saying "the process of implementing MHI is still in its infancy, so it is too early to assess it. It will be possible to see the problems in the long run. It will take at least 3-5 years to achieve the targeted results in the MHI system and see how the system works." According to the doctors, the most important issue to be addressed now is to ensure that "patients receive all necessary examinations and treatment free of charge, and that doctors' salaries are at a level that suit them".

One of the most common problems in the answers to this question was a lack of attention to the role of doctors in the process of preparation and implementation of reforms, and a lack of broad participation of doctors in the process: "Since the beginning of this process, healthcare policy makers have done all this. They seem to think that they are aware of all the problems and know the solutions. However, it would be good if the process of preparation and implementation of the reforms involved specialists from all regions who know local issues and their field in depth. This would allow us to see the problems in a timely and complete manner, find better solutions, and increase doctors' confidence in the process. If what the doctors suggest has no effect on the process, it doesn't matter. Just think. Even now the opinion of medical staff is not considered in the selection of managers of medical facilities. How can serious change be achieved though such activities?"

Separate answers to this question highlighted specific problems in the areas. For example:

- A large number of people residing in a given area are not registered there.[3] For example, only 10,000 out of 40,000 people living in Buzovna, a large settlement around Baku, are officially registered there. Until now, this issue has not been a problem, but from January 2022, citizens will be able to receive the services provided by the insurance system only in the areas where they are registered. However, although a citizen's registration may be elsewhere, his/her property may be located in the area.[4] Or there are cases when a woman is registered in one area, while her family and/or husband are registered in another area.
- There are problems with pregnant women: for example, there are cases when a woman is preparing to give birth to her second child, but there is no official marriage. Or a pregnant woman lives in Baku, but her registration is outside of Baku. It is not possible for her to go to her region every month for medical examination. In this regard, there is a need to give freedom to medical registration and find a solution to this problem before January;
- One of the doctors raised the issue of a lack of inclusion in the Services Package of MHI of the *medical screening of pregnant women for genetic disorders*:

"Another problem with pregnant women is that they should be analyzed for genetic disorders [but it is not included in the MHI Services Package]. This checkup is expensive, and all pregnant women in the world over the age of 35 are screened for it [potential problems]. This is very important for the timely detection of genetic disorders in the unborn child. We do not have to perform this test in the clinical protocol [in Azerbaijan]. Therefore, we only recommend pregnant women be tested. However, in most countries, such tests are recorded in a clinical protocol and funded by the state. Such examinations need to be included in the mandatory health insurance package. In addition, pregnant women with severe diabetes and kidney failure cannot be sent for free screenings. It is only possible to refer them to the Institute of Obstetrics and Gynecology, which is a waste of time."

According to doctors, many of these problems have arisen because local conditions have not been taken into account in the implementation process. In the pilot phase of the reform (over the last 2-3 years), the results could have been better if all medical facilities across the country had continuous trainings; the processes were discussed with doctors and health workers; the whole process were explained to them and instructions were developed.

Thus, from our interviews with doctors, it can be concluded that the level of involvement of doctors in the implementation process of MHI has been low, and doctors are dissatisfied with their insufficient involvement in the process. The problems encountered in the implementation of MHI have lowered doctors' expectations of the reforms. The mechanism and rules used to stimulate the work of doctors in connection with MHI are not completely clear to doctors.

[3] In Azerbaijan, as in other former Soviet countries, citizens and other inhabitants are required to register their place of residence with the government and that place of residence is inscribed in their passport. One's residency can determine one's access to employment, housing, and social and medical services in a given locale in the country. In extreme cases, one cannot access these essentials legally in a locale other than that indicated by their residency permit.

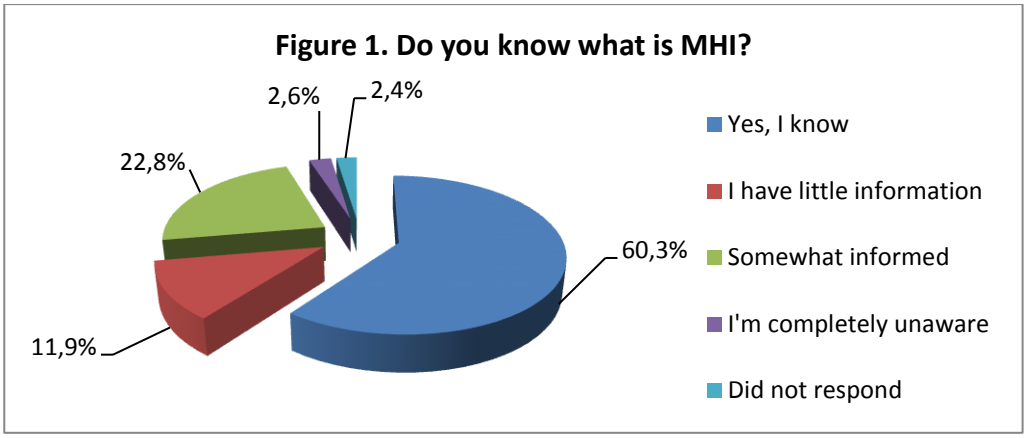
[4] This can occur in several ways. There are houses without state registration, for instance, if one person or family owns multiple houses. Alternatively, people might live and work in one locale while their actual registration is in another region. In quickly urbanizing Azerbaijan, this typically happens when people come to work and live in the capital without registering there because a registration is costly and difficult to obtain.

3. Assessing Public Awareness on Mandatory Health Insurance Services and Accessibility of Medical Services *(using survey data)*

Awareness Level of Health Insurance

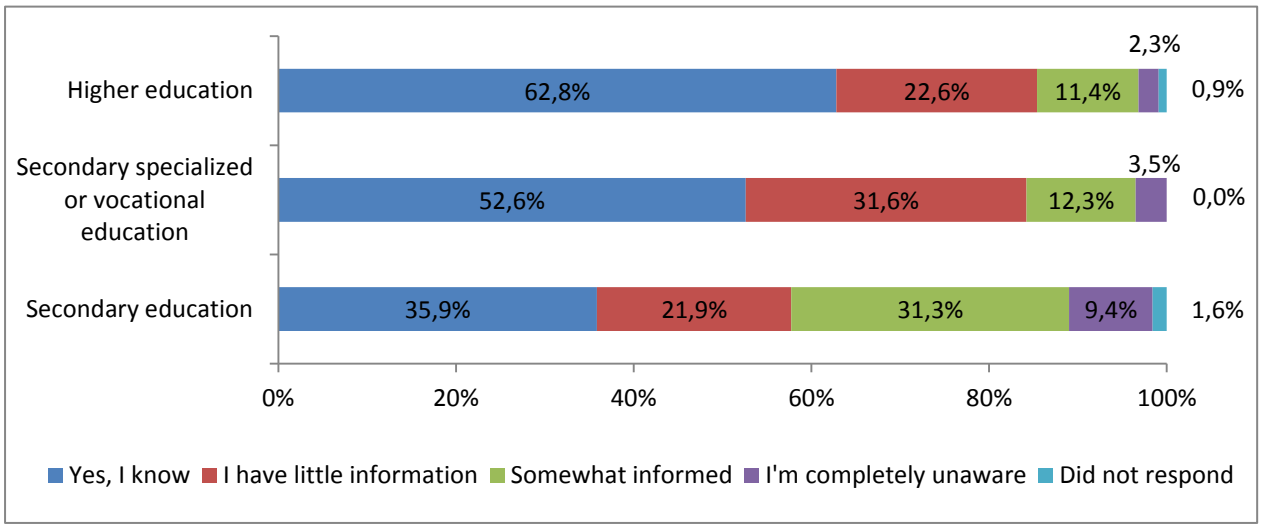
The analysis of the survey responses showed *that respondents' self-evaluation of their awareness of mandatory health insurance is quite high*. Their answers show that only 2.6 percent of respondents are unaware of MHI, and 95 percent are aware of MHI at various levels (see Figure 1).

Figure 1. Do you know what is MHI?



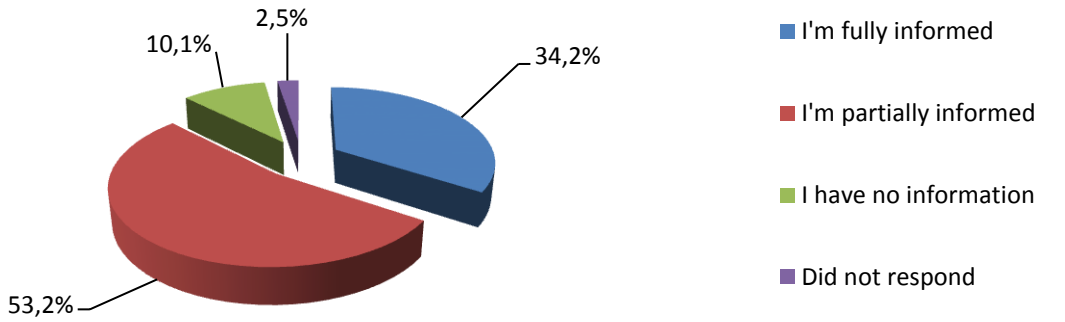
A gender analysis of respondents we initiated shows that *women are less aware of MHI than men*. According to the survey, 62.4 percent of male and 56.8 percent of female respondents, respectively, are aware of MHI. Plus, *there is a direct correlation between respondents' level of education and level of awareness of MHI and its application in the country*. As the level of education of respondents improves, so does their level of awareness. The respondents *with secondary education* who have an understanding of MHI comprised 35.9 percent, while those with *specialized secondary or vocational and higher education* comprised 52.6 percent and 62.8 percent, respectively. A similar proportion is observed in the responses concerning the implementation of MHI in the country (see Figure 1-1).

Figure 1-1. Do you know what MHI is?



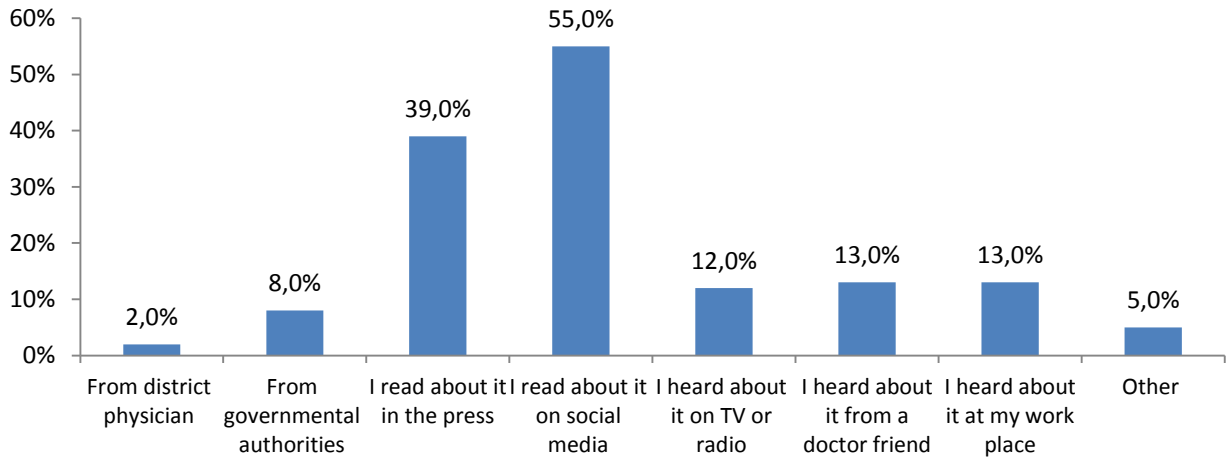
The public is also well informed about the MHI agenda. About a third of respondents said that they were fully informed, and more than half said they were partially informed. The level of full awareness is higher among men (36.8 percent) than women (27.4 percent).

Figure 2. Are you informed about the application of MHT in your country?



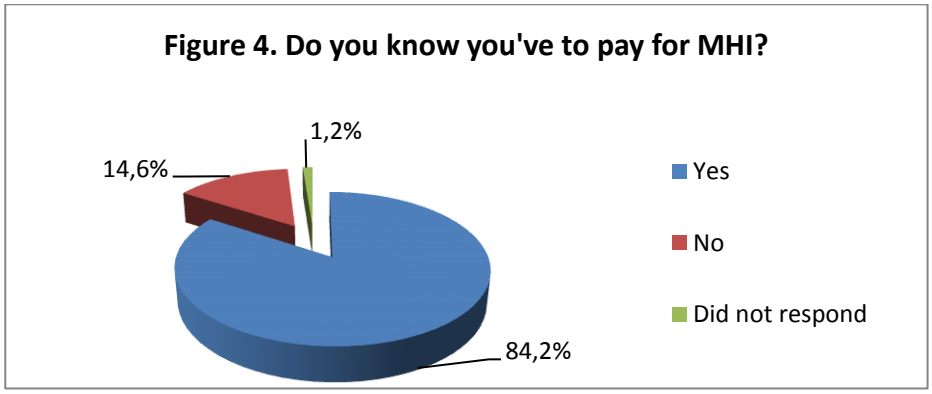
It is clear from the answers of the respondents that *they have received information about the introduction of MHI mostly from social media* 55 percent of respondents indicated *social networks* as the main source of their knowledge. The second source is *the press* (39 percent). In addition, 13 percent of respondents said they learned about it from their *acquaintances and friends*, 12 percent *TV and radio*, 8 percent from *government agencies*, and 2 percent from *the doctor*. For the option *other*, 5 percent of respondents indicated that they *investigated personally*, *found out when fees were deducted from their salaries*, or *when they went to the doctor*, among others (see Figure 3).

Figure 3. Sources through whcih you heard about application of MHI mechanism

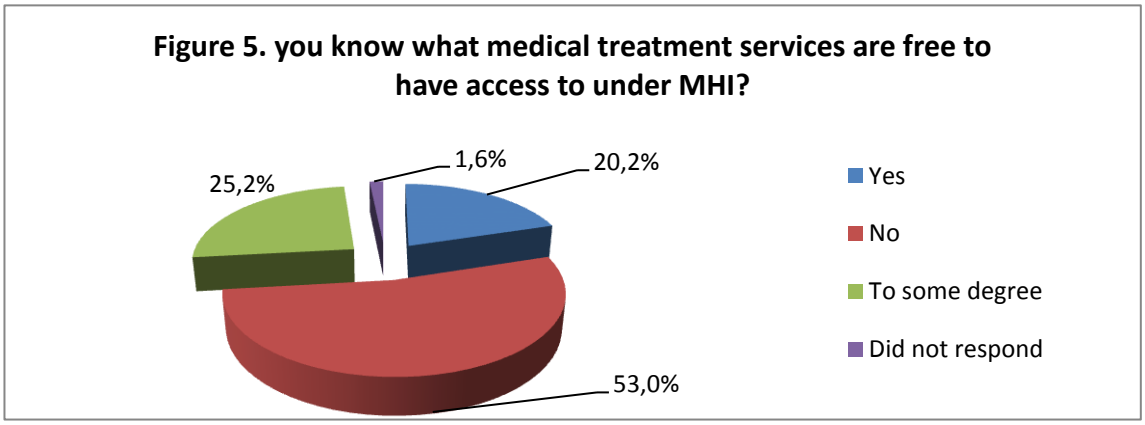


*While most respondents know they have to pay for MHI, only about half know approximately how much***.** 84.2 percent of respondents said they know that they have to pay for MHI, but only 53.6 percent know the amount. *Among women*, this percentage (42.9 percent) is lower than *men* (57.7 percent) (see Figure 4).

Awareness of MHI contributions is higher among respondents with *higher education* (86.8 percent) than respondents with *secondary education* (65.6 percent) and *secondary specialized education* (77.2 percent) (see Figure 4).



The survey results also show that, although the respondents have a high level of awareness about MHI, *they have a low level of awareness of medical services they have free access to under MHI***.** Only 20.2 percent of respondents know which medical services they have free access to. Although 25.2 percent of respondents are partially aware, more than half are generally unaware of the services (see Figure 5).



The level of awareness of respondents with secondary education of free medical services covered under MHI is almost zero. Only 3.1 percent of respondents with secondary education confirmed that they are aware of the free medical services. 75 percent have no information about them at all. 12.3 percent of respondents with secondary specialized or vocational education and 21.1 percent of respondents with higher education evaluated themselves as fully informed (see Figure 5-1).

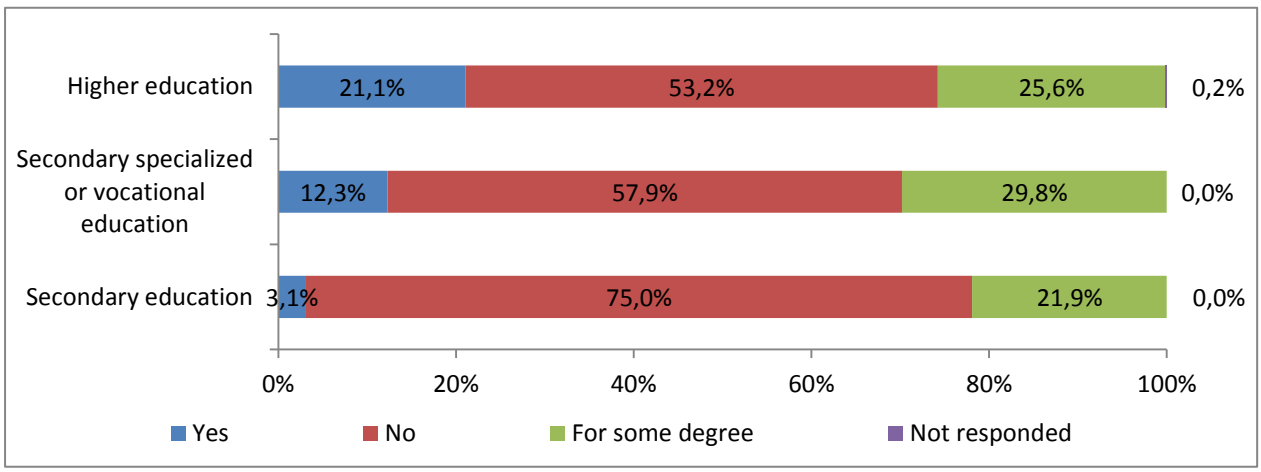
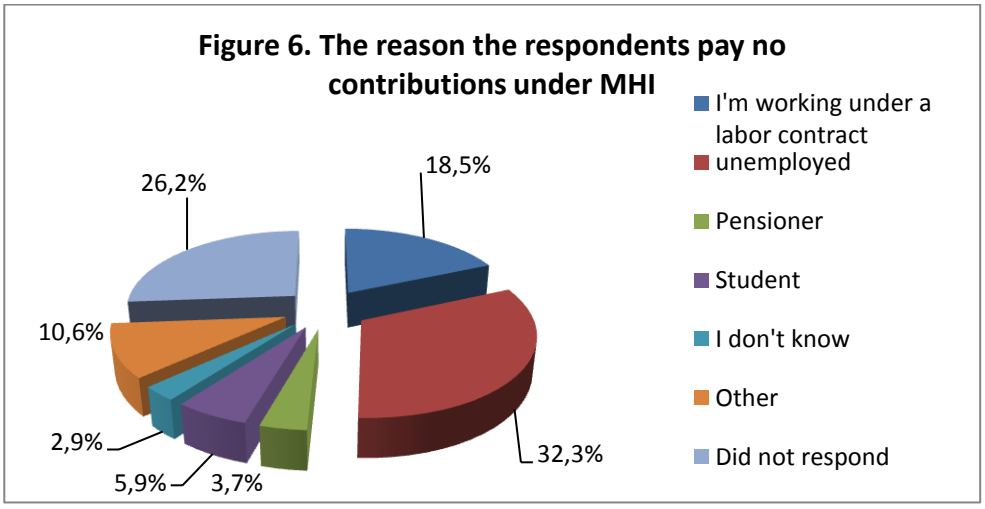


Figure 5-1. Do you know which medical services are free under MHI?

69 percent of respondents said they currently pay MHI contributions. Those who did not pay MHI contributions said that the main reason was that they did not work officially. 18.5 percent of respondents did not work *under an employment contract*, and 32.3 percent *were unemployed*. *Pensioners* (3.7 percent) and *students* (5.9 percent) are also among those who do not pay MHI contributions. 10.6 percent of respondents said that they did not know, did not trust the mechanism, nobody asked for it, lived outside the country, were on maternity leave, or other (see Figure 6).

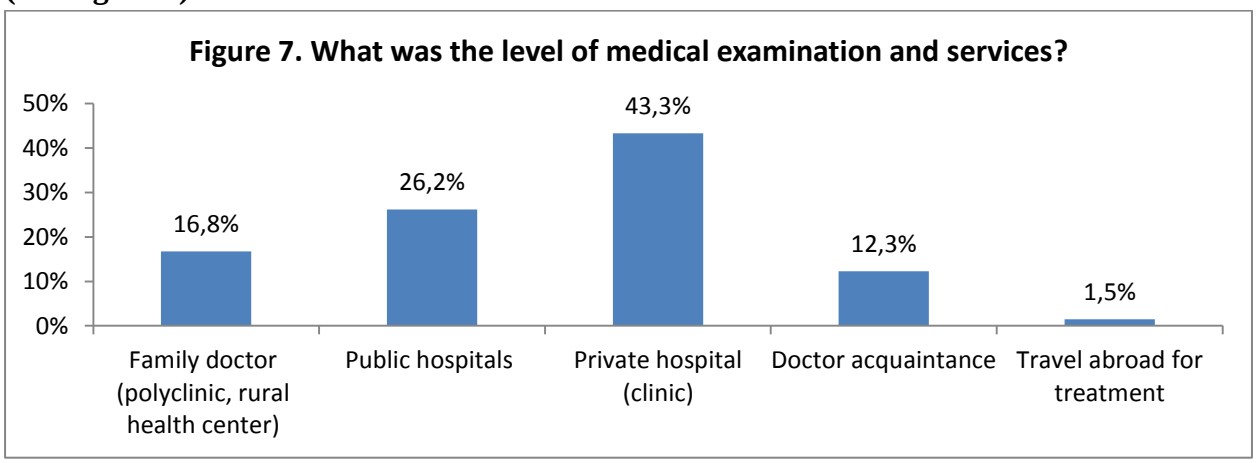


25.6 percent of male respondents and 41.8 percent of female respondents indicated the main reason for not paying MHI fees was unemployment.

Access to mandatory health insurance services

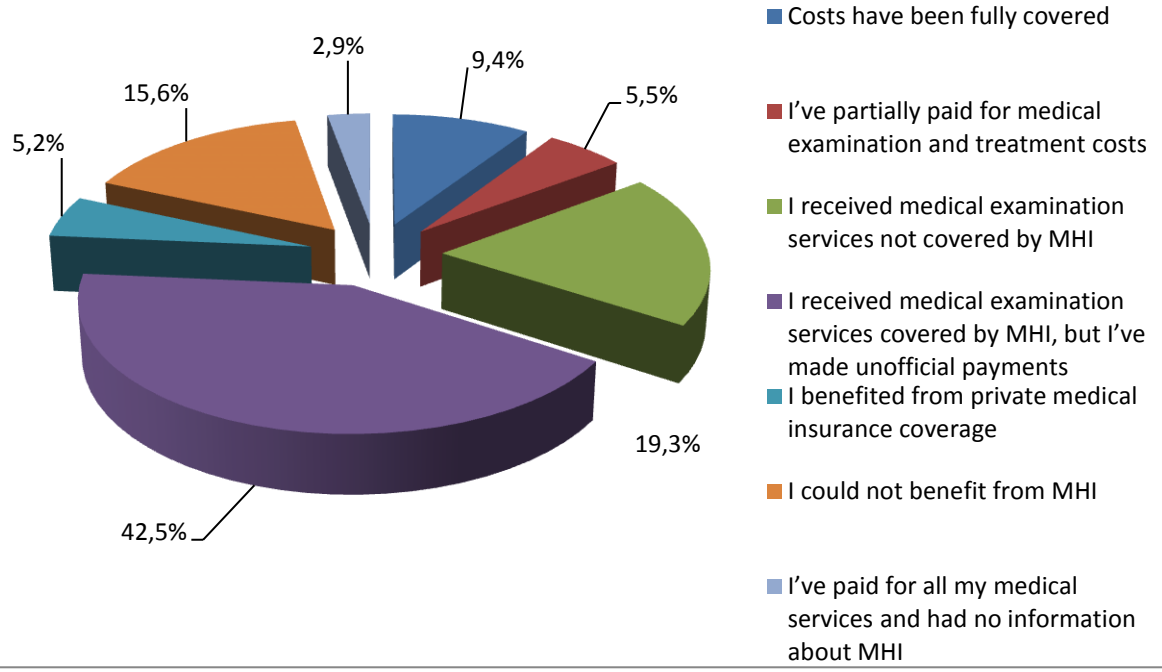
To the question of whether they saw a doctor for healthcare services this year, 51.7 percent of respondents answered *positively* and 47 percent *negatively* (see Figure 17).

Respondents mostly used the services of a private hospital or clinic this year**.** 43.3 percent of respondents said that they visited *a private hospital or clinic for medical examination and services*. It is clear from the answers that the reason for the high number of such visits was the high-quality service, as well as the presence of referrals given by area doctors, and health insurance policy. The share of those who visited the state hospital was 26.2 percent. At the same time, 16.8 percent said that they went to *the family (area) doctor* and 12.3 percent to *their doctor acquaintance*. The answers also show that 1.5 percent of respondents went abroad for treatment **(see Figure 7)**.



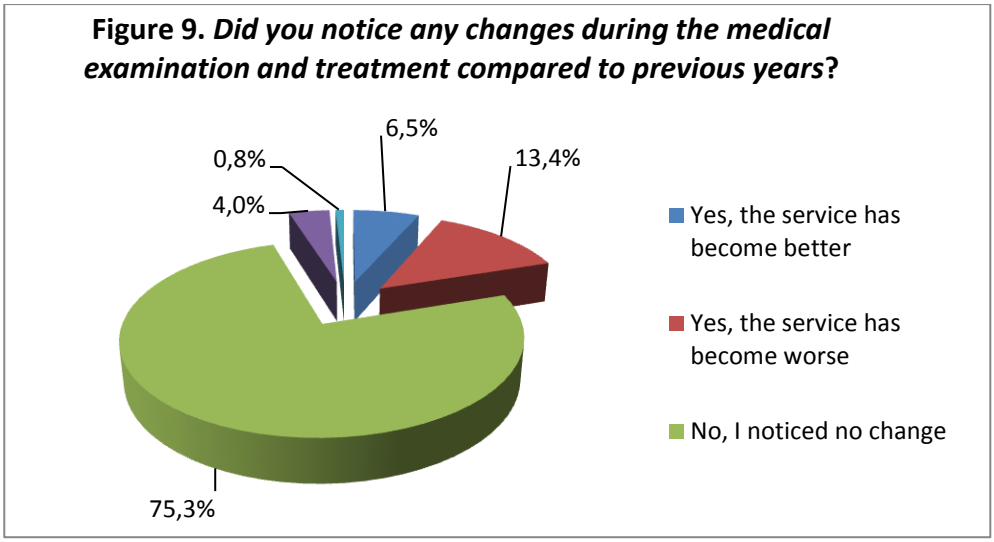
Respondents' self-evaluated level of benefit from MHI in medical examination and treatment is low. Only 9.4 percent of respondents said that the medical examination and treatment were fully, and 5.5 percent were partially covered under MHI. 19.3 percent of respondents noted that they benefit from medical services uncovered by MHI (see Figure 8).

Figure 8. Have you benefitted from MHI in the course of your medical examination and treatment?



The share of unofficial payments in medical services covered under MHI is high. 42.1 percent of respondents admitted that they received and benefited from medical services covered under MHI, but paid for them unofficially. Unlike men, women (24.9 percent) made less informal payments. 5.2 percent of respondents said that they benefited from *private health insurance services*, while 15.6 percent said they *could not benefit from services covered under MHI*. Among the respondents (2.9 percent) there were those who said that they covered all the expenses and *were unaware that the service was included in MHI* (see Figure 8).

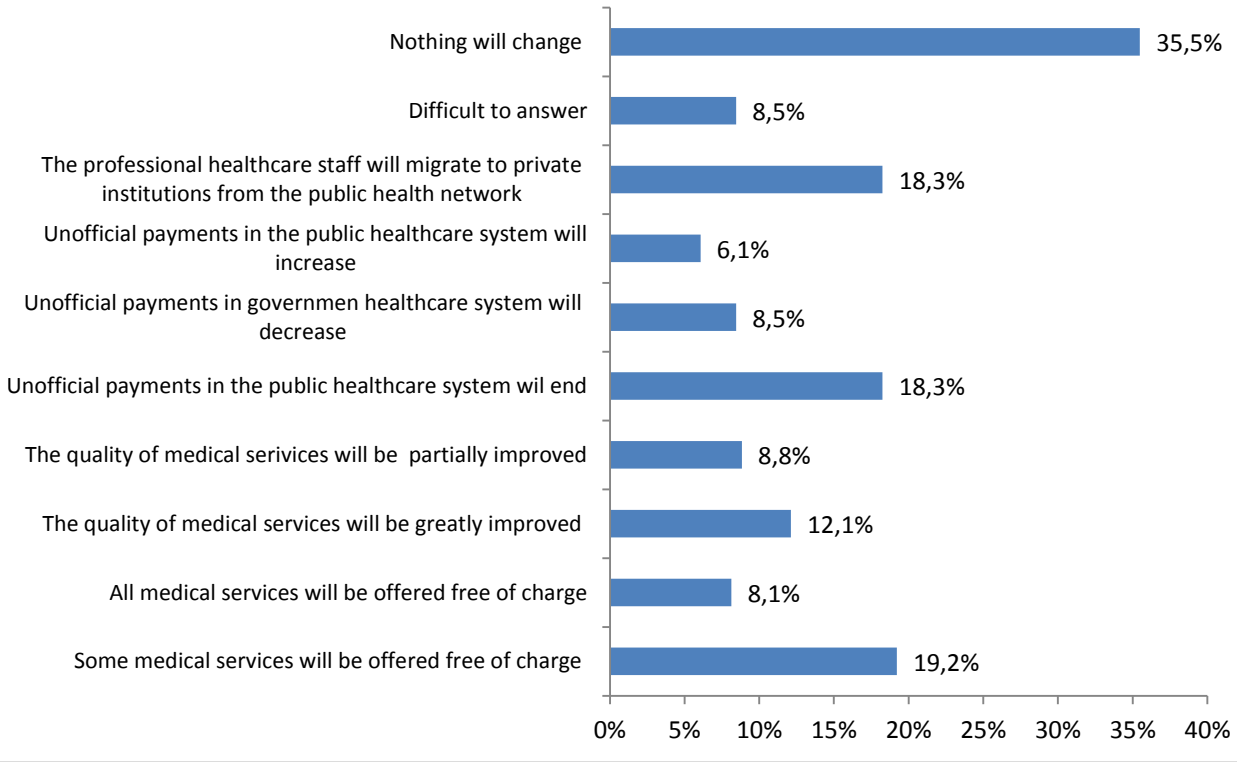
Figure 9. *Did you notice any changes during the medical examination and treatment compared to previous years*?



There has been no noticeable improvement in medical examinations and treatment. In response, 75.3 percent of respondents said that nothing has changed in their medical examinations and treatments compared to previous years. Only 6.5 percent of respondents said that the service *has improved*, while 13.4 percent of respondents believe that medical services have deteriorated *(see Figure 9)*.

Public expectations of MHI are still low. 35.5 percent of respondents believe that the introduction of MHI will not change anything. Most expect either that there will be *a full or partial elimination in informal payments in the public health system* (26.8 percent) or that medical services will be *fully or partially free* (27.3 percent). 19.2 percent of respondents said they hoped to benefit some from *the medical services* and 8.1 percent fully from free medical services. In addition, 8.8 percent of respondents believe that *the quality of medical services will increase in part*, and 12.1 percent *in full*. As for unofficial payments, 6.1 percent of respondents believe that *unofficial payments to the state medical system will increase*. Some respondents think otherwise. 8.5 percent said that unofficial *payments to the state medical system will be reduced*, and 18.3 percent *will be completely eliminated*. 18.3 percent pointed that *professional doctors will flow from public into private facilities* (see Figure 10).

Figure 10. What are your expectations from the introduction of MHI mechanisms?



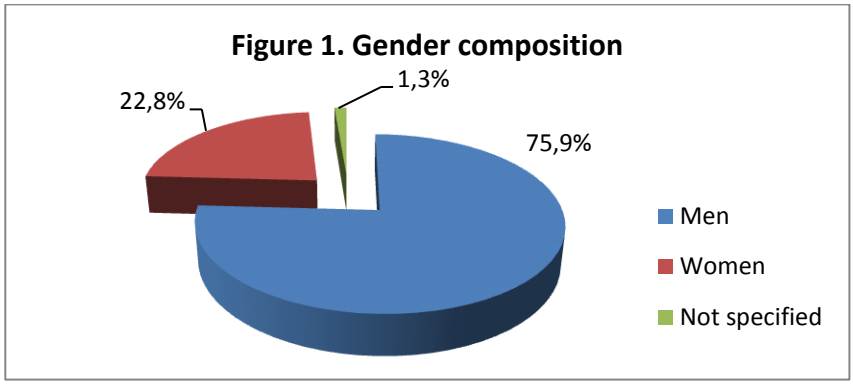
Women's expectations are more related to free medical care. 36.4 percent of respondents said they hoped to receive *some medical services free of charge*, 7.1 percent said they expect *all medical services will be free of charge*. Unlike men, women are relatively optimistic about their expectations and only 30.2 percent of female respondents believe that *nothing will change*. 21.8 percent of women believe that *unofficial payments to the state medical system will be completely eliminated*. However, 18.1 percent of female respondents think that professional doctors will flow from public into private medical facilities.

Appendix 1

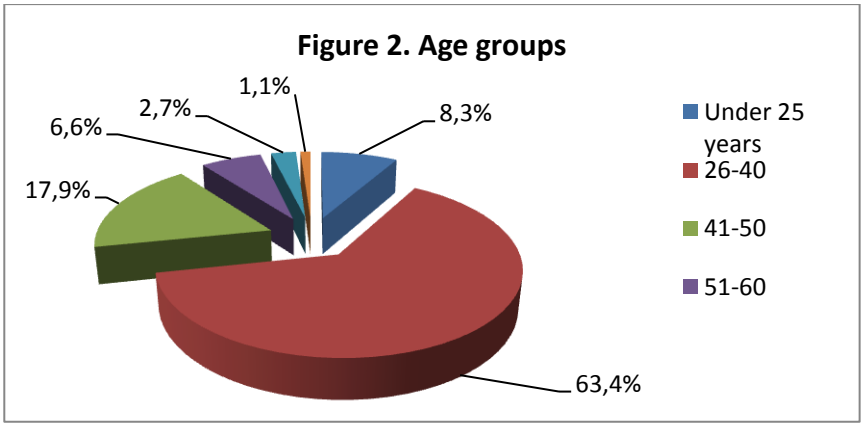
A broad analysis of the survey

We conducted an online survey to assess the attitude of the population to a Mandatory Health Insurance (MHI) scheme. A total of 1,550 respondents took part in the survey conducted through *Freeonlinesurveys.com*.

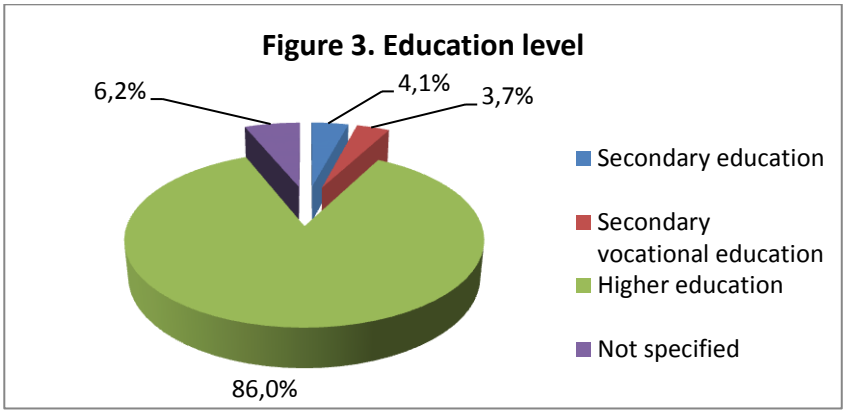
75.9 percent of respondents were men and 22.8 percent women. 1.3 percent of respondents did not indicate their gender. The number of male respondents was 1,176, the number of women was 354, and the number of those who did not indicate their gender was 20 (see Figure 1).



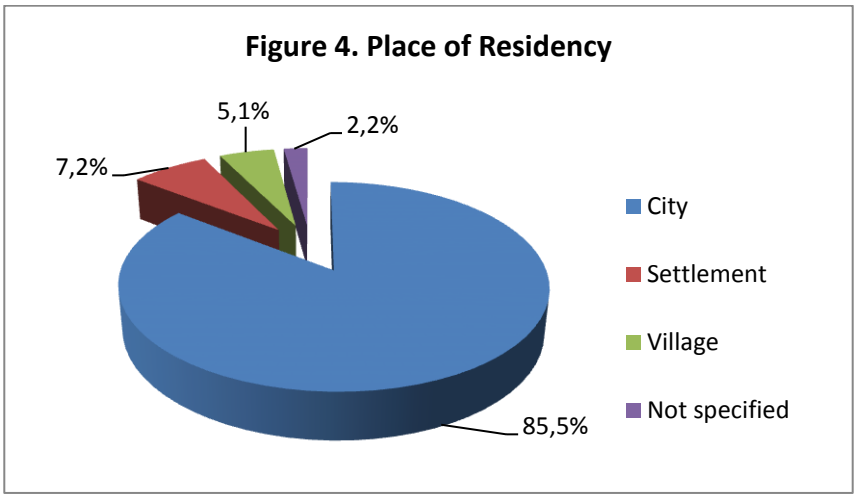
The analysis of the age group shows that the majority (63.4 percent) of respondents were in the age range of 26-40 years. Respondents under the age of 25 accounted for 8.3 percent, those from the age range of 41-50 years accounted for 17.9 percent, of 51-60 years 6.6 percent, and of 60 years and above 2.7 percent. 1.1 percent of respondents did not indicate their age (see Figure 2).



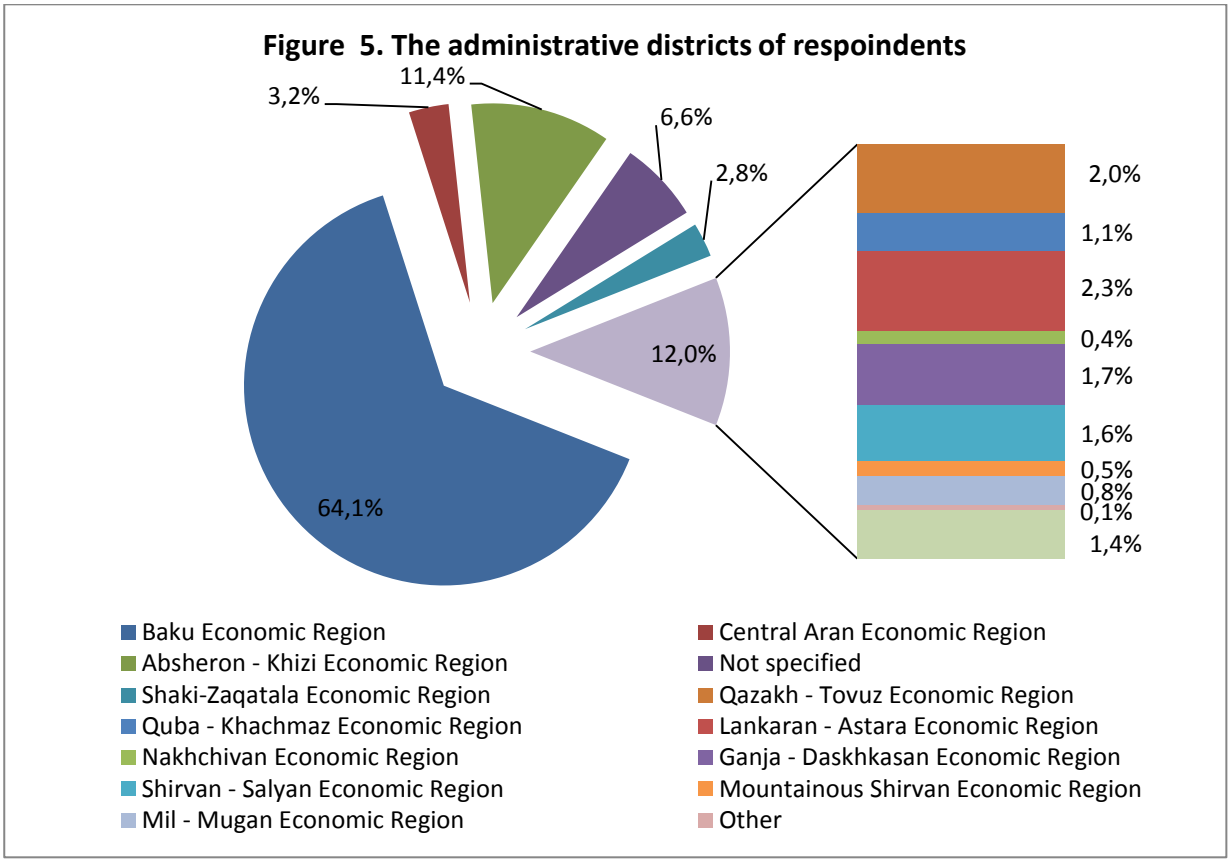
As to level of education, the number of those with higher education was the vast majority, accounting for 86 percent, while 4.1 percent said that they received secondary education and 3.7 percent specialized secondary or vocational education. 6.1 percent of respondents did not indicate their education (see Figure 3).



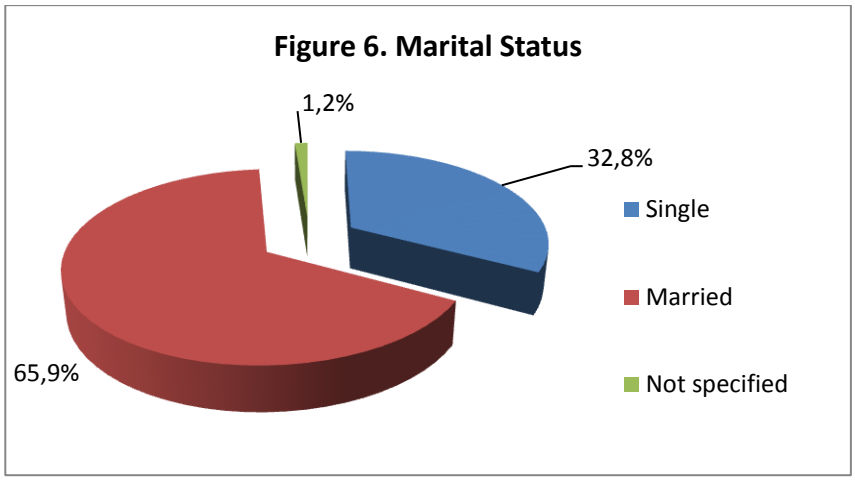
85.5 percent of respondents live in urban areas, 7.2 percent in settlements and 5.1 percent in rural areas. 2.2 percent of respondents did not indicate their place of residence (see Figure 4).



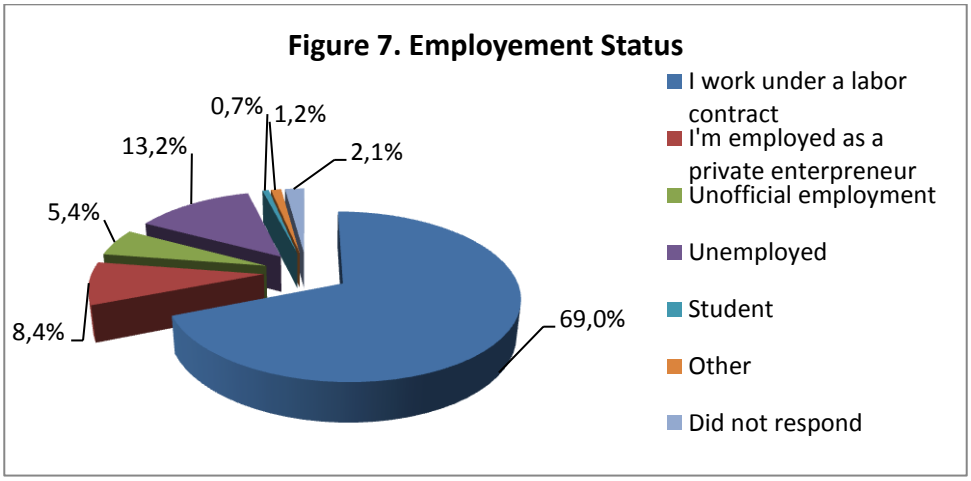
As for the regional distribution of respondents, the survey involved respondents representing almost all the economic regions, excluding the Eastern Zangezur Economic Region. Most of the respondents were from the capital Baku (64.1 percent). Respondents from the Absheron-Khizi Economic Region, which includes the districts of Absheron, Khizi and Sumgayit city, accounted for 11.4 percent of the total. There were a few respondents from other economic regions. Thus, 2.3 percent of all respondents are from the Central Aran, 2.8 percent from Sheki-Zagatala, 2 percent from Gazakh-Tovuz, 2.3 percent from Lankaran-Astara, 1.1 percent from Guba - Khachmaz, 1.7 percent from Ganja-Gazakh, 1.6 percent from Shirvan-Salyan, 0.4 percent from Nakhchivan, 0.5 percent from Mountainous Shirvan, 0.8 percent from Mil-Mugan, and 1.4 percent from Karabakh economic regions. 6.6 percent of respondents did not indicate the region they represent, and 0.1 percent indicated another country as their place of residence (see Figure 5).



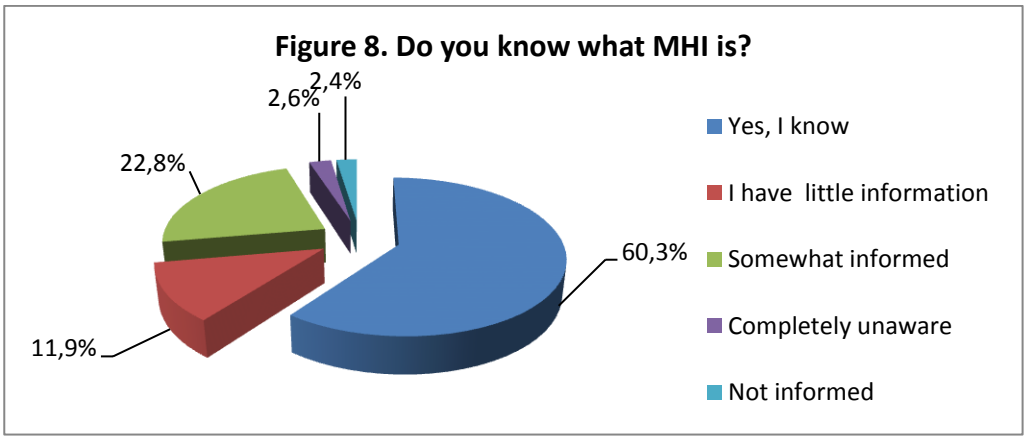
65.9 percent of respondents are married and 32.8 percent are single, while 1.2 percent did not answer (see Figure 6).



As concerns employment, 69 percent of respondents *work under an employment contract*. 8.4 percent work *as a private entrepreneur*, 5.4 percent are *informally employed*, 13.2 percent are *unemployed*, and 0.7 percent are *students*. 1.2 percent of respondents indicated *other* (pensioner, disabled), and 2.1 percent failed to answer the question (see Figure 7).



The survey first aimed at measuring the level of awareness of respondents on Mandatory Health Insurance (MHI). Therefore, the respondents were asked to provide information about what MHI is. Nearly all respondents (95%) are aware of MHI to varying degrees, with 60.3 percent saying that they were fully informed about MHI, 11.9 percent partially informed and 22.8 percent to some extent. 2.4 percent of respondents did not answer (see Figure 8).



Gender analysis of the responses shows that the level of awareness of women is lower than that of men. Thus, 62.4 percent of men and 56.8 percent of women know what MHI is. In terms of lack of information, women (3.1 percent) outnumber men (2.5 percent).

There is a direct correlation between the level of education of respondents and their level of awareness of MHI. As the level of education of the respondents increases, so does their level of awareness. For example, the share of respondents with a *secondary education* who have an understanding of MHI was 35.9 percent, while the share of respondents with *specialized secondary or vocational and higher education* was 52.6 percent and 62.8 percent, respectively. In terms of lack of information, we see the same correlation with awareness declining with level of education. In general, lack of information accounted for 2.3 percent for those with higher education, 3.5 percent with specialized secondary or vocational education, and 9.4 percent with secondary education (see Figure 8-1).

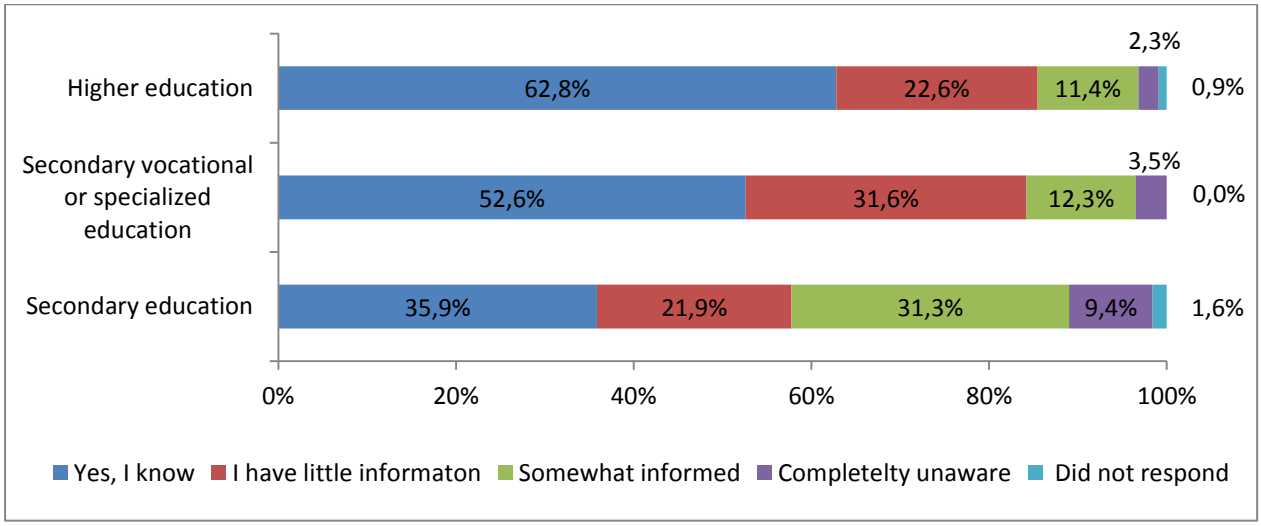
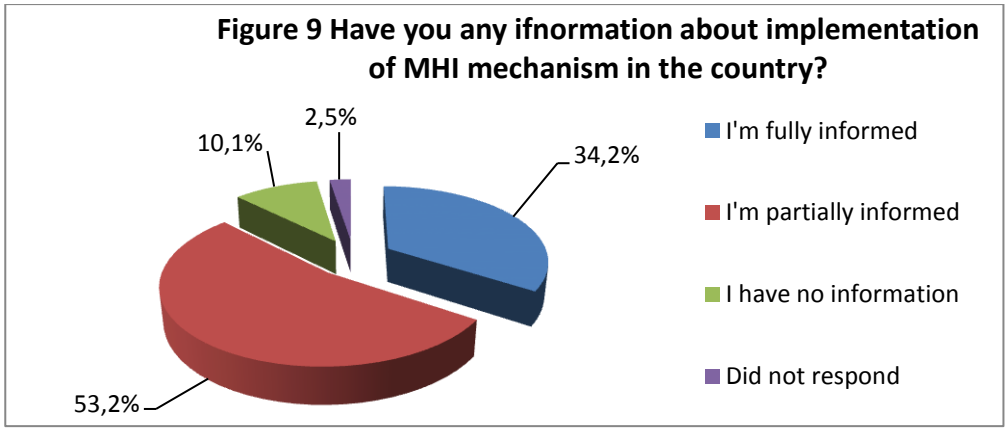


Figure 8-1. Do you know what MHI is?

The next question asked was about the level of awareness of MHI in the country. About one-third of respondents (34.2 percent) said that they were fully informed, and more than half (53.2 percent) said they were partially informed. One in 10 respondents (10.1 percent) admitted being uninformed. In addition, there were respondents (2.5 percent) who did not answer the question (see Figure 9).



The *level of full awareness* is higher among men (36.8 percent) compared to women (27.4 percent). The majority of women (57.3 percent) said that they were *partially informed*. 11.9 percent of women and 9.7 percent of men, accordingly, said that they were unaware of MHI.

Respondents with higher education (35.6 percent) self-report that they are *fully aware* of MHI implementation in our country than those with secondary (15.6 percent) and specialized secondary or vocational (28.1 percent) education. Lack of information decreased as the level of education of the respondents increased. One in four respondents with secondary education (25 percent) said that they *were not informed*, while only one in 10 respondents with higher education (9.7 percent) reported that they *were not informed* (see Figure 9-1).

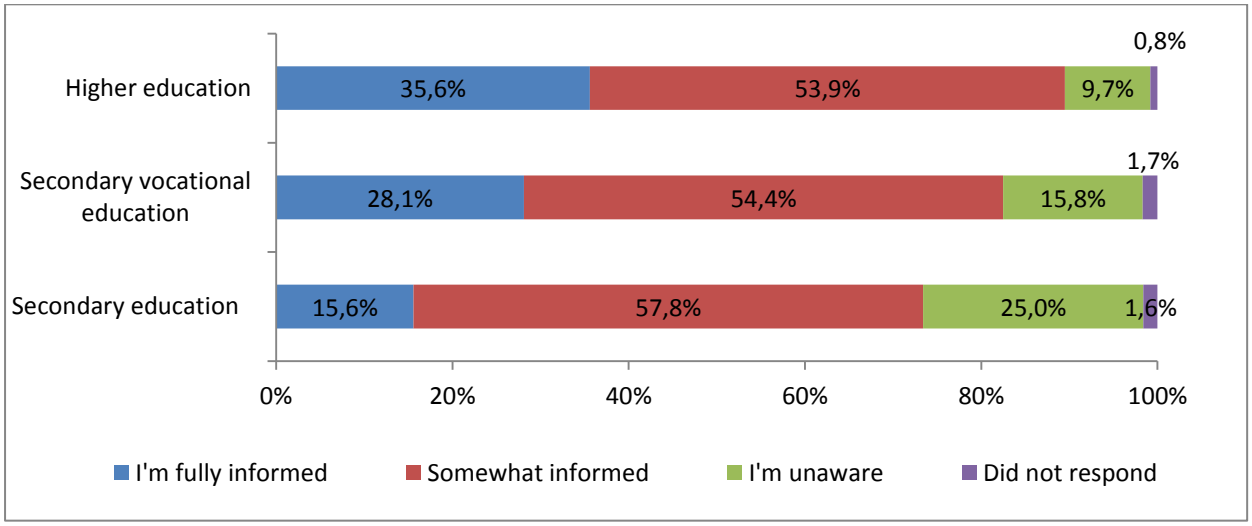
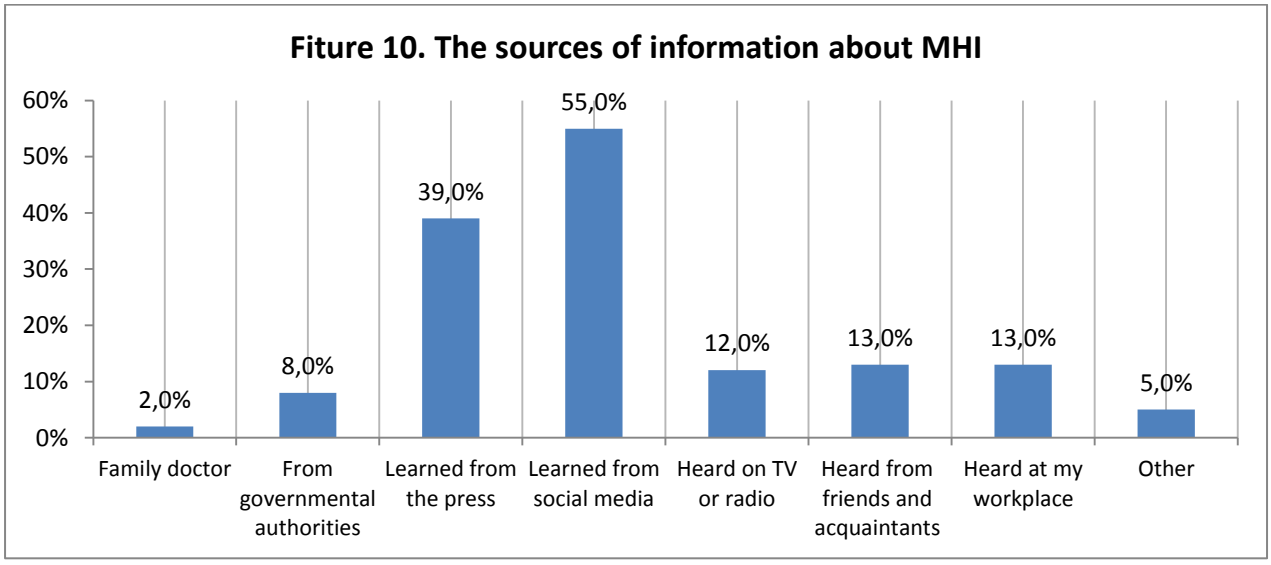


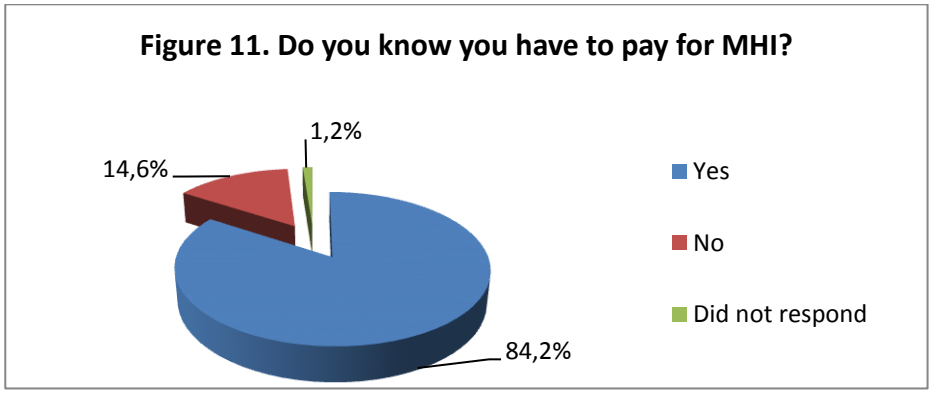
Figure 9-1. Are you aware of the MHI introduction in our country?

In response to the question "how were you informed about the application of MHI" (respondents were instructed to select all applicable sources), respondents pointed to *social media* (55 percent) as the main source. The second most popular source is *the press* (39 percent). In addition, 13 percent of respondents said that they heard about it from their *acquaintances and friends*, 12 percent on *TV or radio*, 8 percent from *government agencies*, and 2 percent from *a family doctor*. For the option *other*, 5 percent of respondents indicated that they *investigated personally*, *found out when fees were deducted from their salaries*, *when they went to the doctor*, among others (see Figure 10).



There is no significant difference between female and male respondents in the usage of sources of information they obtained. In both cases, social media and the press dominated.

In response to the question "Do you know that you have to pay contributions under MHI?", 84.2 percent of respondents answered positively and 14.6 percent answered negatively, but 1.2 percent did not answer (see Figure 11).



Awareness about the necessity to pay MHI contributions is higher among respondents with higher education (86.8 percent) than those with lower levels of education, with 65.6 percent of those with only secondary education giving positive responses and 77.2 percent of those with specialized secondary or vocational education giving positive responses (Figure 11-1).

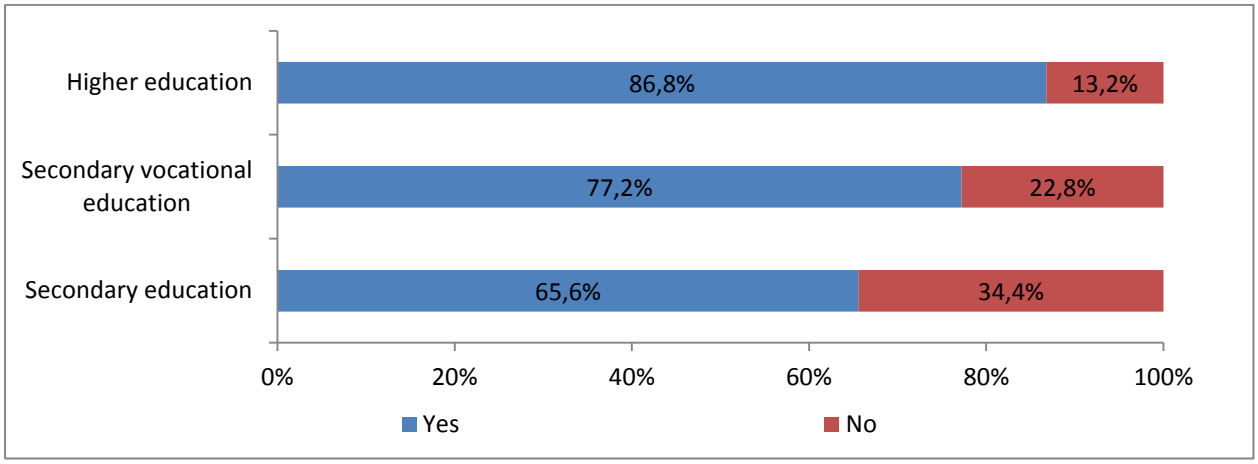
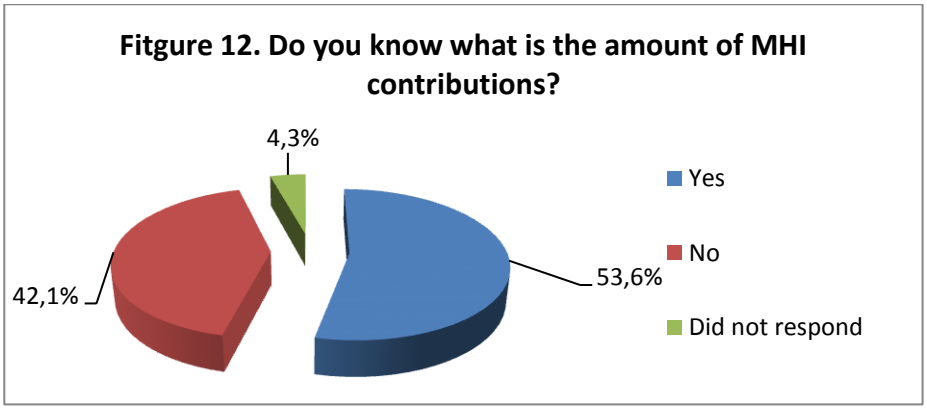


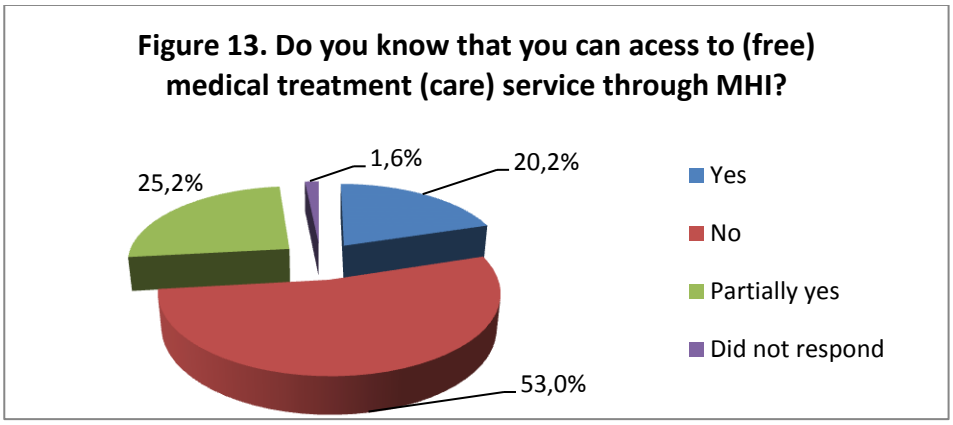
Figure 11-1. Do you know how much you should pay in MHI contributions?

Although 84.2 percent of respondents knew that they had to pay MHI contributions, only 53.6 percent of respondents said they knew how much and 42.1 percent said they did not know (Figure 12).



A gender analysis of the responses shows that 57.7 percent of male and 42.9 percent of female respondents, respectively, knew how much to pay under MHI. 51.7 percent of female respondents have no idea about MHI contributions to be made by them.

The next question was to determine respondents' level of awareness of which free medical services they are eligible for under MHI. The answers show that only 20.2 percent of respondents are aware to which medical services they have free access to. 25.2 percent of respondents are partially aware of such services. More than half of respondents (53 percent) are unaware of them (see Figure 13).



Respondents' level of awareness of free medical services is slightly higher among women than men. Thus, 21.2 percent of women and 20.2 percent of men gave a positive response.

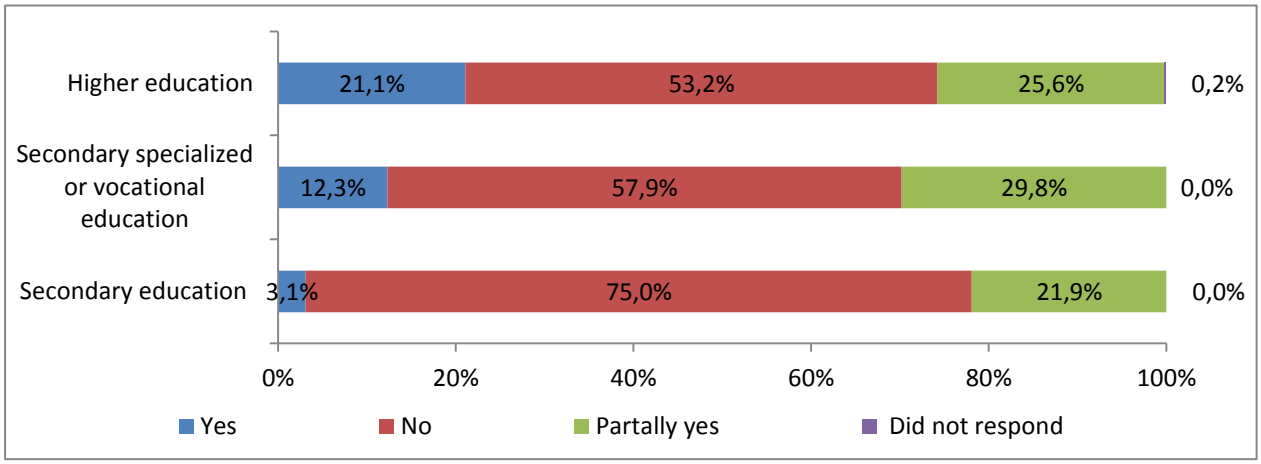
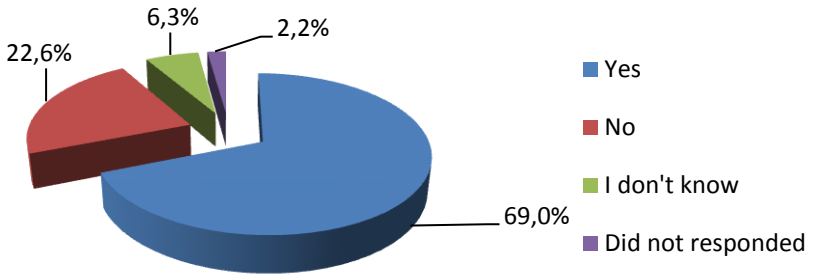


Figure 13-1. Do you know which free health services you are eligible for under MHI?

Respondents' level of awareness of which medical services are free to them under MHI depends on the level of education of respondents, and the level of their awareness went up as the level of education improved. Among respondents who gave a positive response, those with secondary education accounted for 3.1 percent, while those with specialized secondary or vocational education 12.3 percent and those with higher education 21.1 percent (see Figure 13-1).

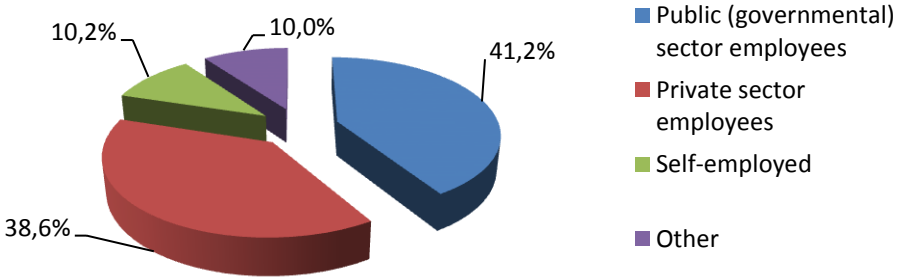
In response to the question of whether they were currently paying MHI contributions, 69 percent of respondents answered positively and 22.6 percent negatively. Among the respondents (6.3 percent) said they did not not know whether they had paid such contributions (see Figure 14).

Figure 14. Are you currently an MHI contributor?



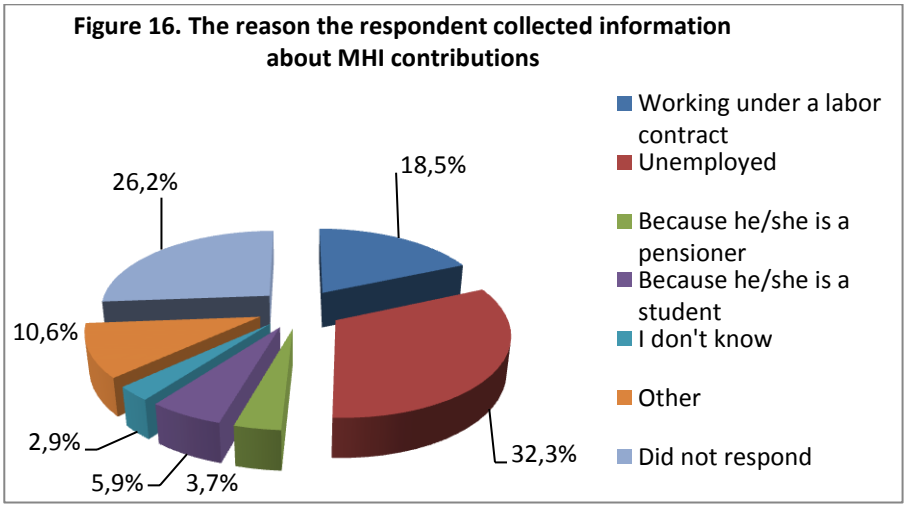
41.2 percent of MHI contributors were employees of *state enterprises and organizations*, and 38.6 percent employees of *private companies*. *Individual entrepreneurs* accounted for 10.2 percent of the respondents. 10 percent of respondents identified themselves as *another group*, which included employees of international and public organizations, pensioners, the unemployed, the disabled and students (see Figure 15).

Figure 15. MHI contributors groups



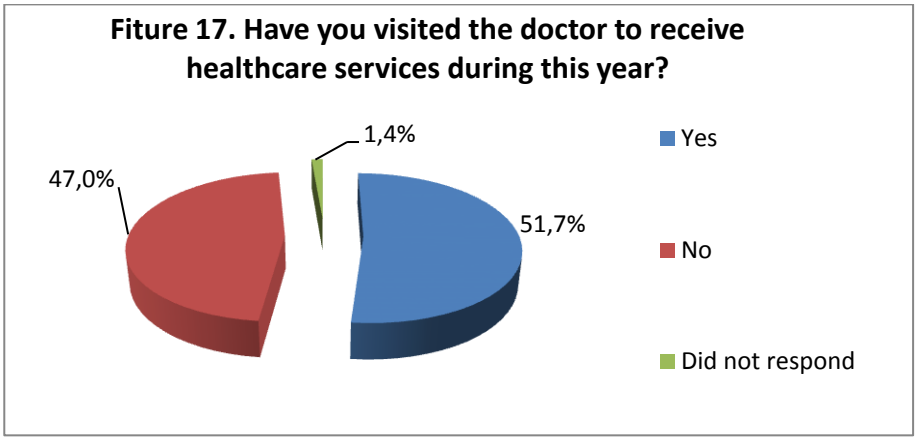
Compared to men, the share of female respondents working in *state-owned enterprises and organizations* is high (49.2 percent), while *their share in private companies* is low (20.3 percent). This ratio for men is 32 percent and 37.8 percent, respectively.

When respondents were asked why they did not pay MHI fees, 18.5 percent of respondents said they *did not work under an employment contract*, and 32.3 percent were unemployed. *Retirees* (3.7 percent) and *students* (5.9 percent) are also among those who do not pay MHI fees. 2.9 percent answered "I don't know" without giving a reason. 10.6 percent who gave other answer options said that they were unaware, did not believe in the mechanism, nobody asked for them, they live outside the country, were on maternity leave and so on. 26.2 percent of respondents did not respond (see Figure 16).



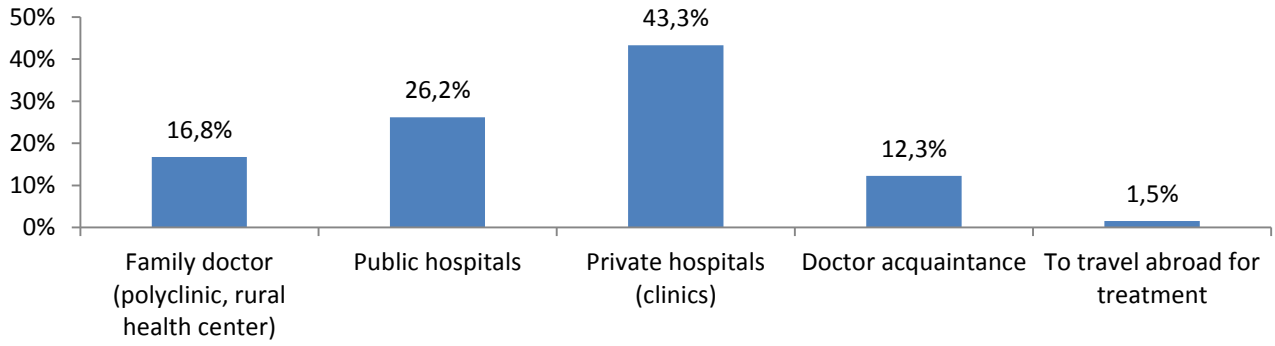
As with male respondents (25.6 percent), the main reason why female respondents (41.8 percent) do not pay fees under mandatory insurance coverage for health services is that they are unemployed. 14.2 percent of female respondents (17.1 percent of men) said that they did not work under an employment contract, while 9 percent named other reasons, such as being on maternity leave and living abroad.

To the question of whether they saw a doctor for healthcare services this year, 51.7 percent of respondents answered *positively* and 47 percent *negatively* (see Figure 17).



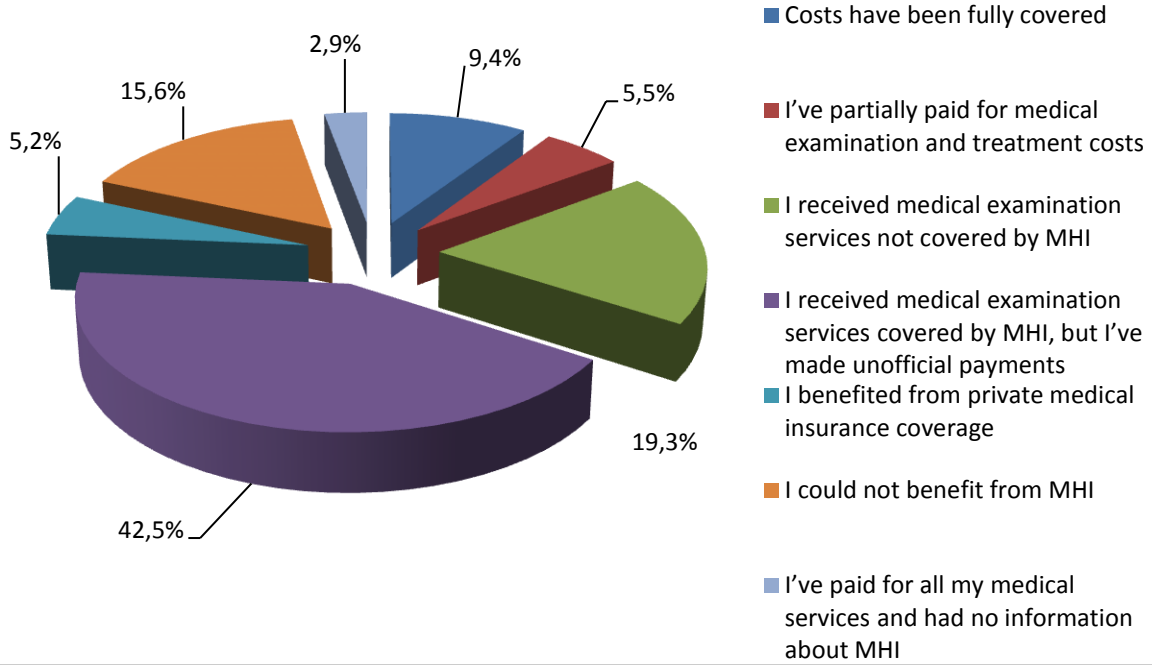
When asked "from where have you received medical examinations and services this year," most respondents answered that they went to *a private hospital or clinic* (43.3 percent). Analysis of the responses shows that not only the quality of service, but also the availability of referrals and medical insurance by area doctors played a role in respondents' preference for private hospitals or clinics. 26.2 percent of respondents said they went *public hospitals*. Beyond that, 16.8 percent went to *the area doctor* and 12.3 percent to *the doctor friend*. The answers also show that there are respondents (1.5 percent), *travelling abroad for treatment* (see Figure 18).

Figure 18. What was the level of referring for medical examinations and services?



In response to the question "have you benefited from MHI in the course of your medical examination and treatment," 9.4 percent of respondents said that *their examination and treatment were free and fully covered under MHI*, while 5.5 percent said that *the costs of medical examination and treatment were partially covered under MHI*, and 19.3 percent said that the *medical services they received were not covered under MHI*. A point on which we focused is informal payments. 42.1 percent of respondents admitted *using the medical services covered under MHI, but made informal payments*, 5.2 percent said they *benefited from private commercial health insurance*, and 15.6 percent said they *never accessed medical treatment covered under MHI*. Among the respondents, there was a group (2.9 percent) who said that they *bore all the cost and were unaware that the service was covered under MHI* (see Figure 19).

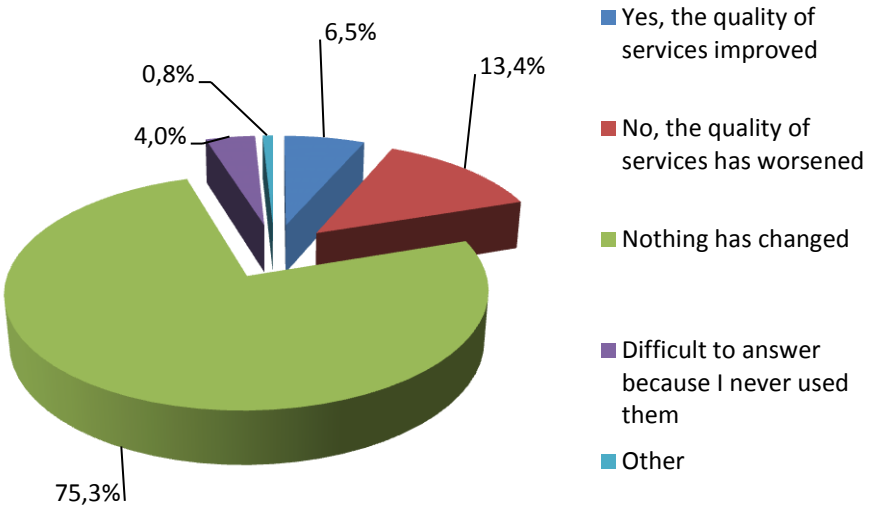
Figure 19. Have you benefitted from MHI in the course of your medical examination and treatment?



3.1 percent of female respondents answered that *medical examinations and treatments have been fully covered under MHI and they paid nothing*, with 3.7 percent saying that *part of the cost of examinations and treatments have been covered under MHI* and 15.3 percent saying that *they have accessed medical services not covered under MHI*. Women acknowledged making informal payments in fewer numbers than did men. Only 24.9 percent of female respondents said that they made informal payments while *receiving medical services covered under MHI*.

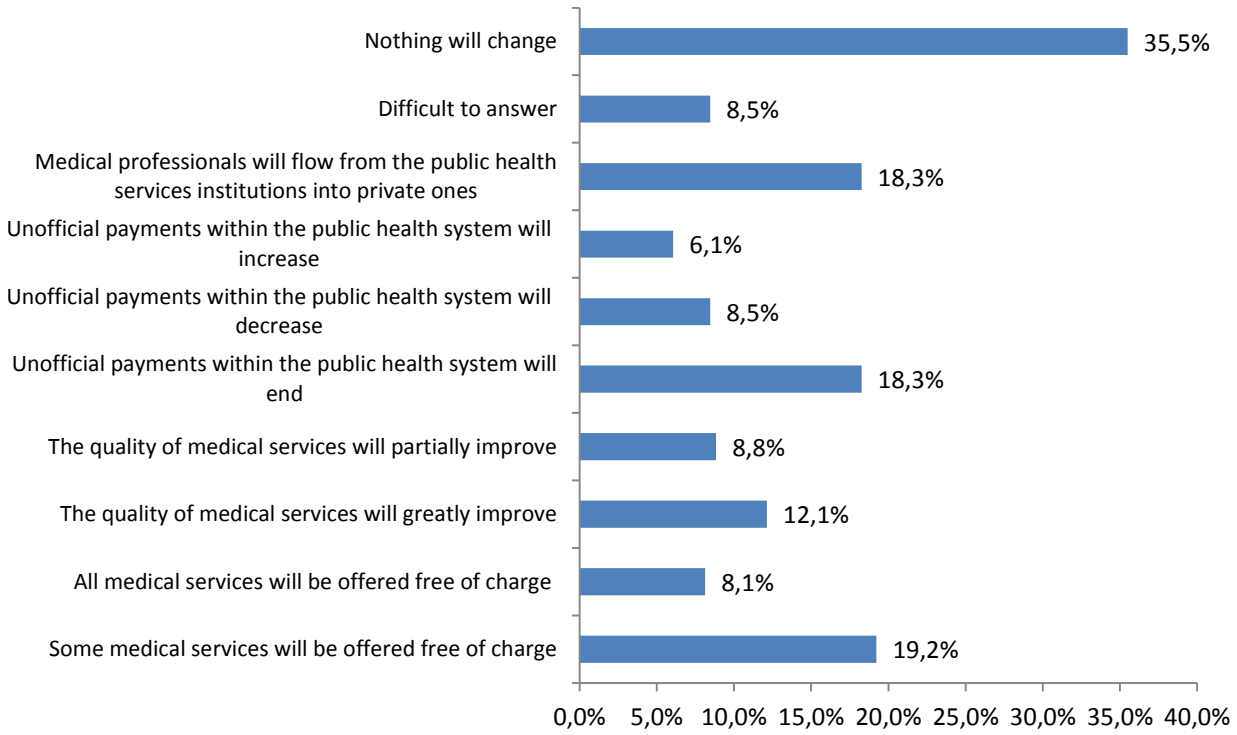
In response to the question on whether they could see "any changes in medical examinations and treatments compared to previous years," 75.3 percent respondents said that *nothing had changed*, but 13.4 percent believe that *medical services are deteriorating*, with only 6.5 percent saying services *had improved*. Out of the total number of respondents, 4 percent said they *were unwilling to express their attitude as they haven't sought treatment*. 0.8 percent who chose the option "Other" said that doctors were careful in receiving money, but some services have improved and some deteriorated, while the number of queues and documents needed have increased (see Figure 20).

Figure 20. Did you notice any changes during the medical examination and treatment compared to previous years?



The last question asked of respondents was related to their expectations from the introduction of MHI. 35.5 percent think that *nothing will change*, while 19.2 percent said they hoped to *access some of the medical services*, and 8.1 percent expected to have *completely free medical services*, with 8.8 percent and 12.1 percent of respondents saying that the quality of medical services would *partially or fully improve*, respectively. As for informal payments, 6.1 percent of respondents think that *such payments to the state medical system will increase*. But some think otherwise, with 8.5 percent saying that *unofficial payments to the state medical system will be reduced*, and 18.3 percent saying that *they will be completely eliminated*. -Another 18.3 percent of respondents worried that *medical professionals will flow from the public health services institutions into private ones* (see Figure 21).

Figure 21. What are your expectations from the introduction of the MHI mechanism?



Women place high hopes on having access to free medical treatment. 36.4 percent of the respondents said that they hoped to be able to access *some of the health services*, while 7.1 percent of them expected *completely free medical services*. Unlike men, female respondents have a more optimistic view of MHI's potential. Of female respondents, only 30.2 percent think that *nothing will change* compared to the 35.5% of both male and female. 21.8 percent of women think that *informal payments within the state medical system will be completely eliminated*. However, 18.1 percent think that *medical professionals will flow from the public health services institutions into private ones*.