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FINANCING HEALTHCARE SYSTEM IN AZERBAIJAN AND FUTURE PERSPECTIVES OF IMPLEMENTATION COMPULSORY HEALTH INSURANCE MECHANISM

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ABSTRACT

Insurance relations are one of the most important elements of the market relations system. In the context of market relations, the principles of insurance, development of insurance market and expansion of insurance services are important factors. The study was aimed to determine the ways of attracting resources for the protection, strengthening and provision of health care of population by the means of health insurance.

Furthermore, the value and quality of resources allocated by both state and other market players, and the effectiveness of their use in the health sector have been analyzed. Moreover, the fundamental models that considered as a ground for different insurance systems has been superficially touched by the author. The mechanism of applying compulsory health insurance in Azerbaijan as a pilot project and the project's outcomes were taken into consideration while conducting a research.

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Introduction. Health insurance is one of the key elements of the system of social protection of population, protection of health and obtaining the necessary medical care in case of illness. In more cases health insurance is often implemented as state protection policy. It is a system of legal, economic and organizational measures of the state that ensures the provision of primary health care and emergency medical care at the expense of financial sources of compulsory health insurance during the insured event.

The way of attracting economic resources for the protection, strengthening and provision of healthcare for the population is a historic process. The value and quality of resources allocated by both state and other market players, and the effectiveness of their use in the health sector, is determined by the economic, political and other complexity of relations in the country. The sustainability of health systems in different countries is determined by the role of government within the country.

Historically, we can see that health insurance, especially compulsory insurance, in its modern form has already emerged in the early 20th century in Germany, England, Russia and some other countries [1].

Currently, health insurance systems are built on three major economic models [2]: the German (Bismarck) model with a multi-channel financing mechanism for market management, the English economist William Beveridge budget-based public health system (some researchers also refer to Nikolai Semashko's Soviet model) and based on market principles and using private health insurance – the American model.

The core idea of the Beveridge model is that the system is often centralized through the establishment of a national health service. The government acts as the single-payer, eliminating competition in the market and generally keeping prices low. Under this system, a large majority of

health staff is composed of government employees. Apparently the common criticism of this system is the tendency toward long waiting lists. Because everyone is guaranteed access to health services, over-utilization of the system may lead to increasing costs. There are fears that a single-payer national health service would lead to an increase in demand for all procedures, even medically unnecessary ones because citizens would not pay upfront costs for these services.

Considering the core idea of the Bismarck model, in other words, social health insurance model, employers and employees fund health insurance in this model – those who are employed have access to “sickness funds” created by compulsory payroll dedications. Regardless of the number of insurers, the government tightly controls prices while insurers do not make a profit. These measures allow for the government to exercise a similar amount of control over prices for health services seen in the Beveridge model. Critics believe it was not initially established to provide universal health coverage, the Bismarck model focuses resources on those who can contribute financially. With a shift in mindset from health as a privilege for employed citizens to a right for all citizens, the model faces a number of concerns, such as how to care for those unable to work or those who may not be able to afford contributions.

For the third, the American model, which is characterized by the provision of medical care on a paid basis, the market of medical services is the main tool for meeting the need for medical services. This model can also be attributed to the fact that the state assumes some of the needs that cannot be met by the market (the needs of vulnerable groups: children, unemployed, pensioners, etc.), and therefore the development and financing of state health care programs. The American model focuses on the free market model of health insurance services, the competitiveness of insurance plans, competition among physicians for the number of patients, and so on. The basis of health care here is non-governmental companies for medical services, completed by government programs. [3]

Healthcare system in Azerbaijan.

The health system currently used in Azerbaijan is based on Semashko’s model. This means that the leading role in the health care system, including all functions within the system - regulator, supplier and buyer - is performed by the state. Speaking of the model of Nikolay Semashko, it is particularly relevant to the treatment and preventive infrastructure, the availability of specialized doctors and medical facilities. The basic principles of Soviet system health, founded by Semashko, are:

- ✓ Centralized government subsidies for the protection of public health;
- ✓ Free, accessible and equal treatment for everyone;
- ✓ Establishment of sanitary facilities in the state health system;
- ✓ Priority of pediatric and gynecological services;
- ✓ Organization of activities aimed at prevention of diseases, etc.

The Soviet model was based on the principle "from everyone in line with his/her financial capabilities to all according to their material needs" [4].

The scheme of financial model of healthcare system in Azerbaijan comprises five main chains: regulatory, financial source, buyer, supplier and patients. By distributing budget funds, namely tax revenues to the main recipients, the Ministry of Finance executes relevant transactions to the Ministry of Health, local executives and other government agencies.

In this case, the role of the Ministry of Health as a regulatory and budgeting body for all participants in state medicine is pivotal. The last chain in the scheme is the process of delivering services by means of the providers of the Ministry of Health, regional hospitals and other state healthcare providers to population. (Figure 1.)

Health development in the Republic of Azerbaijan, provision of population with medical care in line with world standards is one of the priorities of socio-economic policy in the country.

Despite this, according to World Bank research, overall health expenditures in Azerbaijan are moderate to the level of income in the country, but the health care system is largely funded by out-of-pocket payments. For example, in 2017, out-of-pocket payments accounted for 84% of current health expenditure in Azerbaijan [5]. According to the calculations of the above-mentioned financial institution, the share of current health expenditure (out-of-pocket expenditure included) as a percentage to GDP in Azerbaijan in 2017 is comparable to that of the sample countries and neighboring countries. Refer to World Bank the share of healthcare expenditures in GDP in Azerbaijan was higher than in Estonia, Kazakhstan, Russian Federation and Turkey (Figure 2) [6]. However, the main problem of the system is the high share of pocket payments by Azerbaijani citizens.

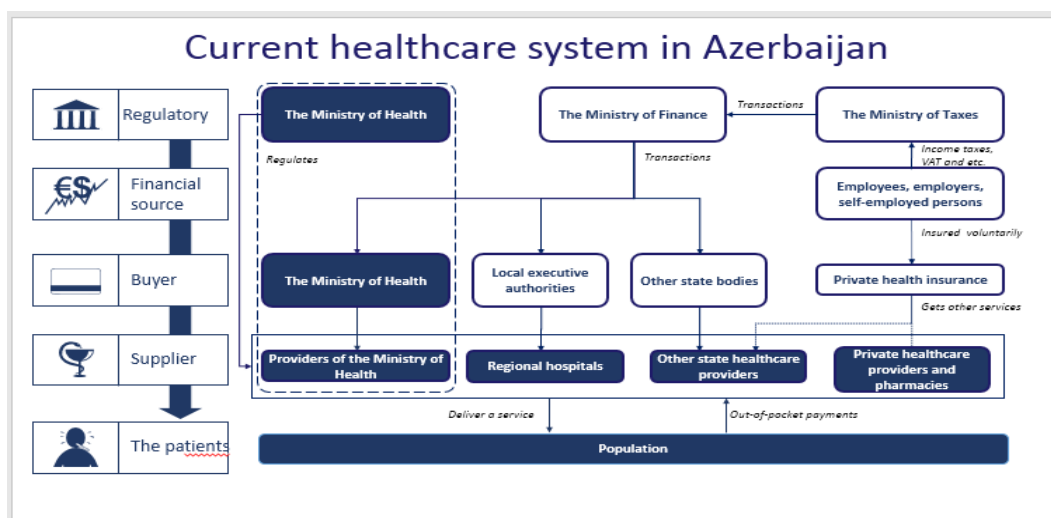


Fig. 1. Current healthcare system in Azerbaijan

Share of healthcare expenditure in GDP, 2017

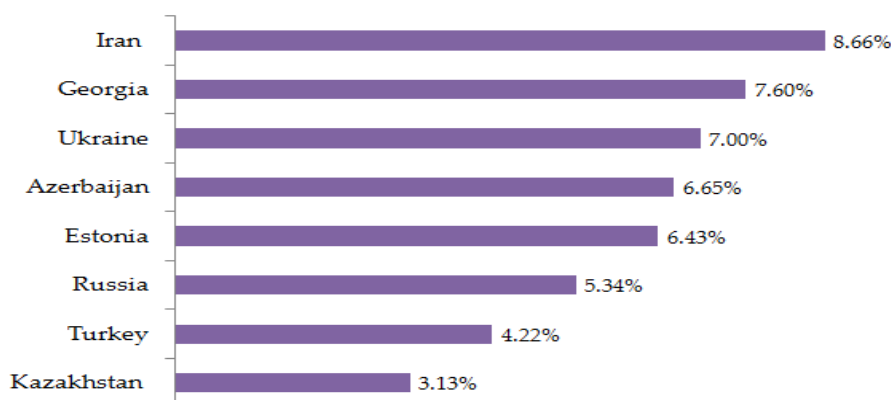


Fig. 2. Share of healthcare expenditure in GDP, 2017 (source: World Bank)

According to the World Health Organization (hereinafter referred to as WHO), out-of-pocket payments (OOPs) are defined as direct payments made by individuals to health care providers at the time of service delivery and use. This excludes any prepayment for health services, for example in the form of taxes or specific insurance premiums or contributions and, where possible, net of any reimbursements to the individual who made the payments.

In recent years, a number of countries have begun to implement health care reform and targeted policies to reduce out-of-pocket payments. The main coverage of policies adopted in the area is the abolition of user fees and charges in public health facilities, exemption of specific population groups such as the poor and vulnerable, pregnant women and children from official payments, delivering a range of health services such as maternal and child care from official payments and deliver them free of charge.

As noted in the WHO recommendations, the implementation of such strategies need political support, decision-making and proper preparation. User fee abolition and exemption can have a large impact on both demand and supply of health services. They likely increase the demand for services which subsequently affects the workload of health workers. On supply side, they can have drastic impact on the income of public health facilities. [7]

Application of compulsory health insurance in Azerbaijan

By adoption of the Law on Medical Insurance in 1999, establishment of the State Agency for Compulsory Medical Insurance under the Cabinet of Ministers of the Republic of Azerbaijan in 2007, the Concept of Health Insurance System Reform and Application of Compulsory Health Insurance in 2008 and finally by the Decree of the President of the Republic of Azerbaijan dated November 29, 2016 it was decided to implement compulsory health insurance as a pilot project in administrative areas of Mingachevir, Yevlakh and Aghdash districts. [8]

The main goal of compulsory health insurance, which is a large-scale social project, is to protect the public from financial risks related to health while ensuring the sustainability of health care financing and access to health services. As mentioned above, the implementation of compulsory health insurance has been launched in the country since January 2017 as a pilot project. The main objectives of the pilot program were to test the health insurance system and gain important experience in this area, as well as the implementation of such important issues as the effectiveness of medical facilities. During the pilot project on compulsory health insurance, certain tools were used to improve public health services:

- ✓ By providing autonomy to health facilities it was started to govern them at the regional level. The new management structure allowed for quick decision-making on human resources issues, as well as investment and allocation of resources.

- ✓ Payments to health care providers were made on the basis of a new payment mechanism. This has encouraged health care providers to increase their productivity.

- ✓ Medical workers' salaries were increased.

- ✓ Participation of health workers in professional training both in the country and abroad.

- ✓ By 2018 The State Agency for Compulsory Medical Insurance has established the “Legal Territory Management Association”, a legal entity that includes public health facilities in the country, including medical institutions, research institutes, medical centers in Baku and regions. Subordinated to “Legal Territory Management Association”, the application of compulsory health insurance in the health care system has spurred institutional changes, the organization of health services, and the improvement of the quality of health services.

Implementation of health insurance system in any taken society demands the determination of essential health benefits that insurance system covers. As it was mentioned above the pivotal elements of insurance system is the cost of certain benefits listed in state's or companies' policy.

In Azerbaijan compulsory health insurance provides the insured with the provision of medical services under the conditions envisaged in the so-called “services envelope”. The document of compulsory health insurance services package has been approved in accordance with Article 15-17.4 of the Law of the Republic of Azerbaijan "On Medical Insurance" [9].

The structure of package of privileged services consists of medical services such as: emergency and urgent medical care, primary health care, specialized outpatient services, inpatient medical services. According to the law in Azerbaijan the package of privileged services includes 2550 medical services. Of these, 6 services for emergency and urgent medical care, 35 services for primary health care, 1265 services for specialized outpatient care and 1244 services for inpatient care.

According to the main results of the household budgets survey conducted among 10.2 thousand households (covering approx. 42.0 thousand people) by the State Statistics Committee of the Republic of Azerbaijan in 2019 the average monthly consumption expenditures per capita amounted to 175 USD, and it was 4.3 percent higher than in 2018 [10]. In recent years, the share of expenditures on food products in the structure of consumer spending has decreased, while the share of expenditures on non-food products and services has increased. Refer to the outcomes of the survey in 2005 the households spent 53.7% of consumer spending on food, but in 2019, the share of household expenditures on food products decreased by 41.5 percent. This is explained by the background of increasing the welfare resources of the population in Azerbaijan, more money is spent on non-food goods, cultural needs, travel, sports, health, education and additional medical services (Figure 3).

If we look at the share of health services in the average monthly consumption expenditures per capital we will see the gradual growth from 4% in 2015 to 4.7% in 2019. It means that people tend to spend more on their health due to different reasons and each citizen of the country spends 8 USD per month on healthcare services. The calculation shows that with the population of just over 10 million Azerbaijani people spend 960 million USD per year on health services

With the budget spending in the year of 2019 around 600 million USD above mentioned figure seems emerging.

The situation demands to reduce the number of payments from personal funds of citizens caused by non-provision of medical services on a free basis or malfunctioning of any kind of health insurance. In order to meet specific social and individual needs to receive free, affordable, qualified and quality medical care the processes of production, distribution, exchange and consumption of medical services should properly be established.

	2005	2010	2015	2016	2017	2018	2019
<i>Consumer spending, total</i>	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<i>Food</i>	53.7	48.2	40.5	40.5	42.4	41.8	41.5
<i>Alcohol</i>	0.6	0.5	0.5	0.6	0.5	0.6	0.5
<i>Tobacco</i>	1.8	1.2	1.0	1.4	1.4	1.4	1.4
<i>Clothes and shoes</i>	6.9	7.1	6.9	6.8	6.5	6.4	6.2
<i>Water, electricity, gas and other fuels</i>	6.2	6.7	7.4	7.5	7.4	7.6	7.6
<i>Household items and daily housekeeping</i>	6.9	6.9	9.4	9.2	8.8	8.8	8.6
<i>Health services</i>	3.4	3.7	4.9	4.9	4.7	4.8	4.8
<i>Transport services</i>	5.2	5.8	6.2	6.3	6.1	6.2	6.4
<i>Communication services</i>	2.0	2.6	3.3	3.4	3.2	3.2	3.2
<i>Recreation and cultural services</i>	3.1	3.2	4.4	4.4	4.2	4.2	4.3
<i>Education services</i>	1.3	1.5	2.0	1.9	1.8	1.8	1.8
<i>Hotel, café and restaurant services</i>	5.4	8.6	8.8	8.7	8.4	8.6	9.0
<i>Other goods and services</i>	3.5	4.0	4.7	4.8	4.6	4.6	4.7

Fig. 3. Composition of average monthly consumption expenditures per capita by years, in percent (source: State Statistics Committee of the Republic of Azerbaijan)

The current situation requires, on the one hand, a significant increase in the availability and quality of medical care to the population, and on the other hand, an increase in the efficiency of the use of available health care resources, as the only possible way to ensure quality and affordability in conditions of financial constraints.

Conclusions. In general, the introduction of the health insurance mechanism allowed for the targeted collection and differentiation of financial resources. Thus, health insurance is considered to be one of the main mechanisms for the effective financing of public health services and increasing accessibility and quality of health services, attracting additional resources in this area and ensuring the public's interests. In addition, the development of the health care system should not only be formally limited to the system of compulsory public health insurance and should be taken into account, including a comprehensive approach to the issue, including fundamental changes in the funding mechanisms of health care providers and competition between insurance and health care providers.

Also, based on the mechanism of compulsory health insurance that has been introduced in pilot areas in Azerbaijan and the results from this process, a number of advantages and perspectives of implementing compulsory health insurance have been revealed as mentioned below:

- analysis of medical insurance as a legal institution in order to improve the medical insurance system, both scientifically and practically;
- establishment of public-private partnership in the field of compulsory health insurance;
- bringing the quality of medical services provided in state medical institutions in line with international standards;
- formation of the Institute of Family Medicine;
- increase the effectiveness and sustainability, as well as increase the productivity of medical personnel should be executed in parallel with increase in salaries and elimination of illegal payments.

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