Health financing in Azerbaijan:
Political barriers on the road to reform

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Azerbaijan is a country in the South Caucasus which gained independence from the Soviet Union in 1991 and which has significant oil and gas reserves. The health care system in Azerbaijan still largely resembles the old Soviet Semashko model with highly centralised planning of resources and personnel, primarily public ownership of health facilities, input-based allocation of funds and no clear provider-purchaser split.[1] What has changed, however, are the dominant sources of funds with private sources now accounting for more than half of total health expenditure.[2] Azerbaijan is characterised by a very large share of out-of-pocket payments made at the time of service provision which significantly affect the population's access to care and expose poor households to the risk of catastrophic health care costs. Reforms to improve equity and efficiency in health care financing have been discussed many times since independence, but thus far implementation has stalled; most recently in 2008 when renewed interest in establishing mandatory health insurance (MHI) based on the legal framework established in 1999 ended in stalemate. This snapshot aims to shed light upon the reasons for this stalemate and discusses potential directions for health financing reform in Azerbaijan.

Health financing system in brief

Government health expenditure as a share of gross domestic product (GDP) was only around 4% in 2007[2] which is low relative to other countries in the WHO European region. The main sources of funding for health care in Azerbaijan are out of pocket payments (61.5% in 2007) and general government expenditure (31.5% in 2007); the role of voluntary health insurance and donor funding is small.[2] In 2008, the share of budgetary allocations for health controlled by the Ministry of Health represented around 63% of all expenditure. The remaining 37% went to the 65 local government administrations which fund primary and secondary state facilities within their district boundaries.[1] As there is no mechanism for the redistribution of funds between district health departments, the funds allocated for local government administrations can be viewed as 65 separate pools. The fragmentation of pooling is an issue in terms of efficiency, but also equity as funding for services is not linked to health needs of the population. Shortfalls in state funding for services have also meant a steady growth in out-of-pocket payments (both formal and informal) which hinder equity and access for poorer households.[3,4]

The Azerbaijani health care system is characterised by an integrated model where the providers are owned by the payers. The public health providers, as state institutions, have very limited financial and managerial autonomy and there is a tendency for the autonomy of actors to be more limited further down the hierarchy of the system. Public health care facilities receive input-based payments based on the number of beds or staff through prospective fixed line-item budgets typical of the Semashko model of health care. Consequently, a hospital will get paid regardless of whether it has no patients or is fully occupied. Moreover, underspending is penalised through reductions in allocations for the next year because the budgeting process is based on historic expenditures. The payment mechanism does not provide any incentives for hospital administrators to reduce costs to improve efficiency and there is no mechanism under current payment arrangements to reward better performing facilities.

Main directions for health financing reform

Unlike many post-Soviet countries that introduced significant changes in the way their health care systems are financed, Azerbaijan has been slow to reform for several reasons. The first years of independence were marked by the military conflict with Armenia and economic turmoil due to the collapse of the Soviet Union. Government efforts were focused on ensuring access to basic health care services and public health interventions rather than health system reforms.In addition, the overall political environment was not conducive to radical changes. The Ministry of Health pursued a more conservative approach by preserving those features of the existing system which proved functional. Discussions about reform only began in earnest once the socioeconomic situation in the country began to stabilise towards the end of the 1990s.

These first serious discussions about systemic health reforms commenced in 1998 when the President of Azerbaijan established the State Commission on Health Reforms led by the Ministry of Health. In 1999, the Commission developed the first conceptual document defining the main directions for health reform including the development of new financing mechanisms and the formal introduction of medical insurance. The Milli Mejlis (Parliament) then enacted the Law on Medical Insurance (1999) that created a legal framework for MHI. This law, however, did not detail the implementation mechanisms for MHI, instead it was suggested that the government develop the necessary regulatory documents setting out how the scheme would operate. This regulatory framework was never developed, which was a reflection of scepticism in government circles about the timeliness of introducing MHI under the prevailing economic circumstances. It was felt that the introduction of MHI required a significant increase in budget allocations for health care to cover

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those sections of the population who were not able to pay for themselves, such as children, pensioners, students and the unemployed. Moreover, considering the significant scale of the informal sector in the economy, the taxation base was considered too small to introduce a viable MHI system. As such, the government decided to wait until the economic situation improved and the budget capacity was sufficiently high to allow the successful introduction of MHI.

A change of leadership at the Ministry of Health in 2005, as well as significant increase in country's oil revenues, renewed the government's interest in health financing reforms. The Ministry of Health became a very active lobbyist for such changes and drafted *The Concept for Health Financing Reform and Introduction of Mandatory Health Insurance* which was approved by Presidential Decree in December 2007. The Ministry of Health considered itself the most capable agency within the government to lead reforms in the health financing sector. Its vision was to pool all budget resources allocated to health in a single body that would be under the Ministry of Health. By 2007, the Ministry already managed a majority of public health funds, including those for all tertiary institutions in the country, as well as all primary and secondary health facilities located in Baku (the capital city). It also managed the budget for all targeted state health programmes, which represented a quarter of all public health expenditures in the country in 2008.[1] The majority of these programmes target specific health conditions aiming to cover the cost of equipment and pharmaceuticals through centralised procurement. The remaining public funds for health are managed by local administrations which fund primary and secondary state facilities within district boundaries.

The pooling of all health funds in one body that would act as a single public payer in the health sector would mean that, with the introduction of MHI, the funds currently controlled by local administrations would move to that body. If the vision of the Ministry of Health had been accepted by the government it would have controlled all public health allocations in the country. However, this vision was not shared by the President who signed a Decree establishing the State Agency for MHI (SAMHI) under the Cabinet of Ministers in January 2008. Effectively this decision meant that not only would the Ministry of Health not control all budget allocations for health but also those funds currently managed by the Ministry would move to SAMHI.

Due to the non-transparent nature of political decision making in Azerbaijan, it was difficult to say what forces advocated establishing an independent body for MHI. This decision may seem technically correct in order to ensure a real provider-purchaser split in the health care sector where the vast majority of health facilities are still state-owned. However, in practical terms this decision led to a loss of interest by the Ministry of Health, a major stakeholder in health sector, in the implementation of health financing reforms.

Although the Cabinet of Ministers approved an action plan for the implementation of the Concept for Health Financing Reform and Introduction of Mandatory Health Insurance in August 2008, the Ministry practically withdrew itself from any policy discussions and activities in this field delegating this responsibility to the Project Implementation Unit (PIU) of the Health Sector Reform Project – a US$86 million project co-funded by the World Bank and the Government of the Republic of Azerbaijan expected to end in 2012.

Consequently, a technically sound decision to establish a separate payer agency for health care under the Cabinet of Ministers led to a political impasse in that there are now no major forces to lead the implementation of proposed health financing reforms. The Ministry of Health was not able to bring persuasive arguments to the Government to justify the establishment of the single payer agency under its supervision. The Presidential Decree of 2008 requiring the Cabinet of Ministers to prepare a statute of SAMHI has never been implemented and despite the fact that in both 2008 and 2009 the state budget included a separate line-item for SAMHI, its statute has not been approved and the agency has never functioned. Again, due to the non-transparent nature of policy making in the country it is not possible to provide conclusive answers as to why it happened, but the Ministry of Health, alone or with other interested parties, has been successful at least in blocking any further advancement of the implementation of the Presidential Decree of January 2008.

Conclusion

There was no consensus in Azerbaijan that establishing an independent single payer was the best option given the country's circumstances and past experience with health reforms. Consequently, by losing its major advocate and driving force (i.e. the Ministry of Health), the reforms in health financing have come to a stalemate. In addition, the Ministry of Health has historically always been a major player in health care and there is a lack of expertise outside the Ministry of Health to lead such challenging health financing reforms. As such, the deadlock may continue indefinitely, as happened with the Law on Health Insurance of 1999, some important provisions of which, including those on the introduction of MHI, have never come into force. There is no guarantee that the health financing reforms would be successful were they led by the Ministry, but an inter-sectoral approach would at least garner the necessary political momentum to push reform forward. Moreover, health financing reforms could be started, at least, in order to allow the accumulation of very valuable national experience based on which more advanced and complex steps could be taken in the future on a more solid footing. Azerbaijan is in an enviable position – even in the face of global economic recession, the country has considerable resources, more of which could be directed to health care. What is needed now is greater coalition building to drive forward health sector reforms in order to break the deadlock.[5] Only then can the system be made more efficient and effective and the Azerbaijani population be better protected from financial risk.

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