Ministry of Education Republic of Azerbaijan

ANALYSIS OF AZERBAIJAN HEALTH FINANCING SYSTEM: IMPLICATIONS FOR HEALTH FINANCING REFORM AND UNIVERSAL HEALTH COVERAGES.

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May 2018

Acknowledgements

İn first place, I would like to express my gratitude to my supervisor, Rovshan Jamalov, for his recommendations, direction, and contribution through the understanding and researching this dissertation topic. I have been extremely lucky for having a supervisor who take care of my work so excessively and who feedback to my all questions so instantly with heart and soul whatever time.

A special thanks go to my friends for their heart-warming and inspirational actions during the writing of this work and for giving me invaluable assistance.

Finally, I would like to owe my sincere profound gratefulness to my family, who have always trusted me, and who have been my supporter at all stages of my life and also throughout my researching process. I am blessed to have them in my life.

ABSTRACT

The relevance of the chosen topic lies in the fact that in the last decade the state of health of the population of Azerbaijan has deteriorated noticeably. This is evidenced by indicators of morbidity, mortality, life expectancy. There is a fall in the birth rate, mortality has increased, and the average life expectancy of the population has decreased. Indicators of life expectancy have worsened. The incidence of tuberculosis, infectious diseases, blood and hematopoietic diseases has increased, and the number of endocrine diseases and mental disorders is on the increase. The proportion of treatment to the doctor for chronic pathologies increases, the course of illness becomes more severe and prolonged. The proportion of neglected diseases is increasing, the treatment of which requires considerable expenditure

Key words: Azerbaijan - Health Coverages - Health financing – Financing reforms – Health care - Planning

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INTRODUCTION

Relevance. The relevance of the chosen topic lies in the fact that in the last decade the state of health of the population of Azerbaijan has deteriorated noticeably. This is evidenced by indicators of morbidity, mortality, life expectancy. There is a fall in the birth rate, mortality has increased, and the average life expectancy of the population has decreased. Indicators of life expectancy have worsened. The incidence of tuberculosis, infectious diseases, blood and hematopoietic diseases has increased, and the number of endocrine diseases and mental disorders is on the increase. The proportion of treatment to the doctor for chronic pathologies increases, the course of illness becomes more severe and prolonged. The proportion of neglected diseases is increasing, the treatment of which requires considerable expenditure. Therefore, in today's environment, the healthcare system acquires a vital importance for the preservation of society and for ensuring national security. However, the state of the health care system is characterized by serious problems that need to be addressed. The main ones are organizational and economic problems.

Health is a complex social dynamic system that human society at every stage of its development creates and uses to implement a large set of activities aimed at protecting and constantly improving the health of every person and society as a whole, in particular, the accumulation of scientific medical knowledge and their use in the purpose of wide individual and public disease prevention, the recognition and treatment of diseases and the increase in the life expectancy of people. Healthcare is one of the priority directions of the social policy of the state in modern countries since the health of the nation is of independent value and an important component of the country's overall potential. Legal regulation gives the healthcare system optimal controllability, focus, and assurance, creates conditions for the development of a long-term program for the development of this system, determines the stability of the

resource provision of the health system as a whole, and on this basis improves the forms and methods of management of this field. Currently, the process of lawmaking in the health sector is developing very actively. This is due to the reform of the sphere under consideration in countries that recently implemented the transition from the command economy to the market economy, as well as the dynamic development of public relations in the field of healthcare in developed countries, due to increased public attention to health. Studying the experience of legal regulation and reforming the health care system in developed countries, as well as in countries with transitional economies, is absolutely necessary for the successful development of this important social sector in Azerbaijan.

Research object. The object of the study is the finance of the budgetary sphere of the Azerbaijann Republic.

The subject of the study is the financing of health facilities.

Research goal. The purpose of this work is to consider the financial provision of the health care system in Azerbaijan and its improvement based on the reform of the health care system.

Proceeding from the **goal**, we determined the range of tasks: to determine the role of the state in financial health care, both at the expense of the federal budget, and at the expense of the funds of mandatory health insurance funds; to consider the improvement of the health care system on the basis of its reform.

In modern conditions, financing of domestic health care requires a thorough rethinking from the position of additional attraction of financial resources and their effective use. Informal co-payment of the population can not be considered as a viable solution to this problem. Today, it is necessary to switch to economic methods of management of medical organizations with a view to withdrawing a significant share of financing medical organizations from the "shadow".

The structure of the thesis. The work consists of three chapters and two figures. An empirical research and three hypothesizes were identified based on the

findings of the past experiences of financing on healthcare in Azerbaijan and the current reforms and models to be used.

CHAPTER I.
MODERN ASPECTS OF FUNDING MEDICAL ORGANIZATIONS

1.1. Sources of financial support for medical organizations

The main purpose of the economy is to provide people with means of subsistence and support the conditions of existence necessary for people. The main condition for the existence of a person is his health, therefore, it is legitimate to maintain the health of people as one of the defining tasks of the economy. The state participates in the implementation of healthcare activities in all countries of the world. The state is understood at the same time in a broad sense and covers legislative and executive authorities of different levels. The main functions performed by the state are (Ministry of Health of the Republic of Azerbaijan. Reorientation of the health care system and reforms supported in the organization and delivery of medical services to the public. Baku, Ministry of Health of the Republic of Azerbaijan, 1999):

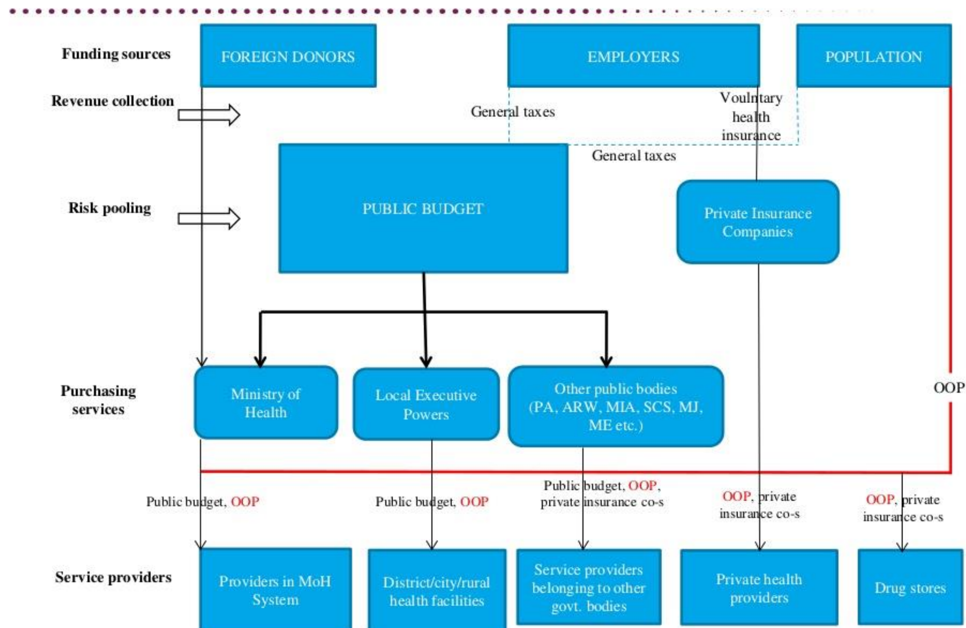
1. Regulation of activities in the field of health
2. Production of services
3. Financing of medical care for the population

In times of the Soviet economy, the financing of institutions, healthcare organizations, which at that time were almost entirely state, was carried out from the state and local budgets. As Azerbaijan's market relations became established, budgetary resources became only one of the sources of financing, along with resources of compulsory and voluntary medical insurance and other sources. Although state medical institutions are able to have their own accumulated cash in the form of money on accounts in banks and in the cash register, securities, they mainly operate with funds from external sources of financing.

Consider the scheme of current financing system in Azerbaijan.

Figure 1. Current health financing system in Azerbaijan

Current health financing system



Source: *https://www.slideshare.net/OECD-GOV/sustainability-and-transition-policy-in-action-gf-session-tural-gulu-azerbaijan*

Financing of medical organizations from the budgets of different levels takes place in the form of budgetary allocations, gratuitously allocated for financial support of the activities of budgetary medical and preventive institutions. It is necessary to distinguish direct, direct financing in the form of the allocation of funds coming to the account of the medical organization from indirect financing in the form of provided tax benefits, full or partial exemption from payments to the budget, obtaining subsidies in the form of the possibility of purchasing goods at prices below market prices, duties. Financing of medicine is also made from the funds of compulsory medical insurance, representing one of the types of extrabudgetary social funds. Such financial funds are created in the order established by the state through normative deductions from the wage fund of any organizations. Compulsory health insurance is a kind of redistribution of funds, in which part of the funds earned by employees are withdrawn from the payroll resources and sent to the extra-budgetary fund of compulsory medical insurance. Subsequently, these funds are transferred to

medical institutions in the form of payment for the services they provide to the population.

Financing of health organizations by organizations, business structures is carried out in different forms. It can be financing through voluntary medical insurance of employees of this enterprise, carried out at the expense of the enterprise, through a state or private insurance company. In this case, the financing is carried out by the insurance company within the limits and on the conditions established by the insurance contract. The organization can also conclude a direct contract with the health care organization on providing medical workers on a paid basis. In this case, the financing is provided through the payment of the services rendered (The International Helsinki Republic for Human Rights. Azerbaijan, 2002). Organizations that have free cash are acting as patrons, sponsors who provide financial resources to health care facilities on a free basis, in the form of loans or other acceptable conditions.

Financing of medical institutions can be carried out by public organizations. More often it is gratuitously provided money resources addressed to certain health organizations for targeted use for the purpose established by the owners of the allocated funds. A significant subject of funding medical organizations is the population in the person of citizens who care for their own health, the health of family members, close people. The population directly pays for medical services, purchased medicines. Indirectly, through deductions to extra-budgetary social funds, people bear the cost of compulsory health insurance. Health organizations can raise funds in the form of loans, loans provided by credit institutions for a certain period on a reimbursable basis, at interest. The possibility of obtaining financial resources from external sources should not lead to neglect of internal sources that are available in any healthcare organization. It means that you need to rationally use your own financial resources.

The choice of the mandatory health insurance system was determined by the desire to expand the sources of health care financing and to obtain new channels for

the stable receipt of additional funds. Consider, on the basis of which laws, medical insurance is implemented in the Azerbaijann Republic (United Assistance to Azerbaijan. Children's institutions in Azerbaijan. Analysis of the situation. Baku, United Aid for Azerbaijan, 2000). The insured is a legal or capable natural person who has concluded an insurance contract with an insurer, and is also an insured under the law. With voluntary medical insurance, the insured themselves are citizens or enterprises representing the interests of citizens. The insurer is a legal entity established for the performance of insurance activities, which has received a license to carry out insurance activities in the territory of the Azerbaijann Republic in accordance with the procedure established by law. In the case of medical insurance, they are an insurance medical organization. The latter means a legal entity that provides health insurance and has a state license, which is issued by the Federal Service for Supervision of Insurance Activities for each type of insurance.

Medical insurance is compulsory and voluntary. The subject of health insurance can be citizens, the policyholder, an insurance medical organization, a medical institution. Working citizens with compulsory medical insurance must be insured by the enterprises where they work, which are their insurers. Non-working citizens must also be insured. From these sources are formed the financial means of the state and municipal health systems, as well as the state system of compulsory medical insurance. To implement the state policy in the field of compulsory medical insurance, the Federal and territorial funds of compulsory medical insurance are established, which are independent non-commercial organizations. They are designed to accumulate financial resources for compulsory health insurance, ensure financial stability and equalize financial resources for its implementation. These funds are in the state property of the Azerbaijann Republic, are not part of the budgets and can not be withdrawn. Currently, the Law of the Azerbaijann Republic "On Insurance Tariffs of Contributions to the Social Insurance Fund of the Azerbaijann Republic, to the State Employment Fund of the Azerbaijann Republic and to Mandatory Medical Insurance Funds" provides for a contribution to the compulsory health insurance fund

-3.6% (3.4% in the territorial fund - TFOMS, 0.2% goes to the Federal Fund - FFOMS) in relation to the labor remuneration fund and less than 10% of all social insurance funds (United Nations Secretariat. Evaluation of aging. 2002).

The procedure for payment of insurance premiums is established by the Regulation on the procedure for paying insurance premiums to the Federal and Territorial Funds of Compulsory Medical Insurance (1993), the Instruction on the Procedure for Collection and Accounting of Insurance Contributions (Payments) for Mandatory Medical Insurance (1993). Payers of insurance contributions to the funds of compulsory medical insurance are: organizations, institutions, enterprises, peasant and farming enterprises, tribal family communities of indigenous peoples of the North engaged in traditional industries; citizens engaged in self-employment, entrepreneurial activities without the formation of a legal entity; citizens engaged in private practice; Citizens who employ the work of hired workers; persons of creative professions not united in creative unions; Councils of Ministers of the republics within the Azerbaijann Republic; bodies of state administration of autonomous entities, regions, territories, cities of Moscow and St. Petersburg, local administrations. From the payment of insurance premiums, public organizations of disabled persons and enterprises that are in their ownership are established, which are created for the implementation of the statutory goals of these organizations. Payments for compulsory medical insurance for non-working population are carried out by the Councils of Ministers of the republics within the Azerbaijann Republic, the bodies of state administration of autonomous entities, regions, territories, cities of Moscow and St. Petersburg, local administrations at the expense of the funds provided for in the respective budgets when they are formed for the respective years. Participation in voluntary health insurance programs is not regulated by the state and depends on the needs and capabilities of the insured.

1.2. Models of health financing in developed foreign countries

In modern conditions, all health care models can be conditionally divided into three types (London School of Hygiene and Tropical Medicine and UNICEF. Report on the evaluation of the PHC project in Azerbaijan. Final report (revised) January 2000).

1. Budget (state).
2. Insurance (social insurance).
3. Private (non-state, or market).

A characteristic feature of the first model, which is known as the Semashko-Beveridge model, is the significant role of the state. The main source of financing is tax revenue. Medical services for the entire population are provided free of charge. The share of total expenditures from public sources in GDP, as a rule, is 8-11%. Private insurance and co-payments play a complementary role. The main funding channel is the state budget. Providers of medical services receive budgetary funds under the control of private management companies. The state plays simultaneously the role of the buyer and provider of services, providing coverage for most (from 70% and higher) of health care costs. The management of the health care system is highly centralized. Most of the medical services are provided by public health facilities (treatment-prophylactic institutions) and private practitioners, but the market, as a rule, is given a secondary role.

The state strictly controls most aspects of the market of medical goods and services, establishes rules for admission and access to the market, forms lists of reimbursement, uses tariff policy and pricing to control the volume of medical services provided. Control over the quality of medical care is provided by professional medical organizations in the form of accreditation of health facilities and licensing of doctors. The level of co-payments under such a system is insignificant.

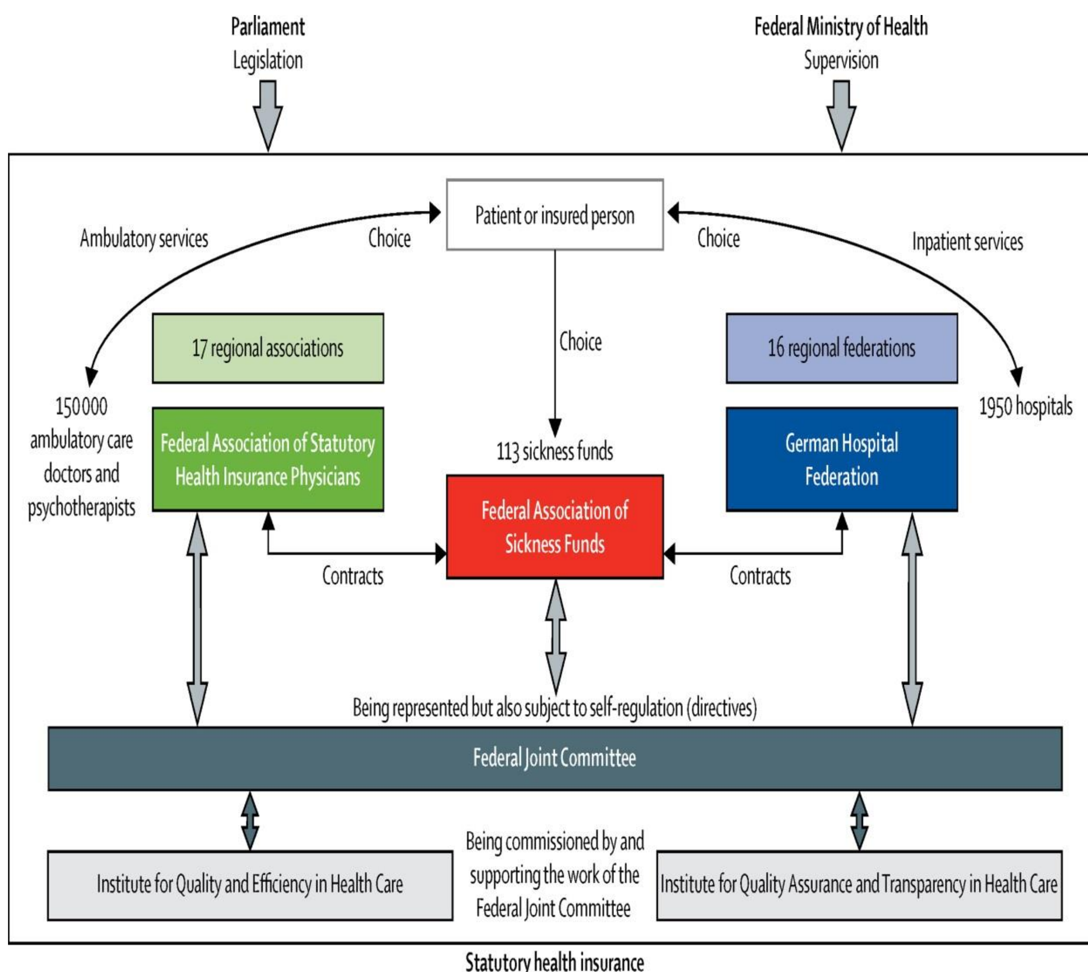
The second model, known as the Bismarck model, is often defined as a system of regulated health insurance. It is based on the principles of a mixed economy, combining the medical services market with a developed system of state

regulation and social guarantees. Compulsory health insurance programs cover all or practically the entire population with the participation of the state in the financing of insurance funds. As in the budget model, the state covers more than 70% of the cost of medical services, but the total public expenditure on health, as a rule, is slightly higher than in the budget model, amounting to 9-13% of GDP.

A crucial role in the distribution of funds is played by private non-profit or commercial insurance funds or companies, the role of the market in meeting the population's needs for medical services is high, and patients have considerable freedom in choosing insurance companies and service providers. The form of health management in the social insurance model can be characterized as decentralized because of the large number of players in the insurance market. Most medical services are paid according to the compulsory list (United States Agency for International Development. Budget justification for Congress. Fiscal year 2004). The system of co-payments is actively used. Medical services are provided by institutions of various forms of ownership, but private non-commercial ones prevail. Primary care is provided by private practitioners. The market of medical services is highly developed, and private insurance plays a complementary role. The role of the state in regulating the market of medical services is significant, but less significant than in budget systems. The state regulates the activity of insurance funds, which together with the associations of providers of health services in turn determine their volumes and quality. A major role is played by professional and patient organizations.

The private health care model is characterized by the provision of medical services mainly on a paid basis, at the expense of private insurance and personal funds of citizens. There is no uniform system of public health insurance. The market plays a key role in meeting the needs for health services. The state assumes only those obligations that are not satisfied by the market, that is, it covers medical care for socially vulnerable categories of citizens - the unemployed, the poor and the pensioners.

Figure 1. Classification of health systems of leading countries according to three main models (source)



In a private model, financing by more than 50% is carried out from private funds. Monetary funds are accumulated in private commercial insurance funds (insurance companies), after which they enter the health facility. The management of the provision of services is decentralized and is carried out by a large number of organizations of different forms of ownership and levels. For most, reimbursable medical services and technology are provided as part of private insurance plans. The state determines the lists of reimbursement only within a limited number of state programs. The market of medical services and private medical insurance plays a dominant role, and the role of the state is limited. Most of the medical services are provided by private health facilities and private practitioners. Thanks to private insurance companies, the level of competition in the medical services market is very high, which positively affects their quality, but only for the financially secured part of the population. At the same time, rational use of resources is not achieved. The share of total health expenditure is higher than GDP in GDP in the budget and insurance

models, but there is no adequate improvement in key health indicators of the population (State Statistics Committee of the Republic of Azerbaijan. Average salaries. 2002).

The role of the state in regulating the market of medical goods and services is less significant than in the budget and social insurance systems. The state controls the access and access of medical technologies to the market, the activities of insurance companies, and protects competition. The issues of quality assurance of medical services are solved through licensing and accreditation of medical institutions and doctors who are in the hands of professional medical organizations. In Fig. 2. The classification of the health systems of the leading countries is shown in accordance with the three main models - budgetary, insurance and private.

1.3. Systematization of financing problems of medical organizations in Azerbaijan

In 2000, 62% of the budget allocated to healthcare was given to the hospital sector. Primary health care sector received 29% (including sanitary epidemiological services), "other" expenses - 9%. These figures do not take into account the money from external sources, which are mainly directed not to the hospital sector, but to primary health care, adding an additional 30-40% to those allocated from the budget. A significant part of the health budget (46%) goes to pay wages. To pay doctors a "full" wage (providing a living wage), it would have taken out the entire state budget for these purposes. 18% are allocated to the article "other", which includes the purchase of equipment and repairs, 8% for "medicines and materials", 18% for "writing materials and other goods". Relatively small amounts of funding for drug provision are due to the fact that most patients need to buy medicines themselves.

Primary health care has many shortcomings, but it does not include a shortage of staff or institutions themselves - both of which are abundant in both urban and rural areas. Azerbaijan, unlike many former Soviet republics, has not yet embarked

on the development of comprehensive family medicine on a countrywide scale. To this day, the vast majority of medical services are provided by specialists, which means that it is necessary to have doctors of different specialties even in sparsely populated areas, which is extremely irrational. Today in Azerbaijan, with the support of UNICEF, the World Bank and the International Medical Corps, a number of experiments are conducted to introduce new approaches to primary health care with the aim of improving its quality and accessibility. In 1995, the Ministry of Health and UNICEF launched a pilot project in Cuba, and then in four other regions (Masalli, Lankaran, Jalilabad and Neftchala). This work served as the basis for a health reform project supported by the World Bank, which is now being implemented jointly by the Ministry of Health and UNICEF (International Medical Corps. Network Survey, 2000).

Another innovative project - a program of primary health care focused on the needs of the local population - implemented in 2000-2003. in the south of the country the International Medical Corps. The program was aimed at increasing the availability, quality and rationalization of primary care and encompassing 240,000 people. It provided for the development of personnel, renovation of buildings and equipment, improvement of management and involvement of the public to participate in the newly created public health committees.

Azerbaijan retained the Soviet public health system. In a wide network of 82 sanitary-epidemiological stations there are bacteriological, parasitological, virological and medical-ecological laboratories. Work in it doctors <hygienists and laboratory technicians. The Sanitary and Epidemiological Service is responsible for the environmental health of the environment (establishes standards for ensuring the safety of water and food products and monitors their compliance), the fight against infectious diseases, the organization and supervision of immunizations, the logistics of immunizations conducted by district medical institutions.

The Soviet Semashko framework sets the setting for the health framework in Azerbaijan as the nation acquired this model health framework from its enrollment of

the Soviet Union. The Semashko framework was sorted out around the controlling rule of all-inclusive access to health care free for the purpose of utilization. It was an assessment based framework with the exceedingly concentrated arranging of assets and faculty in view of a chain of command of offices at the area, provincial, republican and every single association level. All healthcare laborers were utilized by the state, and private practice was not permitted. Care was centered around inpatient treatment and, thus, essential care was extremely powerless. There was an accentuation on the persistent development of staff and offices and a broad arrangement of parallel health administrations, which were joined to extensive mechanical ventures and certain services. The broad scope and all-inclusive access to free care implied that the Semashko framework was fair, in spite of subjective contrasts in arrangement between topographical locales and standard and parallel health administrations. Be that as it may, it was likewise wasteful and asset escalated – especially in the dependence on inpatient care. Additionally, while the Semashko framework demonstrated sensibly powerful in the control of transmittable illnesses, with the epidemiological move towards a noncommunicable ailment trouble, the framework was deficiently adaptable and essential health care and health advancement excessively frail, making it impossible to empower the control of such sicknesses, which prevailed towards the finish of the Soviet period. Until autonomy in 1991, the Ministry of Health in Azerbaijan basically regulated arrangements that had been started in Moscow, as a component of a halfway arranged framework oversaw through a various leveled structure. Following freedom in 1991, the health framework confronted progressively genuine monetary difficulties in financing the acquired broad administrations. Quality and access to administrations crumbled and the mix of acquired rigidities and constrained administrative limit rolled out improvement troublesome. The current authoritative structure of the health framework holds a significant number of the key highlights of a Semashko framework and faces a significant number of a similar key difficulties. The attention on clinic arrangement has held on regardless of expectations to reorientate the

framework for essential care. While general access to the health framework was a key component of the Semashko demonstrate, serious absence of financing and the resultant out of pocket (OOP) installments by patients have successfully diminished access to health care for huge segments of the populace. The circumstance has been exacerbated by the disturbances to acquired frameworks of pharmaceutical and hardware supply following the breakdown of exchanging relations after autonomy. The administration has endeavored to address a portion of these issues with various pilot conspires as a component of a considerable health reform venture that spotlights on creating essential care and advancing the productive utilization of assets.

1.4. Characteristics and features of single-channel financing of medical organizations in Azerbaijan

The system of financing has also changed little since Soviet times: the state is both a buyer and a producer of medical services. The main official source of financing is state revenues from taxation, excise taxes, etc. The financing system is defined in Article 9 of the Law "On Public Health Protection" (1997) (The Government of Azerbaijan is UNICEF. Program of Cooperation, General Plan of Operations 2000, 2004). According to her, the sources of funding for the health system are the state budget, compulsory medical insurance, voluntary deductions from the profits of institutions and organizations, donations from legal entities and individuals, as well as other sources that are not inconsistent with the law. The mandatory health insurance mentioned in the law has not yet been introduced. Most medical institutions are still owned by the state. Therefore, the main official source of funding is central and local budgets: in 2000, 78% of funds came from local budgets through district health departments, the remaining 22% from the central (republican) budget through the Ministry of Health. The Ministry of Finance directly finances the budgets of local authorities. In addition, the state finances departmental medicine through the relevant ministries (roads, defense, State Oil Company). With the

exception, perhaps, of medical institutions of the Ministry of Defense, whose budget is not known, departmental medical institutions are generally small, they account for about 2% of the Ministry of Health's expenditure (State Statistics Committee of the Republic of Azerbaijan. Independent Azerbaijan, 2001, 2002).

Due to the decline in economic activity in the post-Soviet period, public revenues declined significantly, which had a significant impact on the financing of health care. In the 1990s, the share of GDP spent on health has decreased, as has the share of health expenditure in total public expenditure. To supplement the meager government funding, the government introduced fees for certain types of health services. The law "On protection of public health" was adopted, article 3 of which states that the state undertakes obligations to finance medical services. It intends to pay all the costs of the health system, with the exception of a certain list of services that are directly paid by patients. However, in reality the state is not able to fulfill its obligations. The unofficial payment for medical services is so widespread that it can be considered financing the health care system as mixed publicly private. The official payment of medical services, direct or through individual insurance, is about 5% of total health care financing.

The constitution, adopted in 1995, guarantees citizens the right to affordable medical care. Article 41 states that everyone has the right to health and medical care. These rights are detailed in the Law on Public Health Protection and include the following (United Nations Secretariat. Evaluation of aging. 2002):

• Citizens of the Republic of Azerbaijan have the right to medical care and receive medical care. Medical care is provided free of charge by state medical institutions, except in cases provided for by this law. Types of paid specialized medical care are determined by the relevant executive authority.

• The state ensures the protection of the environment, the creation of favorable working and recreational facilities for citizens, as well as health and medical and social assistance.

• Citizens have the right to receive systematic and reliable information about the factors that affect their health. This information is provided to citizens through the mass media or directly by the relevant executive authority on the basis of their requests.

• Children, teenagers, students, pregnant women, disabled and retired people, those involved in sports, and most of the military personnel are entitled to free medical care in public medical institutions.

Thus, medical care is provided free of charge by public medical institutions, with the exception of certain services. Some categories of citizens are exempt from payment, and a low level of income is not the basis for such release.

Until 1998, the main source of financing for the Azerbaijani health care system was income from taxation. However, unofficial payments were also widespread and, in addition, since 1994 some specialized medical services have become payable. In 1998, a payment for medical services was introduced. In part, this was done in order to reduce unofficial payments. Until April 2003, 410 out of 4,310 medical institutions (about 10%) were paid. By Order No. 34 of the Ministry of Health of April 1, 2003, this practice was terminated first in 92 medical institutions, and from January 2004 in 48 institutions in Baku and 2 institutions in Sumgait (Order No. 68 of the Board of the Ministry of Health of November 27, 2003 g.).

Now about 40% of all healthcare expenditures are financed from the state budget. These funds are intended for payment of wages, payment of medical services for all privileged categories and free services.

However, this money is not enough to pay physicians wages that provide a living wage, to finance the necessary support services and medicines (World Health Organization. Monthly report on morbidity, July 28, 2000).

In conditions of inadequate state funding, additional sources are becoming crucial, accounting for about 60% of health financing. In the late 1990s. official and unofficial direct payments of the population amounted to about 49%, and in 2001 - 57% of all healthcare expenditures.

The introduction of official fees could not get rid of unofficial payments. Meanwhile, in a country where the average wage is about $ 40 per month, even a relatively low fee can easily become an obstacle to obtaining medical care. According to the results of the already mentioned survey of workers (2003), not less than two thirds of respondents reported that their income is insufficient to meet the needs for medical care. Poor people usually get sick more often, but knowing that they have to pay, they rarely seek medical help, especially preventive. A survey conducted in 2001 showed that each third family could not use the necessary medical services because of their high cost. Among poor families, this figure reaches 40%.

Direct payments of the population make up from 50 to 60% of all health care costs. Direct payments include both the official payment for certain services of public health institutions introduced in 1998 and informal payment "from under the floor". Unofficial fees are of several types: semi-official payment for medicines and supplies, payment for visiting the patient, direct unofficial payment for services, payment for receiving a position in a medical institution. In addition, payments of the population include payment for goods and services of the private sector, direct payment of OTC medicines and supplies.

It is assumed that the prices for the same services should be the same everywhere, but in reality in different institutions they are somewhat different. The official payment for services is spent mainly on additional payment of work of physicians and purchase of medicines. In fact, the fee for the service is divided into two parts: one gets the person who provided the service, another - the medical institution (which can also spend this money for additional pay). Funds from the official payment of services account for about 10% of the local health budget. The fee is charged for all services not included in the list of services provided by the state free of charge. Some types of traumatological and emergency care also apply to paid services (in particular, dislocation, plaster bandage). The fee ranges from US $ 0.2 per shot to US $ 70 for surgical care (twice the amount of the average monthly wage). Some categories of the population are exempt from payment. Apart from refugees

and internally displaced persons, poverty does not serve as a basis for exemption from official payment for services. Nevertheless, those who can not pay the official price are usually exempt from payment. True, they may be required to pay a bribe for a smaller amount.

Although official prices for outpatient care are available to the majority of the population, due to the lack of qualified family doctors, patients often have to contact several specialists to obtain the necessary treatment. Accordingly, it is necessary to pay, officially and unofficially, several consultations, which can cause serious financial difficulties. According to the World Bank's 2003 poverty assessment, the informal fee for services depends on the quality of services; The payment for obstetrics varies from 100-150 US dollars in small cities to 50-700 US dollars in Baku hospitals, which is 18 times higher than the national average salary. The unofficial fee charged to the population reaches 20% of all health care expenditure (World Health Organization and UNICEF. Overview of the National Immunization Coverage ofm 2001).

Since 1991 (proclamation of independence), health care expenditures in Azerbaijan have declined both in percentage of GDP and in real terms per capita. Analyzing the figures given below, one should remember about their approximate nature. In 1991, 4.3% of GDP was spent on health care; By 1997, this indicator had tripled, to 1.2% of GDP, then rose to 1.6% in 1999, but then fell again, and now it is just under 1%. In real terms, official expenditure on health in Azerbaijan is very low. Over the period from 1991 to 1997, they declined from 148 to 19 dollars per capita per year. Today, these costs are $ 25, well below the average for countries in the WHO European Region of $ 1,341 (2001). This figure includes government and external funding, as well as direct patient payments. For the past several years, the state has spent about $ 6 per capita on health per year. According to forecasts, in the next few years the level of public health financing will not change significantly, and there is no need to expect a significant increase in revenues from external sources. Opportunities to increase the level of cost recovery due to impoverished patients are

also low. All hope is for the development of the oil industry, which can give the budget additional funds.

The share of health expenditure in total public expenditure fell from 8-9% in the early 1990s. to just over 5% in 2000. For comparison, the share of spending on education in 2000 was 24%, and for social protection - 18%. In 2003, it was projected to increase the share of health care expenditures to 8%. However, judging by the latest data from the State Statistical Committee, this was unattainable; in 2002, actual expenditures on health amounted to only 224 billion manat, almost 100 billion less than planned. Thus, the share of health expenditure in total public expenditure appears to have fallen below 5%. But even such a relatively small budget is not spent completely. So, in 1999, 83% of allotments were spent and only 64% of the budget of the pharmaceutical industry.

In spite of critical increments in public health expenditure lately, Azerbaijan is still described by generally low levels of public health expenditure both in total terms and as an offer of GDP. The weight of financing health care is on the health care users, with OOP expenditure coming to very nearly 62% of total health spending in 2007 (World Health Organization, 2009). Public health subsidizing comes principally from general government incomes, which incorporates cash from the State Oil Fund. Formal user charges were permitted in public offices until the point until early 2008 when this practice was banned. A great part of the public subsidizing for health is under the control of locale experts, which fund the system of essential and auxiliary health offices in their wards. The focal spending plan is actualized by the Ministry of Health, which stores republican tertiary health offices, vertical state health programs (fundamentally covering the brought together buy of medications and hardware for certain health conditions, for example, diabetes, genetic blood maladies, tumor and others), and additionally the Sanitary-Epidemiological Service. Since 2007, all Baku city health offices are additionally subsidized through the Ministry of Health. Most by far of health suppliers are state-claimed, in spite of the fact that the private part has been prospering as of late, giving a developing offer of

health benefits particularly in the capital. The installment systems for the state-claimed suppliers depend on inputs, which does not cultivate the productive utilization of assets. In addition, the legislature, through the treasury framework, controls how the money is spent inside the health offices by applying strict confinements for spending along spending details, which leaves health suppliers with minimal administrative and money related self-sufficiency. To conquer these challenges, the Ministry of Health and the Ministry of Finance have concurred on new health financing reforms that will unify subsidizes and account for more prominent supplier self-governance and the presentation of contracting as the reason for Health frameworks experiencing significant reform Azerbaijan new installment instruments, for example, per capita installments in essential care and case-based installments for doctor's facilities. These changes will support the proposed presentation of required health protection.

CHAPTER II.
EMPIRICIAL RESEARCH METHODOLOGY OF THE BASIC APPROACHES TO FINANCING HEALTH CARE IN DEVELOPED FOREIGN COUNTRIES
2.1. Characteristics of Empirical Research Object: Health Financing system in Azerbaijan

Three models of health financing and sources of financial resources

In the modern world, the financial provision of health care is carried out at the expense of budgetary funds, employers' funds, population funds. The share of each of them in the total amount of funds allocated by the society for health, predetermines the model for financing the industry.

Currently, there are three such models:

· The budget-insurance model - health is financed from targeted contributions of employers, employees and budgetary funds. This is the most common model (Germany, France, Austria, Switzerland, etc.)

· Budgetary model - is carried out mainly at the expense of budgetary funds (Great Britain, Denmark, Norway, Finland, etc.)

· Entrepreneurial model - financial support is provided by selling medical services to the population and at the expense of voluntary medical insurance funds (USA)

Until 1991, in our country, the budget model was used to finance health care. The main source of financial resources allocated to health care was budgetary funds, the share of which was about 85% of the total funds. These funds were transferred mainly to medical institutions under the Ministry of Health.

The second source of financial resources was the funds of departments and their subordinate enterprises. The share of these funds was about 15%. These funds were transferred to departmental medical institutions.

The third source of financial resources was the population's funds. Their share was extremely insignificant, as the population paid only dentistry and in a small amount some paid, basically not vital services (UNICEF. Azerbaijan. Multilevel cluster survey. Baku, UNICEF, 2000).

Financing - the provision of money to the enterprise, the entrepreneur, as well as programs for the performance of any work. Financing is carried out from own means or at the expense of the credit, loans, the involved money, the investments given by banks or other people, firms.

Compulsory medical insurance is a form of social protection of citizens in conditions of transition of the country's economy to market relations, insurance is designed to provide affordable and free medical care of guaranteed volume and quality while rationally using available health resources.

Medicine is a field of science and medical practice aimed at preserving and strengthening people's health, preventing and treating diseases. The concept of medicine is closely related to the notion of health.

Healthcare is a system of state and public events for the protection of health, the prevention and treatment of diseases and the prolongation of human life (World Bank. Review of public expenditure in Azerbaijan. Washington, D.C., World Bank, 2003).

Mandatory medical insurance funds are independent state non-commercial financial and credit institutions and are designed to accumulate funds for compulsory medical insurance.

Medical insurance is an integral part of social insurance, which provides financing for medical assistance through the formation of special funds at the expense of contributions from organizations, public authorities and local governments, as well as citizens' funds.

The social importance of the compulsory health insurance system (hereinafter referred to as MHI) is that, on the one hand, it is an integral part of the state system of

social protection of the population, and on the other hand, MHI funds supplement, and in some cases replace, budgetary allocations for health care.

Analysis of the practice of financing and organization of health care in foreign countries made it possible to conditionally distinguish three basic models of the economic mechanism of health care. The first one is mainly state free medical care, for example, in England, Denmark, Ireland. The second is the financing of the bulk of medical assistance to private insurance companies, as, for example, in the USA. In most developed countries, such as France, Germany, Italy, etc., health financing has a mixed fiscal and insurance nature. In this case, targeted programs, capital investments and some other expenses are paid for at the expense of the state, and the main medical aid is financed through the system of medical insurance. At present, medical and social assistance insurance systems continue to develop. Health insurance is introduced in more than 25 countries. These are mainly industrially developed countries of Western Europe, North America, Australia, Israel, Japan, some countries of the Middle East and Asia. The health insurance systems are diverse - public, private, commercial. Mixed insurance systems have been established in most countries.

Health insurance systems are generally governed by the state, but are financed from three sources: targeted contributions from employers, state subsidies, contributions from employees themselves. In some countries, state subsidies for the payment of medical assistance are not available, and health insurance premiums are provided by entrepreneurs and employees. Overall, in the 1980s, in some major developed countries, various health insurance systems covered about 90% of the population, to which 74% of health insurance costs were compensated from public funds. Along with this, some Western European countries continue, and not unsuccessfully, to develop systems of predominantly government health financing. The main tasks that were solved during the transition to OMS in Azerbaijan were:

· Attraction of additional funds to the health care system on the basis of contributions from organizations for CHI;

· Increase the efficiency of using health care costs by moving to a system of contractual relations between the customer and medical and preventive institutions, as well as introducing methods of payment for medical care based on performance;

· Improvement of the quality of medical care and protection of consumer rights through the inclusion of an independent intermediary in the form of insurance medical organizations (SMO);

· Other socially and financially important tasks (The Government of Azerbaijan is UNICEF. Program of Cooperation, General Plan of Operations 2000, 2004).

Compulsory medical insurance is fundamentally different from other types of insurance. First, the means of compulsory medical insurance are intended for payment of medical services, and not for the production of payments in cash. Secondly, organizational functions when paying for services are performed by commercial organizations - insurance medical companies that are insurers of the population. Third, in the case of insurance, the means of the budgets of the subjects of the Azerbaijann Republic are involved, since the executive bodies act as insurers of the non-working population.

The financial basis of compulsory medical insurance is based on a single social tax, the total rate of which is 35.8% of the accrued salary for most taxpayers, and the collected funds are distributed between state non-budget funds in accordance with the established proportions. In particular, 3.6% are enrolled in the compulsory medical insurance funds, of which 0.2% goes to the federal fund of compulsory medical insurance, 3.4% - to the regional MHI funds. Therefore, the financial and organizational mechanism of compulsory health insurance depends on its level.

The general way to deal with reform usage in Azerbaijan has been founded on incremental change and the conservation of those highlights of the current Semashko system that demonstrated practically. The nation's political condition, with an accentuation on social security and political congruity, and the nonappearance of solid resistance were additionally not positive for radical changes. Successes so far

have been restricted to particular territories, for example, the foundation and Health frameworks experiencing significant change Azerbaijan systematization of confirmation based medication in the improvement of national clinical rules, the advancement of family solution as a claim to fame, the reinforcing of pharmaceutical direction and the advancement of a model framework for sound medication utilize. The approach discourses about more profound fundamental health reforms were restored in 2005. Among the initial phases here was the improvement of another idea for health reforms in 2006. In 2008, the Concept on Health Financing and Introduction of Mandatory Health Insurance was drafted by the Ministry of Health and affirmed by the President. In 2009, the Cabinet of Ministers affirmed the Action Plan to Introduce Health Financing Reforms.

The abnormal state of OOP installment with respect to prepaid government stores demonstrates that health income accumulation remains prevalently backward. The absence of hazard pooling in coordinate installments implies that numerous family units are in danger of cataclysmic health care costs despite genuine sickness. Family unit overviews demonstrate that health administrations use among low-salary bunches was lower than among wealthier families, recommending that the use of health administrations is identified with a financial status more than required. Since state subsidizing represents around 33% of total healthcare expenditure, just piece of asset assignment can be directed by the legislature, however, the present portion of assets for healthcare supports the doctor's facility area over essential care. Global confirmation proposes this isn't the most effective allotment of assets. So also, the dependence on high-cost diagnostics as standard and the powerless capacity of essential care suppliers would show, based on worldwide experience, that the present framework does not give great incentive to money. Azerbaijan is an asset-rich nation that has the genuine money related potential to give its natives meet access to great quality and effective health administrations while shielding them from the danger of cataclysmic health expenditures. This would seem surely known by people with significant influence, as confirmed by the current push towards more key health

financing reform. While expanding the level of spending designations to the health segment is essential, it is lacking without anyone else to determine the circumstance. Simultaneously, the health framework needs to increment and exhibit its ability to utilize the money in a judicious and straightforward way.

2.2. Research Goal and Problem

The first level is represented by the Federal Compulsory Medical Insurance Fund (FFOMS), which provides normative and organizational guidance to the MHI system. The main financial function of the FFOMS is the provision of subventions to territorial MHIF funds to equalize the conditions for providing medical services to the population of various regions in economic development.

The second level of the organization of compulsory medical insurance is represented by the territorial funds of CHI and their branches. This level is legislatively the main one in the system, as it is the territorial funds that accumulate and distribute the financial resources of the MLA. Territorial funds of the MLA (hereinafter referred to as the TFOMS) are established in the territories of the constituent entities of the Azerbaijann Republic by the bodies of representative and executive power of these entities, are independent state non-profit financial and credit institutions and are accountable to the authorities that created them.

The main task of the TFOMS is to ensure the implementation of CHI in the territory of a constituent entity of the Azerbaijann Republic on the principles of universality and social justice. The TFOMS is entrusted with the main work to ensure the financial balance and sustainability of the CHI system. However, at the present time, territorial funds are reminiscent of the transfer, rather than the main link of health insurance. Territorial programs for providing citizens with medical assistance and citizens' insurance rules are approved by the executive authorities of the subject of the Azerbaijann Republic, while the TFEMS is only involved in their development.

As noted above, the financial resources of the TFEMF are formed mainly from two sources (The State Program for Poverty Reduction and Economic Development. The annual report on the accomplished work 2003):

· Parts of insurance contributions paid by enterprises, organizations and other economic entities to the compulsory health insurance of the working population in the amounts established by the single social tax scale;

· The funds provided for in the budgets of the constituent entities of the Azerbaijann Republic for compulsory health insurance for the unemployed population (the amount of payments is established by the law on the budget of the subject of the Azerbaijann Republic).

The share of budgetary contributions is no more than 25% in the total income structure of these funds, while the share of unemployed is equal to 55% of the total population of the country, and the rate of consumption of medical services by children and the elderly is estimated to be twice as high as for working citizens.

The third level in the implementation of CHI is represented by insurance medical organizations (SMO). It is they who are given the direct role of the insurer under the law. SMO receive financial resources for the implementation of CHI by the TFOMS according to the per capita norms, depending on the number and sex and age structure of the insured population, and pay the medical services provided to the insured citizens.

Financing of medical and preventive institutions through the CHI system is carried out at agreed rates. Tariffs for services are determined on the basis of the level, structure and composition of the compensated expenses of a medical institution within the framework of territorial CHI programs. In accordance with the Methodological Recommendations on the Procedure for the Formation and Economic Justification of Territorial Programs of State Guarantees for Providing Citizens of the Azerbaijann Republic with Free Medical Assistance, only remuneration with fixed incomes, medicines and dressings, food and soft equipment, and uniforms are subject to reimbursement at the expense of OMI funds. Other costs of state medical and

prophylactic institutions providing medical assistance in the framework of territorial programs of CHI are covered from the budget: utility payments, purchase of equipment, repair of premises. It is in this and is one of the features of the budget-insurance model of health care financing.

It should be noted that along with financial functions, medical insurance organizations monitor the volume and quality of medical services provided. On the facts of violation of the provisions of CHI or causing damage to citizens, they make recourse claims and suits to medical institutions.

One of the most important tasks is the creation of a single methodological basis for planning and financing health care expenditures (UNICEF. Azerbaijan. Multilevel cluster survey. Baku, UNICEF, 2000).

2.3. The Empirical Research Hypothesis

Financing of medical aid to the population is carried out from the state budget, formed at the expense of general taxation. In some countries, fixed tax revenues are used as a source of financial resources for health care. For example, in Brazil since 1998. part of the tax on banking turnover, calculated at a rate of 0.2%, is directed to health care needs.

In the system of budget financing, the state health authorities act as fund managers. They pay for medical care provided to citizens by private practitioners and medical organizations, which are mostly state-owned. In some countries, where this system is used. Provision is also made for co-payments of the population for the medical services they receive. But they are small and not burdensome for patients and serve the purposes of limiting excessive demand.

The system of budget financing and the system of compulsory medical insurance are alternative ways of organizing public health financing. The most important difference between these systems and the system of private health financing is the independence of the volume of medical care received by the sick person from his solvency. The advantage of the budgetary system in comparison with

the insurance system is the lower level of administrative costs required - the costs of maintaining health authorities. Such a system has relatively better opportunities to provide state control over the activities of health care providers at the lowest cost. In the insurance system, more control subjects are insurers themselves, and public health authorities that perform functions of regulating the entire system and controlling the activities of medical organizations and insurers. In the insurance system, more volumes of information collected and processed, workflow.

The disadvantage of the budgetary system is the greater dependence of health financing on changing political priorities. Each year, the size of the budgetary allocation for health is determined in the fight against competing directions of budget expenditures. On the contrary, health financing in the insurance system has clearly fixed sources and, therefore, depends to a lesser extent on the political conjuncture. In the insurance system, a more precise linkage of the guarantees of medical care for the insured with the amount of financial income is provided. The amount of insurance contributions is balanced with the amount of guarantees included in the CHI program (State Statistical Committee of the Republic of Azerbaijan. Statistical yearbook of Azerbaijan. Baku, State Statistics Committee of Azerbaijan, 2003).

But these comparative advantages may in certain cases become flaws. The CHI system has a narrower financial base - insurance premiums are set as a percentage of the wage fund of the employees. In case of poor economic conditions, the amount of collected contributions may be reduced, and in the MHI system there will be insufficient funds to pay for medical care guaranteed by the CHI program. At the same time, an increase in tariffs for insurance premiums or a reduction in the CHI program may prove politically unacceptable. As a result, it will be necessary to either subsidize the state, or ration the consumption of medical services, which will limit their accessibility.

The advantage of the insurance financing system, in comparison with the budgetary system of health financing, is a clear institutional division of functions and responsibilities between the subjects of financing of medical services and their

producers. Insurers are responsible for ensuring that the insured receive the medical care they need and for paying for this assistance. They are intermediaries between medical organizations and the population, economically interested in protecting the rights of the insured and in effectively using the financial resources that they manage.

In budgetary systems, state bodies historically performed the functions of not only financing the producers of medical services, but also managing the work of public medical institutions under their jurisdiction. Budgetary systems emerged as parts of the public sector of the economy, managed by administrative methods. Health authorities, in contrast to insurance funds, are responsible for the results of medical care, and for the state of the network of state medical institutions subordinate to them: for their resource support, for the financial coverage of their expenditures, etc. This creates conditions for the reproduction of the cost-based type of management and does not stimulate more efficient use of resources. Health authorities tend to sacrifice the interests of patients in favor of the interests of medical institutions.

Research of healthcare financing in Azerbaijan has distinguished the accompanying key issues: (I) a low level of public spending on health; (ii) discontinuity of pooled incomes; (iii) allotment of assets as indicated by recorded spending plans that support huge offices with a high number of beds and personnel; (iv) a nonattendance of connections between designation of assets and results accomplished; (v) an expanding part of casual payments in financing the health segment and their antagonistic effect on use of healthcare administrations, particularly by poor people; (vi) developing disparities in local distribution of healthcare stores; (vii) underexecution of arranged health expenditures; and (viii) an unbalanced offer of assets committed to inpatient care and compensations.

Hypothesis 1 - An unbalanced offer of public resources is given to hospital care and pay rates. These levels of expenditure are high contrasted with those of other FSU nations. On the off chance that Azerbaijan looks to move towards a family-based PHC demonstrate, where people can, as a rule, be dealt with by a

general specialist, a move of assets from inpatient to outpatient essential care is fitting. In spite of the fact that a high offer of resources committed to hospital care may not be wasteful as such, the low use rates of clinic offices in Azerbaijan proposes that these resources are being spent on underutilized offices. Essentially, albeit total healthcare staffing isn't over the top contrasted with different nations, the way that doctor's facility offices are vacant shows that clinic faculty are likewise underutilized.

Hypothesis 2 - High hospital spending swarms out spending on public health and essential care. The PHC offices right now have a tendency to be underfinanced. The absence of a maintainable framework to back these offices impacts the adequacy of PHC suppliers and the accessibility of assets, for example, pharmaceuticals and medicinal supplies, fundamental to their task. All in all, PHC stores are just adequate to cover pay rates.

Hypothesis 3 - Spending on compensation adversely impacts spending on medications and medicinal gear. Wage costs additionally adversely affect the cost-adequacy of administration conveyance, which is resolved by general spending as well as by the blend of spending (which influences the accessibility of medications and medicinal hardware). Wages are basically a settled cost that must be financed paying little respect to the number of restorative supplies or other health creation inputs.

Each of the above hypothesizes is one puzzle of the more noteworthy perplex of health reform. None of these pieces can, in separation, be required to give the answer for the numerous difficulties looked by the Azeri health framework, or some other health framework so far as that is concerned. Just their synchronous usage will start changes toward more fair, proficient and better-quality health administrations.

2.4. The Empirical Research Logic, Stages and Methods

At present, health financing systems in different countries combine several types of financing systems. Only in the USSR and in countries of Central and Eastern Europe before the early 1990s. Only budget systems operated. Now in almost every country the leading role is played by either the budget system or the system of compulsory medical insurance. Together with them, a private financing system coexists. Budget financing systems operate, for example, in Australia, Great Britain, Denmark, Canada, New Zealand, Norway, Finland, Sweden. Based on the MHI, health financing has been built in Austria, Belgium, Germany, the Netherlands, and France. In Spain and Italy, the existing MHI systems are complemented by the development of budget financing systems. Most countries of Central and Eastern Europe, as well as in Israel in the 1990s. OMC systems were introduced, and budget financing is combined with insurance. A private financing system prevails in the US and Switzerland (UNICEF. Azerbaijan. Multilevel cluster survey. Baku, UNICEF, 2000).

A new approach to financing medical institutions in the Azerbaijann Republic is connected with the adoption of the RSFSR Law "On Medical Insurance of Citizens in the RSFSR", which was adopted in 1991. In 1993, the Law was amended. Thus, at present in Azerbaijan there is a way of financing medical services - "social insurance". In the transition to social insurance, the following main tasks were set (UNDP. HIV / AIDS in Eastern Europe and the Commonwealth of Independent States. Reversing the epidemic. Facts and policy options. Bratislava, UNDP, 2004):

1. improving the quality of medical services (through the introduction of competition elements - free choice of a medical institution and a doctor);

2. Improving the financing of medical institutions (through a new source of financing medical institutions, the introduction of an insurance element in payment for medical services).

Consider the participants of the mandatory health insurance system.

A) Citizens. They have the right:

· Choice of medical insurance organization;

· Choice of medical institution and doctor;

· Receiving medical care throughout the territory of the Azerbaijann Republic, including outside the permanent place of residence;

· Receiving medical services that correspond to the terms and conditions of the contract, regardless of the amount of the premium actually paid;

· Presentation of the claim to the insured, insurance medical organization, medical institution, including material compensation for the damage caused through their fault, regardless of whether it is provided for or not in the health insurance agreement.

B) The insured. As an insured act:

· For the working population - employers and persons engaged in entrepreneurial activities;

· For the non-working population - the executive bodies of the authorities of the subjects of the Azerbaijann Republic, the local administration.

The policyholder has the right to free choice of the insurance organization, control over the fulfillment of the conditions of the contract of medical insurance. The duties of the insured include:

Conclude a compulsory medical insurance contract with an insurance medical organization; to make insurance contributions in the manner prescribed by law and the contract of medical insurance; within the limits of its competence, take measures to eliminate adverse factors affecting the health of citizens: provide the health insurance organization with information on the health indicators of the contingent to be insured.

C) Insurance medical organizations. These are legal entities that carry out health insurance and have a corresponding license.

The main functions that health insurance organizations must perform are

(Claeys, at all, 2001: 372):

· Work with policyholders;

· Work with medical institutions for the organization of medical assistance to the insured;

· Financing of medical care for insured citizens;

· Checking the compliance of the volume and quality of medical care provided to insured citizens with the requirements of the territorial program of compulsory medical insurance;

· Work with the insured, issuing policies, working with applications, protecting the rights of the insured;

· Investing temporarily free funds;

· Organization and financing of preventive measures;

· Advertising activity.

The medical insurance organization has the following rights:

· Choose medical facilities for medical assistance and services under medical insurance contracts;

· Participate in the accreditation of medical institutions;

· Determine the amount of insurance premiums for voluntary medical insurance;

· Participate in the definition of tariffs for medical services

· To file a lawsuit against a medical institution or a medical employee for material compensation for physical or moral damage caused to the insured through their fault.

The insurance medical organization has no right to refuse to insure the conclusion of the contract of compulsory medical insurance, corresponding to the current insurance conditions.

2.5. The Empirical Research Data Sample

The Compulsory Medical Insurance Fund (MHIF) was established in accordance with the Law of the Azerbaijann Republic of June 28, 1991, No. 1499-1,

and is intended to accumulate financial resources and ensure the stability of the state system of compulsory medical insurance.

The financial resources of the fund are formed at the expense of the deductions of the insured for compulsory medical insurance.

Between citizens and policyholders, the interaction is carried out on the basis of an insurance medical policy. The policy is a document of the established type that confirms the conclusion of the Compulsory Medical Insurance Agreement and gives insured citizens the right to receive free medical assistance in the amount and under the conditions provided by the Obligatory Medical Insurance Program.

Between the insured and the insurance medical organization is a contract of medical insurance, under which insurance medical organizations are obliged to organize to the insured contingent medical assistance of a certain volume and quality. The contract is concluded for a period of not less than one year (Ministry of Health. Rollback of malaria in Azerbaijan. Baku, 2000.).

The policyholder passes certified lists of insured citizens to the insurer when concluding the Compulsory Medical Insurance Agreement.

Between the medical insurance organization and medical institutions is a contract for the provision of medical services. Medical institutions are obliged to provide medical assistance in the amount determined by the program of compulsory medical insurance. The basic program of state guarantees for the provision of free medical care to citizens of the Azerbaijann Republic is being developed at the federal level, the territories accept their Program, taking into account the socio-demagrophic and financial and economic characteristics of the territory, but not below the Basic Program of Mandatory Medical Insurance.

As already noted, Azerbaijan's budget system includes federal, regional and local budgets. Expenditure on health is carried out from all parts of the budget system. The federal budget finances the largest medical centers, clinics, federal hospitals, scientific institutions, departmental medical institutions. From regional

budgets, republican, regional, regional medical institutions, anti-epidemiological measures are financed, etc.

The main, most significant, source of budgetary health financing is local budgets. The mass network of medical and preventive institutions - hospitals, polyclinics, outpatient clinics, etc. - is financed through these budgets. It is from the state of the revenue base of local budgets that the level of financial support and the state of medical care of the population depends.

Budget funds are the largest source of health financing. They largely ensure the implementation of state guarantees for the population to receive free medical care. These guarantees are fixed in art. 41 of the Constitution of the Azerbaijann Republic: "Medical assistance in state and municipal health institutions is provided to citizens free of charge".

To ensure these guarantees and obligations of the state for medical services to the population, the Government of the Azerbaijann Republic of September 11, 1998, No. 1096, approved the "Program of State Guarantees of Providing Free Medical Aid to the Citizens of the Azerbaijann Republic for 1999". This program included a list of types of medical care, formed in the Soviet era. Indicators of the size of medical services that are to be financed by the state were also established.

The basic program of state guarantees includes (International Medical Corps. Database of services, 2002):

1. list of types of medical assistance provided to the population free of charge under the program of state guarantees.

2. Basic program of compulsory medical insurance

3. Normative indicators of the volume of medical assistance provided to the population free of charge as part of the State Guarantees Program

4. The per capita standard used to finance health care in order to cover all costs associated with providing free medical care in accordance with the guaranteed normative indicators of its volume.

Financing of the program of state guarantees is carried out from the following sources: from the means of budgets of health of all levels; from the funds of compulsory health insurance funds; from other sources of income to health.

The normative indices of the volume of medical assistance provided to the population free of charge under the State Guarantees Program are used as a basis for the formation of the federal, regional and local budgets in the "health care", as well as federal and territorial compulsory health insurance funds.

Using the basic program of state guarantees, regional government bodies create and then approve territorial programs of state guarantees. Territorial programs of state guarantees may include additional types and volumes of free medical care, which should be financed by the subjects of the Azerbaijann Republic at their own expense and taking into account their financial resources.

Within the framework of state guarantees programs, per capita health financing standards are developed that are defined as cost indicators calculated per person and used to show the distribution of financial health resources obtained from all sources necessary to finance the cost of providing free medical care to the population.

Within the framework of territorial programs of state guarantees, the bodies of management of the constituent entities of the Azerbaijann Republic formulate per capita standards, taking into account the norms for the cost of all types of free medical care calculated by them in accordance with federal methodological recommendations on the procedure for the formation and economic justification of territorial programs of state guarantees for providing Azerbaijann citizens with free medical care.

The fundamental benefits bundle ensured by the state was being talked about and wasn't expected to be set up until 2012. Most administrations and pharmaceuticals were paid for out of pocket for the purpose of access. The abnormal state of OOP payments with respect to prepaid government reserves (2:1 out of 2007) shows that health income gathering remains dominatingly backward. The absence of

hazard pooling in coordinate private payments implies that numerous families are under danger of cataclysmic health care costs even with genuine ailment. There are no current assessments of cataclysmic levels of health expenditure, however in light of the Azerbaijan review of living conditions directed in 1995, the extent of families with disastrous health expenditures was evaluated at 5.77% (Xu et al., 2003). Empirical confirmation for five locale of Azerbaijan demonstrated that the wealthiest quintile spent a higher offer (9.3%) of family expenditure on health than the most reduced quintile (6.7%) in 2006 (Djibuti et al., 2007). Instead of demonstrating that poor patients were charged not as much as rich patients while getting to a similar administration (vertical value), this finding can be in any event incompletely clarified by bringing down usage among poorer family units. Truth be told, the extent of people with intense ailment having the capacity to get to health care was altogether lower in the poorest quintile (52.4%) contrasted and the wealthiest quintile (68.5%). The explanation behind not getting to required care was accounted for by 90.5% to be money related for the five locale overviewed in 2006 (Djibuti et al., 2007). Family unit reviews demonstrate that health administrations use among low-salary bunches was lower, recommending that the use of health administrations is identified with a financial status more than required (Djibuti et al., 2007; State Statistical Committee of the Republic of Azerbaijan and Macro International, 2008). Azerbaijan's healing facility confirmation rates were low by global guidelines, which may likewise demonstrate get to issues. By and large, there is by all accounts no extreme lack of essential, auxiliary or tertiary specialist co-ops in the nation in general. In any case, contrasts exist amongst urban and country zones. There is high variety in the per capita designation of state health spending assets between regions. While this additionally reflects contrasts in the size of healthcare offices between locale, the opportunity to benefit from state financing may likewise be unequal. As per the Demographic and Health Survey of 2006, 52% of all women announced that having no supplier accessible was a noteworthy worry in getting to health care when they are debilitated (State Statistical Committee of the Republic of Azerbaijan and Macro

International, 2008). As per the Ministry of Health, contrasts in get to and the nature of administrations accessible additionally result from the way that up to 30% of posts for pediatricians and gynecologists in provincial locale are empty, while in enormous urban areas it is regular practice to part the posts of experts between a few doctors each working low maintenance. To address this, the administration is thinking about whether to reestablish the three-year required arrangement of restorative graduates in provincial zones, and there are plans to present money related motivations for therapeutic specialists in country zones. The current activity of the administration to assemble diagnostic– treatment focuses all through the nation through SOCAR underlines the administration's responsibility regarding decreasing geological obstructions to getting to top-notch administrations.

2.7. Methods of the Empirical Research

Regional authorities annually form territorial programs of state guarantees, to which there are the following sections (Internet portal of the Ministry of Health of the Republic of Azerbaijan, 2002):

1. list of types and volumes of free medical care provided to the population within the framework of the State Guarantees Program and financed from the budgets of health at all levels; list of types and volumes of free medical care provided to the population in the framework of the State Guarantees Program and financed from the budgets of compulsory health insurance;

2. list of treatment and prevention institutions funded from the budget of the health care system; list of treatment and prevention institutions funded from the funds of mandatory health insurance funds

3. The calculated total volume of medical services provided within the territorial program of state guarantees, and the total cost of the program (state order);

4. types and amount of free medical care provided by municipal medical and preventive institutions and financed from the budget of the healthcare and

compulsory medical insurance funds and within the municipal part of the territorial program of state guarantees ("municipal order");

5. Plan for the implementation of "state and municipal orders";

6. a list of the most important medicines, medical supplies and materials used in the framework of the State Guarantees Program;

7. conditions and procedure for providing free medical care on the territory of a subject of the Azerbaijann Republic;

8. The total cost of the approved territorial program of state guarantees, including the territorial program of compulsory medical insurance (Peto, at all, 2003:10).

1. funds of budgets of different levels

2. CHI funds

3. national project "Health"

4. Means of the population

Ш Means of the population

This is the second largest source of health financing. If we take into account the shadow costs, i.e. the delivery of money for medical services directly to doctors, then the excess of the population's spending on public expenditure is even greater.

Ш Means of departments and enterprises

This is the third significant source of funds allocated to health care. At present, about 15% of all outpatient facilities and 6% of hospitals, where 10% of medical workers are located, belong to agencies and enterprises. Departmental medical institutions are funded from two sources (UNDP. Human Development Report, 2003. New York, Oxford University Press, 2003).

1. Funds of the budget.

2. Many state and non-state enterprises and organizations have their own medical facilities financed from the funds of these enterprises. In addition, a significant amount is sent by commercial organizations to public health facilities for their paid medical services (Fuller, 2003:10).

National project "Health"

Great importance in the development of health care in our country, in increasing the funds channeled into this branch of the social sphere, is attached to the implementation of the National Project "Health". The project includes such areas as "Development of primary health care" and "Provision of population with high-tech medical care"

The main objective of the direction "Development of primary health care" is to increase the availability and quality of primary health care. This will be achieved on the basis of increasing the level of qualification of the doctors of the district service; decrease in the coefficient of part-time in institutions providing primary health care; reduction of the waiting time for diagnostic tests in polyclinics for up to one week; renovation of the ambulance park of the ambulance service; reducing the incidence of: hepatitis B - not less than 3 times, rubella - not less than 10 times, influenza during the epidemic, early detection of diseases of at least 250 children; reduction of maternal mortality; reduction of infant mortality to 10.6 per 1000 live births and a decrease in temporary incapacity for work of at least 20%.

To achieve such indicators, it is planned:

· Additional training of doctors (in 2006-2007 it was planned to prepare 13 848 thousand doctors)

· Raising the level of pay for certain categories of doctors and nurses;

· Equipping municipal health facilities with diagnostic equipment and ambulance services with ambulance vehicles.

· Carrying out activities to prevent, identify and treat HIV-infected people;

· Conducting additional immunization within the National calendar of preventive vaccinations;

· Payment for medical care provided by state and municipal health institutions to women during pregnancy and childbirth.

The second task of the direction "Providing the population with high-tech medical care" is to increase the provision of the population with high-tech medical care. For this purpose it is planned:

· Construction of new centers of high medical technologies in the subjects of the Azerbaijann Republic. Taking into account the needs of the population, it is planned to create centers in the following areas: cardiovascular surgery, traumatology, orthopedics, endocrinology of neurosurgery, transplantology, and reproductive technologies;

· Increase in the volume of high-tech medical care purchased from the federal budget from existing federal specialized medical organizations and newly established centers for high medical technologies.

2.6.1. Methods for Assessment (or analyzing) of health financing in Azerbaijan

One of the main tasks of the health financing system is to provide the entire territory of the Azerbaijann Republic with the opportunity to implement the program of state guarantees to the population in free medical care at the expense of budgetary funds and compulsory medical insurance. Improving the health financing system should be based on:

· Use of financial resources not only as payment for certain medical services, but also as an economic tool for managing the quality of medical care and increasing its social, medical and economic efficiency (UNICEF. The state of children in the world. New York, UNICEF, 1994-2001, 2004);

· Realization of the interest of the primary link of health care in optimizing the structure of medical care at all its stages;

· Rational use of expensive types of medical care, development of stationary substitution technologies;

· Payment for all types of medical and preventive care in the amount of state guarantees at the expense of MHI funds;

· Provision of targeted health programs, as well as health infrastructure through budgetary financing using the mechanism of state orders, which, on the one hand, allows to concentrate resources for solving health development priorities, and on the other hand to monitor their effective and targeted use.

Expenditure on health is annually provided for in budgets of all levels: federal, subjects of the Azerbaijann Republic and local. An important way to assess the envisaged expenditure on health care is the approach to their planning, not on the basis of the stated needs of the department, but on the basis of real budget possibilities. The federal budget expenditures on health care are focused on:

· Realization of priority directions of reforming and improving the industry, which have the maximum effect and are defined by the Concept of the Development of Health Care and Medical Science in the Azerbaijann Republic;

· Conformity of allocated funds to guaranteed amounts of medical services;

· Ensuring real accessibility and high quality of medical care for all segments of the population.

Regional aspects of health financing are no less important than national ones. The peculiarity of health services is their location, a certain isolation in specific administrative-territorial units. The most effective production of them can be organized by regional and local authorities, which are closer to the consumer, better know the structure of the population of the subordinated territory, the peculiarities of the social and hygienic situation in it. Therefore, the primary responsibility for providing and financing activities related to health care lies with regional and local authorities. The amount of expenses for the maintenance of health institutions is made up of the costs for each target article. In addition, payments are determined from the budget for compulsory medical insurance for non-working citizens.

In general, budget expenditures are determined on the basis of the current network of institutions and its anticipated development in the planned period in

accordance with the standard forms of settlements for economic items of expenditure. Expenses for food and medicines in hospitals are calculated according to established norms for the projected number of bed days; medicines in polyclinic institutions - according to established standards for the number of medical visits at home and visits to doctors.

It is advisable to consider issues related to the financial provision of medical assistance within the framework of the territorial CHI program on the board of the regional CHI fund together with the health authorities and the financial body of the subject of the Azerbaijann Republic, taking into account the need (UNICEF. Social Monitoring 2003. Florence, UNICEF, 2003):

· Correlations of the calculated territorial indicators with the norms, both in terms of the volume of medical assistance, and in the unit cost of the service;

· Opportunities to expand the use of inpatient replacement technologies and the use of intensive therapies;

· Optimize the cost of one bed-day, one visit at the expense of increasing the efficiency of using available material and human resources;

· Rationalization of the health care delivery system, taking into account the regional integration of the network of treatment and prevention institutions.

Thus, in the process of planning health care expenditures in budgeting projects at all levels, there are a number of difficulties: limited funds; insufficiently precise regulation of the distribution of costs (legally) between the budget, MHI and other sources; obsolete methods of calculation (the most progressive is the method of planning based on state minimum social standards); the lack of a balanced system of regulatory indicators, etc. Therefore, when forming and approving the budget, there are fairly acute disputes every year, during which the coordination of the volume of the industry's expenditures to the draft budget is carried out. It is obvious that the successes of the development of the economy as a whole, the increase in budget resources, scientific developments to improve the economic mechanism of the healthcare sector will help solve the listed and other problems (Fuller, 2003:11).

In spite of the appropriation of the principal idea of reforms as right on time as in 1999, no foundational changes were presented in the health division, which still conveys all the fundamental basic highlights of the Semashko health framework. The general way to deal with reform execution in Azerbaijan has been founded on incremental change and the preservation of those highlights of the current framework that demonstrated practical. The nation's political condition, with the accentuation on social steadiness and political agreement and the nonappearance of solid resistance to get the health motivation, was likewise not ideal for radical changes. Thus, the reform endeavors made so far have focused on just certain territories of the health framework, for example, essential care or have been guided in a constrained geographic zone. Besides, huge numbers of them were started and executed by universal associations with little contribution and responsibility from the local government, which brought about an absence of supportability once giver financing finished.

2.7. Limitations of the Empirical Research

To implement the state policy in the field of compulsory medical insurance, the Federal and Territorial Funds of Compulsory Medical Insurance have been established as independent non-profit financial and credit institutions in accordance with the resolution of the Supreme Council of the Azerbaijann Republic "On the Procedure for Compulsory Medical Insurance of Citizens" for 1993 (from February 24, 4543-1)

In Azerbaijan, since 1993, medical insurance exists in two forms: compulsory and voluntary. Mandatory medical insurance is characteristic of countries with socially-oriented market economies and is part of the state's social insurance system. Voluntary is an independent type of health insurance, serving as a supplement to the mandatory.

The first limitation of the research is that by local and worldwide norms, public financing is still low and the country spends far less on health than it can manage. There are large amounts of OOP payments for health administrations, issues with getting to and inadequate security for the populace from financial risks. In the meantime, the present health framework is set apart by wasteful aspects that require significant changes previously extra subsidizing can be put to compelling use. For instance, increments in the pay rates of restorative laborers ought to be joined by workforce justification. Additionally, the other limitation of the research is that there is a requirement for a move in standards so supplier payment rewards execution as opposed to contributions, as is right now the case.

CHAPTER III.
EMPIRICAL RESEARCH RESULTS OF FORMATION OF A SOCIALLY-DIRECTED AND FINANCIALLY-PROVIDING MODEL FINANCING OF MEDICAL ORGANIZATIONS IN AZERBAIJAN (ON THE EXAMPLE OF BAKU)

3.1. Modern model of financing of medical organizations (on the example of Baku)

Public health is one of the priorities of the social policy of the state. Today, the health indicators of the population are deteriorating. The problems of accessibility and quality of medical care are aggravated, which can lead to serious social and economic problems.

The health crisis, the difficulties faced by elderly citizens and other population groups in obtaining free or subsidized medicines, the growth of paid medical services, the deterioration of health services due to inadequate funding for

the health sector in recent years have a profound impact on the entire population (UNICEF. Social Monitoring 2003. Florence, UNICEF, 2003).

In the modern world, the financial provision of health care is carried out at the expense of budgetary funds, employers' funds, population funds. The share of each of them in the total amount allocated to health care determines the model for financing the industry.

The budget-insurance model of health financing provides for funding from two sources - budgets of all levels and the MHI system, which helps to attract additional funds, improve the quality of medical care and ensure the protection of the rights of consumers of medical services (The Government of Azerbaijan and the World Bank. A study on poverty assessment in Azerbaijan / internally displaced persons and refugees. Azerbaijan, the Government of Azerbaijan and the World Bank, 2002).

In some countries, fixed tax revenues are used as a source of financing, as well as payments of the population for some medical services.

The insurance model of health financing is based on the principle of competition between insurers. They offer different types of insurance programs, different in terms of cost and conditions of medical care. The types and volumes of medical services that can be received by the insured depend on the amount of private insurance.

The Azerbaijann health financing system is a budget-insurance one. It assumes the existence of two sources of financing medical care: funds of budgets of all levels and means of CHI. The main source is the state budget, formed at the expense of taxes levied on the population and enterprises. A similar model is called a two-channel model.

Personal means of the consumer of medical services are also one of the sources of health financing.

With the transition to the system of compulsory medical insurance, there was an imbalance between the state's obligations to provide free medical care to citizens

and the allocation of financial resources. The program of state guarantees of providing citizens of the Azerbaijann Republic with free medical care determines the minimum of medical assistance and financial resources for their provision in the health care system (Constitution of the Republic of Azerbaijan, 1995.).

Thus, none of the models of health financing are ideal, each has its advantages and disadvantages. The sources of funding for medicine can not be fully provided with the necessary means, therefore, it is necessary to introduce new methods of payment for medical care, and to improve the system of insurance medicine.

3.2. Systematization of approaches to the formation of a model for financing medical organizations in Baku

In 2010, the Organization for Economic Co-operation and Development (OECD) concluded: "There is no health system that is systematically and permanently best in providing affordable and cost-effective medical care." Therefore, and also because of the high costs associated with the transition to new models, developed countries rarely significantly change health financing systems. Nevertheless, they are introducing some additional useful elements from other models, so that now the health financing systems in developed countries are mixed - in each of them there are elements from other models.

The main sources of health financing in OECD countries are: taxation, private health insurance, social health insurance and individual payment (from the patient's pocket). But none of these states rely on private or individual payment for health services as the main source of health financing. However, in OECD countries, partial payment of medical services by the patient (co-payment) is allowed (UNICEF. Azerbaijan. Multilevel cluster survey. Baku, UNICEF, 2000).

The National Health System (NHS) of the UK is experiencing the longest and most serious recession in its history. In 2017, this raised questions about the

sustainability of the health financing model and the search for new additional approaches to its organization.

In fact, in the UK there are 4 national health systems - England, Scotland, Wales and Northern Ireland. The most capacious among them is the health care system of England. We will consider it.

The NHS is a centralized system, financed mainly by general taxation (tax revenues to central and local budgets), supplemented by contributions in the framework of national insurance.

Although it is considered that the NHS is "free at the place of delivery," patients co-pay for some services (for example, dental).

Interesting fact: in the British centralized system of health care financing, centralized purchases of medical services and medicines are practically not carried out (with some exceptions). The Health and Social Care Act, adopted in 2012, provides that from 1 April 2013, the procurement of health goods and services is decentralized to the Clinical Commissioning Groups (CCGs). Currently there are 207 of them. Acting on behalf of the NHS, on the ground, CCGs are responsible for the health of the population in the territory they serve. Their functions include, among other things, the procurement of medical goods and services. Centralized purchases of medical services and medicines directly through the NHS are not implemented, although the budget of CCGs is obtained from the NHS.

The task of CCGs is to achieve the best results for public health. This includes determining the needs based on priorities, and then buying goods and services from suppliers. CCGs are independent and accountable to the Secretary of State for Health (through NHS England). Although CCGs are accountable to the NHS, the NHS does not indicate to CCGs what to purchase locally.

Procurement regulation is implemented through standards that the NHS establishes with the help of the National Institute for Health and Clinical Excellence (NICE).

The NHS statute and legislation do not specify the exact scope of medical services. Absolute right to receive specific treatment in patients is not. However, according to the NHS statute, it is the responsibility of the Secretary of Health to ensure that the population is fully covered by health services (State Statistics Committee of the Republic of Azerbaijan. Independent Azerbaijan, 2001. CD Rom compendium of official state statistics, 2002).

In practice, the NHS provides preventive services, including screening, immunization and vaccination programs; inpatient and outpatient medical care; services of a doctor; medicines for outpatient and inpatient treatment; necessary dental care; some eye care products; Psychiatric care, including assistance in the education of persons with disabilities; palliative care; partially long-term care; rehabilitation, including physical therapy (eg post-operative care); visiting a nurse at home.

The Concept of Reforming the Health Financing System and Application of Compulsory Medical Insurance in the Republic of Azerbaijan that was approved in 2008 and Action Plan for the Implementation of the Concept of Health Insurance Reform and the Introduction of Compulsory Medical Insurance in the Republic of Azerbaijan that was approved in 2008 considered to be implemented till 2012, however the provisions of these regulations have been continuing to be realized till the current day.

3.3. Author's model of financing medical organizations in Baku: directions of reform and expected results

In general, despite the fact that the country's territory is almost covered by healthcare facilities, there are problems with the availability of existing buildings and equipment, as well as the quality of services provided by the medical staff, along with the formal and informal payments made for these services. Differences in the quality of health care services contribute to inequality in urban and rural areas. From this

point of view, improving the quality of health services provided is of particular importance. In order to provide high-quality health care services in all regions of the country, public investment in this area should be increased. Thus, the ratio of public health spending to GDP in 2007 was less than 1%. This was a sign lower than the financing level in a number of developing countries.

In addition to increasing the cost of health care, it is also important to ensure the efficiency of current expenditures. The Concept of Reforming the System of Health Financing and Application of Compulsory Medical Insurance in the Republic of Azerbaijan approved by the Order of the President of the Republic of Azerbaijan dated January 10, 2008, No. 2620, provides for the modification of existing mechanisms of public finance management, the creation of new economic basis for financing and, compulsory health insurance. This will, on the one hand, promote the use of state-funded public funds more closely with the medical needs of the population, on the other hand, to create a new source of health financing and, in general, increase the transparency of the system.

The model needs to be improved and established by considering the current facts of healthcare financing and findings from the empirical research.

1. Although adequately endowed in terms of facilities and staff, the healthcare system in Azerbaijan has not been successful in delivering essential health services, nor has it been able to respond to the evolving, needs, preferences and aspirations of the people of Azerbaijan. Indeed, the country has very large unmet preventive and curative healthcare needs. The shortcomings in the quality and adequacy of health services presented in the previous section all point towards the healthcare system as the main "culprit." An equally, if not more, important determinant of the present status of healthcare in the country is the attitude of policymakers, who continue to defend the reliability and validity of inaccurate administrative data.

2. There is broad consensus among national and international policy analysts and health system specialists that the healthcare system of Azerbaijan has failed to reform centralized financing and normative allocation of human, physical and financial resources. This failure is evidenced by persisting skewed budgetary allocations that overfund excessive hospital facilities and inefficient tertiary-level services while underfunding highly fragmented and poorly managed primary healthcare services. Compared with other countries of the FSU, Azerbaijan is truly lagging behind in the modernization of its healthcare system.

3.4. Research Generalization and Comparison with Other Researches

Models in which the main source of financing are revenues from general taxation are usually built taking into account the general risks for large groups of the population and provide for the universality of the provision of medical services.

Taxes that finance health care in centralized systems are divided into direct and indirect types; by level - to central and local; by targeting - for general and targeted (when the tax on medical services is made in a separate article).

In addition to the UK, Australia, Canada, New Zealand and the Nordic countries rely on general taxation for health financing. However, general taxation is not the only source of financing. In the countries mentioned, for the provided medical services, partial payment from the patient (co-payment) may be levied and there are elements of private medical insurance.

In the UK, the share of co-payments in the overall health budget remains low - 1.2% in 2007-2011. In Canada, about 70% of health care expenditure is financed by the state through general taxation, and the remaining 30% is funded by patients (personal and private health insurance).

The model of health financing through general taxation has a number of advantages, namely: it allows to concentrate a significant financial resource, ensures social justice, contributes to the development of an effective system of general taxation, and also motivates the optimization of health care expenditure.

However, alongside with advantages there are also disadvantages: a constant increase in the share of health care expenditure in the overall state budget, the risk of a budget deficit, unpredictability of the level of coverage of medical services, which leads to politicization of the budget adoption process.

CONCLUSION

For the last seventy years, medical care for the population of the Republic of Azerbaijan was provided on the basis of administrative standards that did not take into account the needs of the local population and the availability of funds. Personnel policy was aimed at ensuring a large number of medical workers, and not the quality of their work. Medical care, albeit most basic, was widely available, but there were no levers to ensure its quality. The collapse of the Soviet Union led to serious changes in Azerbaijan. The country faced the most difficult tasks in the field of politics, economy and health. Political tasks were connected with the transition of Azerbaijan from the administrative-command system to a partially pluralistic system, and democratic institutions had to be built in a country where there was never democracy. It was not easy. The economy of the country, which for decades suffered from a lack of investment in both basic and labor resources, caused a huge damage to the break in the trade ties that developed during the Soviet period. The conflict with neighboring Armenia aggravated the situation, leading to the emergence of a million refugees and internally displaced persons. As for the health of the population, in Azerbaijan, as in other countries of the Commonwealth of Independent States, low life expectancy and infectious diseases are widespread.

The reform has matured, but it is still very slow. An inflexible health system that suffers from acute shortage of funds is not able to satisfy even the most basic needs of the population. In 1992 and 1993, Even such major public health programs as immunization were suspended. The result was an outbreak of diseases such as poliomyelitis, diphtheria and malaria, which seemed to be over. The incidence of other diseases, in particular tuberculosis, also increases. In 1993, the government urgently conducted a serious evaluation of the health system. At that time, other tasks were on the agenda, but the health situation also depended on their solution. These

tasks included ensuring the stability of the political system, ceasefire and launching a large-scale program of social assistance to refugees and internally displaced persons. The health reform was planned to be included in the overall program of restructuring the country's industrial and social infrastructure. Only recently, in the sphere of health care, reforms have finally begun. Among them - a pilot project to introduce new methods of primary health care, the privatization of pharmacies and some medical institutions, the recognition of patient rights and the improvement of management at the local level. Much remains to be done to create a healthcare system in Azerbaijan that can meet the needs of the country's population. Some features of the current system are responsible for a vicious cycle of poverty and disease, which is a heavy burden on the shoulders of society. These features include the following: health is focused on treatment, not prevention, and the current incentive system encourages doctors to delay and delay treatment to the detriment of the well-being of patients; lack of incentives and opportunities to improve the quality of services; the lack of a coherent system of accountability and the closure of cash flows; the lack of information systems that allow a reliable assessment of the health status of the population, which is a prerequisite for the rational management and planning of health services; and finally, a meager funding of health care. Solving these critical tasks will ultimately contribute to improving the performance of the entire system as a whole. However, this requires not only economic growth, but also a strong political will and willingness to invest in health care. The first steps in this direction are made within the framework of the state program on poverty reduction and economic development, but it is too early to judge the results.

To sum up, fact-based analyzes have to be conducted to assist decision makers in conceptual development of this field in healthcare management, healthcare managers have to be improved, the current funding mechanism has to be improved in accordance with the "Concept of Health Financing System Reform and Compulsory Medical Insurance in the Republic of Azerbaijan" in order to improve the effectiveness of budget allocations to the health sector, transition to the principle of

per capita funding, the paid services system have be developed, and a compulsory health insurance scheme has to be established.

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