Country Briefs: Social Health Protection and Health Financing Reforms

Prepared by International Labour Organization

BRIEFING NOTE: AZERBAIJAN

Since the late 1990s Azerbaijan has experienced substantial economic growth, outpacing most of the Commonwealth of Independent States (CIS) countries in the speed of economic expansion. The population has benefited from that growth in many ways, with life expectancy increasing from 72.4 years to 76.4 years between 2005 and 2019 (*1)*.

However, the country's health system encountered a range of challenges following the transition to independence, which hindered equitable access to quality health services *(2)*.

In the 1990s and the 2000s, budgetary allocations for health care in Azerbaijan were lower than in all other CIS countries. Out-of-pocket payments accounted for the largest share of the total health expenditure *(3)*. In 2014–2016, health expenditure per capita dropped sharply due to reduced budget revenues from oil. In 2019, the estimated universal health service coverage index in the country was 65.3 *(4)* while out-of-pocket spending was estimated to account for 68% of current health expenditure *(3)*.

In 1999, the government took the first steps to secure an additional source of funding by establishing a legal basis for the introduction of a compulsory health insurance. However, the compulsory health insurance was not implemented immediately due to the complicated political and economic environment and high prevalence of informal employment (estimated as high as 58.3% in 2001 *[5]*), as well as the existence of a large group within the population who could not pay for themselves *(6)*. As a result, the reform of the national health protection system occurred gradually.

In 2007, the parliament established the State Agency for Mandatory Health Insurance (SAMHI), and in 2016 compulsory health insurance was launched as a pilot in two regions of the country *(2)*. With a gradual rollout, the SAMHI achieved 100% geographic coverage by April 2021 *(7)(8)*. Employers and employees started contributing to the national mandatory health insurance scheme by paying the fees in January 2021.

The mandatory health insurance guarantees access to a comprehensive package of both inpatient and outpatient services and covers citizens of Azerbaijan, foreigners permanently or temporarily residing in the country, and stateless persons under the guardianship of the Office of the United Nations High Commissioner for Refugees. Voluntary affiliation is allowed for those who are not eligible for mandatory participation *(7)*. Significant investments have been made to promote and enhance the impact of the compulsory health insurance through information and communication technology and the integration of digital health services and tools.

The introduction of the compulsory health insurance is expected to contribute to the availability of resources to ensure the upgrading of the health care system and attainment of universal health coverage and Sustainable Development Goal 3.

BRIEFING NOTE: KAZAKHSTAN

The first attempt to introduce a compulsory health insurance system in Kazakhstan was made in 1996. However, local governments and employers were unable to fulfill their obligations to form a guaranteed funding pool, and as a result the insurance system was abolished in 1998. The state returned to budget financing.

After thorough preparation at the national level, Kazakhstan successfully introduced a mandatory social health insurance system in 2020.

Active reform of social health protection in the country began in the period 2015–2016, through the establishment of the Social Health Insurance Fund (Government of Kazakhstan Decree No. 389. of 2016). Mandatory social health insurance was piloted in 2019 in Karaganda region before being rolled out in the rest of the country *(9)*.

Before the introduction of mandatory social health insurance, Kazakhstan operated a budget-financed health care model that provided a state guaranteed benefits package free for all citizens. Between 2000 and 2018, the total health expenditure per capita increased substantially (from US$ 51 to US$ 275), but the growth of health expenditure has been average relative to the other CIS countries *(3)*. However, unlike in many other CIS countries, most of the health financing burden was born by the state. Since 2000, in Kazakhstan, the share of the government health expenditure in the total health expenditure has been one of the highest among the CIS countries, while the share of out-of-pocket payments has been one of the lowest (estimated at 33.5% in 2018) *(3)*.

A range of important health system reforms have occurred since 2010, including liberalization of health services, improved regulation and harmonization of health service procurement, strengthening of the role of primary health care, and active digitalization aimed at creating a unified medical records system and improved interoperability between different agencies and public databases. Reforms in other sectors, such as labor and social protection, helped prepare for the launch of health insurance. These reforms include introducing a single payment for the informally employed to ease their participation in health, social protection, pension and income tax systems and reducing the share of informally employed individuals. These and other reforms have facilitated the introduction of mandatory social health insurance throughout the country *(9)*.

Currently, a large share of the population (58%) is exempt from mandatory contributions to the Social Health Insurance Fund, and the state makes payments on their behalf. The introduction of mandatory health insurance has already substantially improved the availability of financial resources for health care funding, which were estimated to have increased by 112% in 2020 compared to 2019 *(9)*. The state guarantees access to a universal (guaranteed) package of benefits that does not depend on contribution amount and covers a broad range of inpatient and outpatient health services, including outpatient provision of free medicines, available to 100% of residents. The additional insurance benefits package, which covers elective care, certain diagnostic procedures and high-cost treatments, is offered to the insured population, currently available to 84% of residents of the country.

BRIEFING NOTE: KYRGYZSTAN

The health system of Kyrgyzstan has undergone three major reforms since the country's independence: first between 1996 and 2005 (a reform program titled "Manas"), second between 2006 and 2010 (titled "Manas Taalimi"), and third between 2012 and 2018 (titled "Den Sooluk") *(10)*.

As a result of these reforms, the government introduced a mandatory health insurance and a single-payer system with consolidated financing for health services and medicines managed by the Mandatory Health Insurance Fund. Major efforts were also made to increase spending on health, improve the efficiency of resource allocation, strengthen primary health care, and improve health outcomes through the introduction of needs-based core health services as well as identification and removal of key barriers to access and effective coverage *(10)*.

While not all objectives of the reforms have been achieved *(11)*, there has been an increase in the effective coverage of the social health protection and diversification of health financing sources. Between 2000 and 2019, WHO's estimate of the universal health service coverage index in Kyrgyzstan improved from 52 to 70 *(4)*.

Currently the social health protection system in Kyrgyzstan includes two major schemes: 1) a State Guaranteed Benefits Package (SGBP) and 2) an Additional Mandatory Health Insurance (MHI) Package. Both are financed through the Mandatory Health Insurance Fund *(10)*.

The SGBP provides all citizens with free access to a basic package of primary and outpatient specialist services, as well as access to specialist inpatient services with co-payments. The additional MHI package is accessible only to those who contribute to the mandatory health insurance and provides outpatient medicine at reduced prices. The additional MHI package also enables reduced SGBP co-payments for specialist inpatient care. The government contributes on behalf of children under five years of age, pensioners, students, soldiers and veterans. The total share of active contributors is currently estimated at 66%. Under the existing system, groups with high expected health care costs and other privileged patients are exempt from, or entitled to, reduced co-payments for inpatient care *(11)*.

Between 2000 and 2009, the positive effects of mandatory health insurance manifested in the reduction of the share of out-of-pocket payments in the total health expenditure from 51.6% to 38.6% *(3)*. Progress stalled and then reversed in the period 2010–2018. Some of contributing factors to this stall and reversal were the large informal sector, insufficient coverage of expenses related to medicine, challenges arising from costing and financing gaps in the SGBP and additional MHI package, and an epidemiological shift from communicable disease to non-communicable ones *(11)*.

The COVID-19 pandemic has exacerbated many of the above challenges and has also created incentives and opportunities for further strengthening of the health system, to which the Government of Kyrgyzstan has voiced its commitment in its latest twelve-year national health strategy "Healthy person—prosperous country" *(12)*.

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