



**Center for Economic and Social Development
(CESD)**

Compulsory Medical Insurance System in Azerbaijan

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Preface

Implementation of compulsory medical insurance in Azerbaijan is planned within the health care reform framework. Like in most of the European countries, in our country too, the application of compulsory medical insurance has been accepted as a positive step. Besides raising people's access to health care services, this might also prevent unofficial payments within the system. But the successful transition into compulsory medical insurance highly depends on the mechanisms for the application of this new system, and these mechanisms have not been fully identified yet. This, may result in the failure of the reform in Azerbaijan; the reform which is seriously accepted in European countries.

Law on "Medical Insurance" has been adopted in 1999. But at that time the President Heydar Aliyev put a veto on this law until 2005. But during this period three more legal documents on "Public health protection", "Private health care" and "Medical insurance" were developed and adopted. Yet the

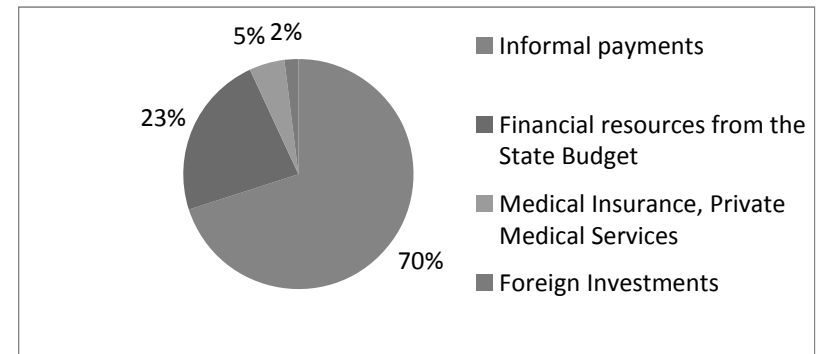
application of compulsory medical insurance was not possible in 2005. The law assigns 4% of employer salary fund to the medical insurance, but this law is not yet applied. Besides, some insurance companies still have not identified and selected the health care entities to work with. The issue is that, only 0,52 million manats, out of 102,56 million manats for insurance payments, are for life insurance. This is not only because of people's decreased interest in life insurance, but also due to the insurance companies not being able to work with health care entities. In some cases, the amount requested from insurance companies by health care entities is so big that the insurance companies lose their interest in getting involved with life insurances. This makes the life insurance an activity not financially attractive for insurance companies.

The compulsory medical insurance of unemployed population has not precisely been identified. This is a compulsory insurance, therefore all citizens, including unemployed population, who are unable to make payments, should have access to

this system. In this case, the state needs some financial support.

The application of compulsory medical insurance, as a part of health care system reforms, should be accompanied by complex actions. It will not have an effect if implemented as a separate component. Also, it is important to note that the insured people are not requested to pay unofficial payments and they receive free services as mentioned in their insurance contracts. But, this requires strengthening the control on the system, besides the application of compulsory medical insurance. According to the World Bank, 70% of health care expenses go to unofficial payments as showed in the table. The share of the state budget is 23%.

Diagram 1.
Financing of Health Sector in Azerbaijan



Source; World Bank 2007

In Azerbaijan, the number of hospital beds per thousand capita is 7.6. This indicator is 3.8 in Germany, and 2.3 in Turkey. The number of beds is high, but the use of these beds is very low in comparison with other countries. Only 26,1% of hospital beds are used in Azerbaijan. This indicator is 89.5% in Germany, 86.0% in Russia, 61.0% in Turkey, 76.9% for EU and 85.9% for CIS. Even though the number of beds is high, they are not efficiently used. Allocations from the state budget is based on the number of hospital beds, and more beds leads to more money from the budget. That is why,

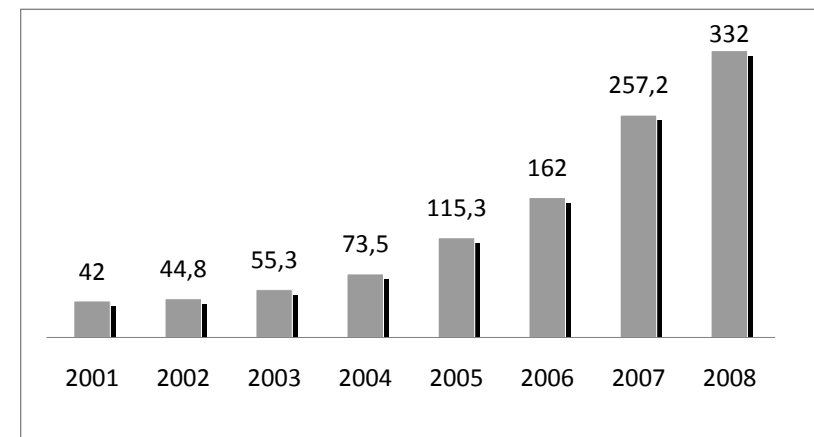
besides the application of compulsory medical insurance, improvements of health care financing system is also important. Otherwise, insurance will not make big changes in the health care system.

Application Issues of Medical Insurance in Azerbaijan

Even though law on medical insurance has been adopted in 1999 in Azerbaijan, the pace of reforms in this direction is not satisfactory. The budget for health care is increasing in Azerbaijan, but the share of health care budget in GDP is still low (it was 3% in 2005). Health care budget's organizational division is the following: 95,3% Ministry of Health Care, 2,3% National Oncologic Scientific Center under Ministry of Health Care, 1,9% State Railway Department and 1,7% other entities. Functional division of the health care expenditures for the 2008 year: 55,6% other services which has to do with health care, 15,7% polyclinics and out-patient hospitals, 0,8% applied researches in health care field and 2% other services in health care field. According to the finals of

household budget of 2007, in Azerbaijan 3,4% of household budget is spent on health care. The capital changes according to the household size. As in household with one person health care expense is 10,9 manat, for 2 people - 6,8 manat, for 3 people - 4,5 manat, for 4 people it is 3,2 manat.

Diagram 2. Public Health Expenditures



Source; Ministry of Health, Azerbaijan, 2009

Payment of insurance amount by the government in centralized manner is under consideration for the compulsory medical insurance base services package for the people financed from the budget and for privileged groups. At the present

time, the work is going on in identifying the minimum health care services.

According to the January 1, 2008 information, the total number of doctors with different specializations is 32,4 thousand, the number of medical staff with lower education is 62,2 thousand and the total number of hospitals is 1 692. Since 2005 the state's financial resource have increased significantly due to the oil revenues. The amount allocated to the health care from the state budget is increasing every year. But still people pay the 70-75 percent of total amount of health care services by themselves.

In August 11, 2008 The Cabinet of Ministers of Azerbaijan Republic has adopted a decree on approving "The action plan on health care funding system reforms of Azerbaijan Republic and application concept of compulsory medical insurance". This decision includes the following:

1. Evaluation of current situation of healthcare financing system;

2. Normative legislative regulation of healthcare funding reform process Application of best international practices and capacity building of the State Agency on compulsory medical insurance by the Cabinet of Ministers;
3. Improvement of healthcare funding system;
4. Training and enlightenment;
5. Monitoring and evaluation.

According to the plan, in 2008 the Ministries of Health Care and Finance will conduct the monitoring of current situation (funding the first medical-sanitary aid, and out-patient services, the quality of health care material and technical basis and etc.) of health care funding system. During the year Ministries of Health Care, Finance and also Labor and Social Protection will evaluate the current salary system (the factors identifying salaries, the level of average monthly salary, the effect of salary to the quality of labor).

According to the Action Plan, suggestions on development of information bank of compulsory medical insurance and on establishment of single information system will be prepared in 2009-2010 years. The bank will ensure the application of new financing system.

According to the “Health care funding system reforms of Azerbaijan Republic and the application concept of the compulsory medical insurance”, it is important to carry out sound reforms to achieve more efficient use of state funds allocated to the health care. The main directions of health care reforms are improving health care funding mechanism and application of compulsory medical insurance.

The following are included into the legislative base of compulsory medical insurance system of Azerbaijan Republic:

- “Medical Insurance” Law of Azerbaijan Republic (Baku, 28 October 1999)

- Azerbaijan Republic’s Law on making additions and changes to some of the legislative acts of Azerbaijan Republic (Baku, 07 December 2007)
- The order of the Prezident of Azerbaijan Republic on establishment of State Agency on Compulsary Medical Insurance by Cabinet of Ministers of Azerbaijan Republic (27 december 2007)
- The order of the Prezident of Azerbaijan Republic on “Approving the healthcare funding system reforms of Azerbaijan Republic and the application concept of the compulsory medical insurance” (Baku, 10 January 2008)
- The decree of the Cabinet of Ministers of Azerbaijan Republic on approval of the “Action Plan on implementation of the healthcare funding system reforms of Azerbaijan Republic and the application concept of the compulsory medical insurance for the 2008-2012 years” (№179 Baku, 11 August 2008).

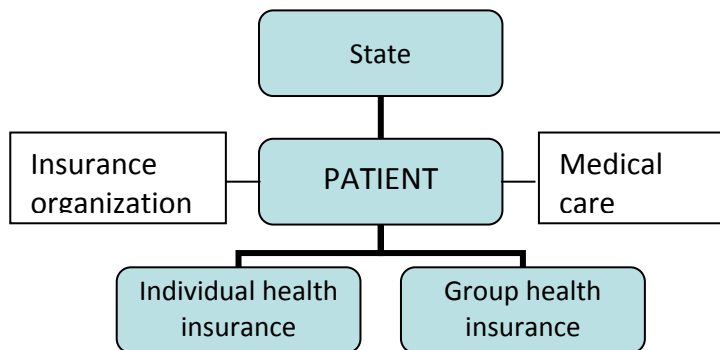
According to the law, in compulsory medical insurance system the insurers pay the amount to working citizens, and the compulsory medical insurance fees as identified by the appropriate executive bodies.

- Compulsory medical insurance fee is identified by the amount which makes the implementation of the compulsory medical insurance possible.
- The compulsory medical insurance fees for unemployed pensioners, people who are temporarily unemployed after the close down of institutions and organizations, people who are unable to work, children, students and employees of budget organizations are paid by the appropriate executive bodies, taking into account the price indices for medical services, and using the resources from the budget and social protection funds.

Opportunities for Application of Medical Insurance in Azerbaijan

According to our country's legislation on insurance, there are life and non-life insurance (general insurance) depending on the operation directions of the insuring companies, and there are personal and property insurances depending on the object of insurance. Each insurance field consists of some insurance classes.

Medical insurance - in case of sickness indicated in the insurance contract to cover examination and treatment expenses and the partial or full cost of the medicine of the insured person. No one can identify the real financial value of one's or someone else's life or part of the body (such as foot, eyes and etc.). For that reason financial compensation principal, except medical insurance, is not applied to personal insurance classes. However, in medical insurance the cost of medical services is financially measurable.



According to the researches conducted in the field of medical expenditure, the argument on population not being ready to pass into medical insurance system is a false one. However, even though the services are free of charge in the polyclinics or hospitals funded from the state budget, in reality the citizens still pay unofficial fees. Researches show that citizens pay 75 % of the medical services expenses by themselves. Five percent (5%) of this is official and 70% is unofficial payments. Government covers only 25% of medical expenses. In this case, the legalization of medical services payment by population can serve to the benefit of the budget.

Though insurance is voluntary, there are also compulsory insurance programs in Azerbaijan. In 1999 after the adoption of the “Insurance Law” some laws on compulsory insurance has also been adopted. These laws are directed to the social protection of citizens of definite category. For example, the most widely spreaded one among them is the law on “The compulsory insurance of the responsibility for automobile owners in front of the third party”. In 1999 “Law on Medical Insurance” has been adopted. At the present time in number of enterprises and private enteties use of medical insurance can be observed.

There are different approaches to the funding of healthcare by the state. The economists, who support government’s operations particularly in this field, besides the government’s main role of funding the system, also find the intervention into the managment of healthcare important. Others find the government’s intervention useless and in long run inefficient.

In Azerbaijan the population’s opportunities of equal access to qualitative healthcare services are

limited, and the quality of offered healthcare services is very low. Once the compulsory medical insurance is applied, those entities that perform better and attract more patients will get more finances through the insurance. The entities that do not attract patients, will not get anything through the insurance.

Funding the healthcare from the budget and non-budget resources is compulsory everywhere in the world. Healthcare insurance is the most important and wide spread form of this system: private, state and municipal healthcare systems should be fully developed and mutual relationship system among them ensured. There are two kinds of insurance: compulsory medical insurance and voluntary medical insurance. Compulsory medical insurance covers wide-spread illnesses, diagnostics, treatment, recovery, nursing services, birth and emergency call services. There are special sources to fund this program. It can approximately be classified as following: first group covers pensioners, children, students, and mothers with several children. That mainly means people who do not have income source.

State, charity funds and sponsors allocate funds for these people. For the people of this category fund should be allocated from the budget. The second group consists of registered unemployed people. For this group of people the funds should be allocated from the employment centers. The third group includes employed people. For that group the fund is allocated from their own salaries. The fourth group consists of public servants and businessmen with high income. They pay for insurance from their salaries.

Since 2008 the Azerbaijan-Turkish Business People Association implements relevant research program with an aim to support the actions in line with the development priorities of the country. Within the program's framework healthcare field has been analysed by the union's projects and researches department. Research shows that, among the healthcare services, the hospital service still is the most priority service. Thirty five percent (35%) of the allocated funds from budget go to emergency call services, remaining 65 percent go to hospital services.

The percentage of healthcare expenditure in the state budget has gone down. This is mainly due to the increase in military and investment expenditure. According to the calculations, funds allocated to health care from state budget and fees paid by the patients themselves in 2007 was 67 manat per person.

The number of people who died from all kinds of illnesses was 603.9 for every 100 thousand in 2003. In 2007 this number was 634.1, which means 5 percent increase. This is mainly due to population's decreased use of medical entities for check-ups and treatments and environmental pollution. Official data also confirm this. If the percentage of population going through check-ups in 2003 was 38, this indicator in 2007 was 35.

It is mentioned in the report that the number of beds per 10 thousand persons is 1,3 times higher in Azerbaijan in comparison with European countries and the average usage of hospital beds is between 30 and 40 percent. Besides, in comparison with

European countries the number of the doctors providing first medical-sanitary aid is twice less. The number of private health care entities is over 300. Thirty seven percent (37%) of them provide check-up services, 18 percent are hospitals, 14 percent provide dentist check-up services, and 31 percent provide different services on treatment of health.

According to the analyses, the share of private health care entities in providing medical services is lower than 10 percent. Approximately 80 percent of those entities are located in Baku. That is because, the network of private health care in the regions is less developed. Evaluations show that, in tourist regions of the country, such as Quba, Khachmaz, Lenkaran, Sheki-Zaqatala and Gence-Qazakh, there are more chances for effective development of private entities.

All parties try to minimize their own risks in any type of insurance agreement. For medical insurance users and insurers management of insurance risk is different. From insurance users

perspective, person (or family) gets medical insurance because they want to get protected against future financial losses while health care use. From insurers perspective, they use many methods to minimize the risks they take for profitable business management while providing services. One method is covering the expenses only for the previously identified collection of services. Another method is involving healthy people to insurance, as they don't require many medical services as sick people do. The methods used by insurers for insurance users have one objective which is minimizing the future risks.

The question "does the accessibility of medical insurance satisfy you?" was addressed to all experts. It should be mentioned that, the respondents can be grouped into two groups with opposite answers. The first group (NGO leaders, independent experts and employees of private health care entities) mentioned that problems in this field still exist. Government should make serious efforts for sound results in this field and accessibility of the healthcare services should be equally spread in all the regions. The

second group (employees of state health care entities and entities which has direct or undirect connections with the Ministry of Health) mentioned that the level of providing medical services is satisfactory.

It is predictable that the main problem of the health care system in transition countries is the widespread unofficial payments. Economic and organizational mechanisms should be prepared and implemented to get rid of unofficial payments in the state health care entities. Observations show that, in state health care sector the most effective way of getting rid of unofficial payments is the application of economic mechanisms. Naturally, it is very important to provide the health care providers with high salaries. It is possible to provide this through medical insurance system. According to the experts, it can also be effective to hold active propagand among the health care servants on negative consequence of taking unofficial payments. According to the researches, both in state and private health care entities it is also important to follow the motto "Patient is always right!", because it is an important

factor in improving the quality of health care services. But observations show that, except few private health care entities, almost all health care entities do not follow this motto. That is why the responsibility system on consequences of the low quality medical services should also be established and the control system strengthened. Researches show that, at present, patients face major problems in their health because of the mistakes made by health care providers. These are mainly due to anti-sanitary and irresponsibility infectious diseases getting spread, and due to low level of financial interests and professionalism resulting in incorrectly written treatment recepies; these are the cases very frequently met in their practices. But for these doctors and health care entities, almost, do not carry any responsibility. Besides, in private health care system the prices of services should be regulated and control over contract between the patients and the entities should be strengthened. According to the health care legislation, tariffs are identified within the framework of the contract signed between the parties upon agreement. But in current situation this

practice is not being implemented. As it is known, establishment of compulsory medical insurance system has started since 2008. Pharmaceuticals field has been fully privatized; legislative base has been established for private health care entities' operations; law on implementation of medical insurance has been adopted. But still medical insurance system has not been established. According to experts' words, in last 18 years in the development of Azerbaijan health care sector by using some elements of existing models mixed model has been established. This resulted in decrease in the level of service quality of the health care sector and professionalism of personnel. It also increased the level of unofficial payments. For mid and long term run the application of medical insurance system and reforms in health care field should become a pressing matter. In the country unofficial payments together with official payments limits the health care use opportunities of the poor people. Both the people with low income and the people who can afford paying for unofficial payments lost their trust in the provided medical services and this results in self-treatment of sick people or they

don't go to doctor in time. As a result the illnesses either get into chronic form, or into more serious stages and citizens face with the situation where they have to pay even bigger amounts.

In the nearest future, the increase of investments and dynamic increase in the current expenditures in state budget is expected in the field of health care. But in the mid- and long-term perspectives, the pace of health care expenditure increase will go down. That is why from now on, the state entities should implement necessary actions to involve investments from private sector into the health care. Besides, big medical entities now under the ministry's subordination should pass into the system of self financing, receive financial independence and improve their management. This is one of the main conditions in the application of compulsory medical insurance. At the present time, medical entities do not have the capacity to handle compulsory medical insurance system.

Realities should be carefully studied and considered while referring to international practises in the application of compulsory medical insurance system in Azerbaijan. Most importantly, private medical entities should also be involved in to the providing health care services through compulsory medical insurance system. The competition provided in the application of it will have strong positive effect in the quality of the services. The control mechanism in the application of the system should also be established. This is because, the quality of the medical services provided by the entities working with compulsory medical insurance system should be periodically checked and the control over it strengthened. According to the experts, the compulsory medical insurance system savings system should also be formed from the salaries. We should take into consideration that, it is possible to involve only 1,6 million of employed population into the medical insurance at the moment, because the rest of the employed people are working unofficially. All these issues should be considered starting from now and appropriate measures should be implemented.

International Practice

Medical services provided through insurance dominate over the medical services funded either by private or state sectors in the majority of countries of the world. The quantity and the quality of resources applied to the health care field by public and their effective usage is identified by the complicated system of formed economical, political, moral-ethical and other relations in the country. Almost in all industrial countries the major part of the expenses are met either by government or social insurance entities. All existing health care systems are reflected in 3 main economical models:

1. Health care – market model which is based on market relations using the private medical insurance;
2. State health care – state model which is based on budget funding system;
3. Health care system – social insurance model based on social insurance principles and regulated with many channeled funding system.

The USA health care is based on the first model: private health care services market is the base of the health care system organization in the country, but it is completed with state health care service programs.

In the second model, the funding of the health care mainly is being implemented from the budget. Population receives medical services free of charge. As a rule, here market relations, under state control, is in the second place. This model exists in United Kingdom since 1948. This model is also being used by different countries.

Even though in the UK almost all health care expenses are covered by government, the citizen has a right to take paid treatment in private health care entities. National Health care Service (NHS) is a health care system which is funded from the British state budget. NHS offers normal health care services free of charge to all British citizens. But for eye, dentist and other personal check-ups they should pay additional amount.

Provision of free health care services for the country's population is supported by some experts. But this model also has some disadvantages. For example, at the state hospitals where medical treatment is free of charge, the person who wants to go through check up, might face long queue and his/her check-up might take a long time. Existence of such cases, of course, is not desirable mainly because the person who applied for medical intervention should be examined immediately. Absence of immediate check-up might cause some health problems for the sick person in the future and that makes the free health care system ineffective.

The third model is based on mixed economic principles. This model is characterized by the presence of compulsory medical insurance for all strata of society. Regardless of their income level, the state is the health care service provider for the most of the citizens in this model. Multi-channeled (from budget, from insurance company's incomes, from shares, from the salaries and etc.) funding system develops necessary flexibility and stability on the health care funding basis which is based on social-

insurance model. This model is more successful in Germany, France, Holland, Austria, Belgium, Switzerland, Canada and Japan. Market elements dominate in the social-insurance model applied in France.

In Germany, the funding the health care is being implemented from the consolidation of funds entered from various sources. Here compulsory medical insurance funds are formed from state budget, employers' transfers and employees' payments. The average medical insurance payment is 13 percent of the salary fund.

Germany is one of the countries in Europe with the oldest universal health care system. Here the first legislation on medical insurance was adopted in 1883. At the present time 85% of population uses medical insurance. According to the numbers of the World Health Care Organization, 77% of the state health care system is funded from the state budget, the remaining 23% is funded from private sources. Medical insurance expenses of the employees with low incomes is partly being compensated by government.

During the recent years the average hospitalization duration in Germany decreased from 14 days to 9 days. Some experts explain this decrease with sharp increase (60%) in medicine prices between the 1995-2005 years. Generally, since 2005 health care expenses consists the 10-12% of annual GDP. Even though in comparison with other Western European countries this number can be considered as a big amount, in USA these expenses is 1,5 times higher.

In 2007 in Azerbaijan only 25% of general health care expenses were covered by the state. According to the World Bank's research, in 2003 this indicator was 23%. Nevertheless, in the countries which are the members of the Organization of Economic Cooperation and Development, the average level of this indicator is 73%. In Czech Republic, Slovakia and Luxembourg up to 90%, in Great Britain, Sweden, Denmark, and Norway up to 85%, in Germany 79%, in Switzerland 58%, in France 76%, in Italy 75% of population's health care expenses are covered by the state. With the existing superiority of market relations in the US health care expenses, the states' share has increased up to 45%.

Even though the amount of money allocated to the health care sector from state budget has increased in the last years, some of the problems in this sector have taken traditional feature. The amount of health care expenses in 2008 was 332 million, but this was only 1% of GDP. Besides in 2008, in comparison with 2007, it has decreased from 4,4% to 3,9%. According to the World Bank's calculations, unofficial payments consisted 70% of health care expenses. In these expenses the share of state budget is 23%, the share of foreign grants is 2%, but the share of medical insurance is 5%. This means that, unofficial payments in health care sector is still dominating. Though the Ministry of Health Care has given an order on making the health care services free of charge, the problem of unofficial payments still exists. In Azerbaijan the number of hospital beds per thousand person is 7.6, in Germany it is 3.8, in Turkey this number is 2.3. Nevertheless, in comparison with European countries, the coefficient of usage of these beds is much lower. In Azerbaijan only 26,1%, in Germany 89,5%, in Turkey 61% of hospital beds are being used. This indicator for CIS is

85,9%. As allocations from the state budget is being calculated based on hospital bed quantity, this doesn't allow the effective distribution of the amount. Only 0,52 million manat out of 102,6 million manat insurance payments is for the life insurance. This is not only due to small interest in the life insurance, but also insurance companies' not being able to cooperate with health care entities. In some cases, the amount required by health care entities from insurance companies is so high, that the insurance companies loose their interest in signing life insurance contracts with them.

At the same time, the people who live in Azerbaijan but are not citizens, and also the foreigners have the same rights and privileges as local citizens in the health care system. The insurance market of the country is young; therefore, the high development temp is out of question and this has some objective and subjective reasons. But in many countries of the world the insurance market has developed along with the medical insurance in this market's context. For example, In the USA, annually 2 trillion dollars are being spent for funding health care

expenses. Forty four percent (44%) of these expenses is being funded from the state budget, the 37% from private insurance. Fifty four (54%) of the population in the US has been involved to private medical insurance through their work places. Only 16% of the population in this country has not been insured.

According to the medical insurance law of Azerbaijan Republic, the executive organs identify the form and contracting rules of the medical insurance contract. Medical insurance entities are not included to the health care system. Taxation of medical insurance entities is being regulated according to the convenient legislation of Azerbaijan Republic. In medical insurance system, regardless of ownership, health care entities have a right to give a document on approving the insured people's temporary lose of work ability.

Between the years 2003-2008 in Azerbaijan GDP has increased 4,2 times and from 7,2 billion has reached up to 30,4 billion. If the GDP per capital in 2003 was 888 manat, in 2008 this number was 3554 manat.

Table 1

Functional Clasification of Public Health Expenses

Functional Clasification	2005	2006	2007	Comparison with 2007 project	
				2005 fullfilment	2006 fulfillment
				Percentage	Percentage
Health Care Expenses, Total	110942	179143	269546	243	151
Hospitals	82356	121072	149012	181	123
Polyclinics and ambulance stations	20795	33734	44931	216	133
Other Services	2803	13892	5220	186	38
Applied investigations in the medicine area	1094	1692	2323	212	137
Related other Services	3895	8753	68061	1747	778

Source: World Health Organization, 2008

At the present time, in Azerbaijan 70% of population's income is spent on obtaining consumer goods. Other 10% is spent on taxes and duties. As the

remaining amount is small people can not get insured. From other side people are not well informed about medical insurance. According to studies, today the high number of insured people in America and Europe is due to people's income. That is why people can afford to spend 1/3 of their income on insurance and other such kind of issues. In USA 8%, in Europe 11% of GDP is insurance payment. However, this number has not even reached 1% in Azerbaijan.

The accepted conditionalities on compulsory medical insurance contracts is not included into insurance responsibility of volunteery insurance contracts. Medical insurance contracts are being signed without requiring medical reference beforehand. Only the citizens who are registered at the health centers with main profile on narcology, psycho-neurology, tuberculosis, oncology, and venereology are not accepted to insurance.

Development features of insurance market

Development of insurance market is very important for state economics and mainly for economies in transition. As a result of the dynamic progress in state economics during the last years, as in other fields in insurance field also progress was observed. As a main indicator, increase on the level of competition environment in insurance products market and by providing the variety of offered services international practice is being successfully applied in the country. As mentioned, at the present time there are 28 insurance companies and in addition, one reinsurance company in the country. As a result of economical stability and new opportunities for insurance market in the country, the charter capital of the insurance companies in 2008 was 79.8 million and in comparison with past year it has increased for 23.2%.

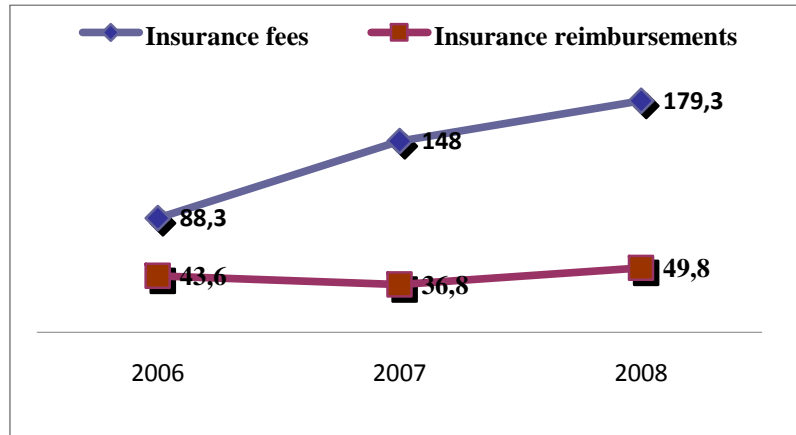
Though in Azerbaijan insurance market is not fully developed, it can be observed based on the

country's insurance market studies that, among CIS countries Azerbaijan insurance market differs with special development features. Even though, in 2008 insurance payments in GDP was 0,71%, insurance fee per person was 9,17 euro, and also the registered rapid progress in insurance market's size during the last three years, proves that among the CIS countries Azerbaijan has the most potential for development. Different dynamics have been observed in insurance fees and volume of the payments during the last three years. All these indicators prove that in the future, the insurance companies will not face any difficulties in carrying out insurance processes necessary for their services.

As showed in diagrams 3 and 4, in 2008 the volume of insurance payments in total collected by the insurance companies functioning in Azerbaijan was 179,3 million manat. This is 103% more than 2006 year's and 21,1% more than 2007 year's analogic indicators. But during this period changing dynamics was registered in the volume of insurance payments. Insurance payments for 2007 in

comparison with 2006 by decreasing 15.6% was 36,8 million manat. But next year the volume of this indicator increased 35,5% and was 49,8 million manat.

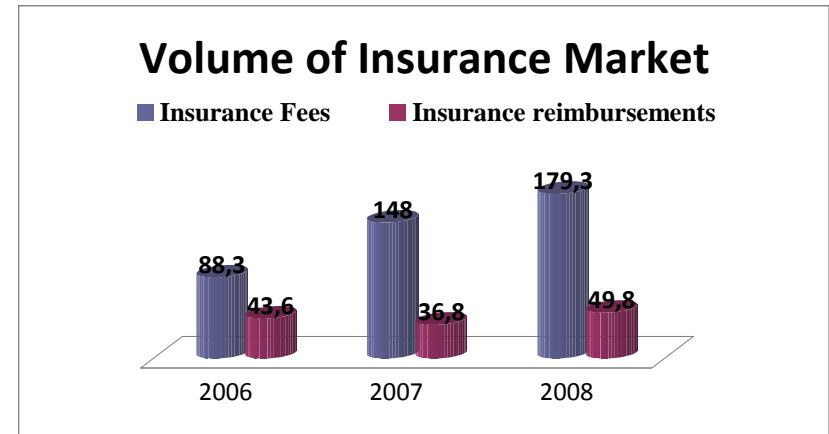
Diagram 3. Insurance Payments in Azerbaijan



Source; Ministry of Finance, Azerbaijan, 2009

In the last three years, the development of insurance market demonstrated itself in the volume of insurance products. Different dynamics was observed, especially for the past reporting periods, within the life, non-life and compulsory insurance products groups, as classified by the Ministry of Finance in its classification of insurance products.

Diagram 4. Insurance Payments in Azerbaijan; Comparative Analysis



Source; Ministry of Finance, Azerbaijan, 2009

One of the special features of the country's insurance market is the leading role of non-life insurance within the overall volume of insurance products. During the recent years, this insurance product had the share of 87-92% within insurance payments. Obviously, different tendencies of international insurance practice can be observed. Lately the life insurance started to take a leading position in the world insurance market. During the last years the life insurance captures 58-60% of the

world insurance market, and it shows an increasing dynamics. The volume the life insurance holds a very low and unimportant place in the country's insurance payments. In 2008 this product's share was 1% of total insurance products. Small share of these insurance product can be first of all due to the low level of development of overall society and separately of the population, and also due to the poor promotion opportunities of this product and the poor development level of the insurance institutions.

As mentioned the non-life insurance has a leading position in the country's insurance market. This insurance product's volume in 2006 was 81,35 million manats and in 2008 by increasing 75,06 million manats, 92,3%, became 156.41 manats. In 2008, 87% of country's insurance market was consisted of this insurance product.

During the last years, a progress on compulsory insurance products' share is being observed in the bases of country's insurance fees market's volume. The government's recent steps

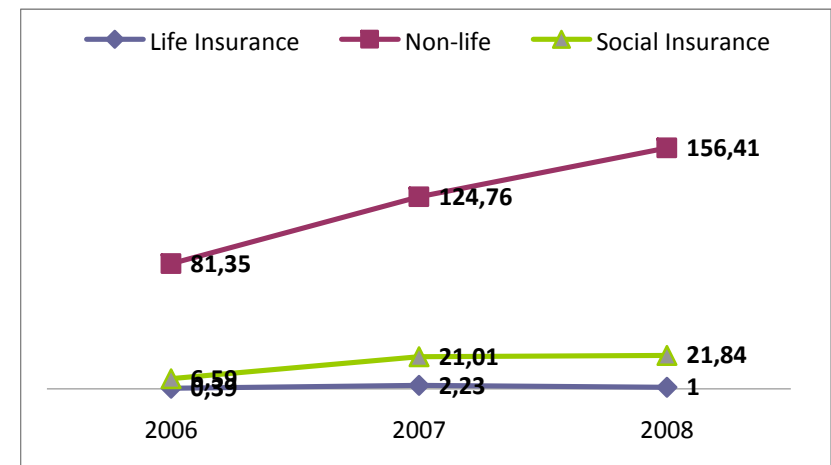
towards improving normative legislative base on some products, with the aim to speed up the development of insurance products' market have supported the strengthening of this tendency. As a result, the volume of the compulsory insurance products from the level of 6,59 million manat in 2006 has increased up to 21.84 million manat, which is 231% increase.

During the last reporting years the offered insurance products have also developed different varieties. If in 2006 the number of offered and used products in insurance market was 15, the next year this number became 30, and in 2008 the number of active products in the market was over 35. The development of the varieties of offered insurance products besides the development of economics, is also due to the development of insurance institutions of the country.

During the last reporting year, the amount of collections in the country's insurance market from the types of voluntary insurance was 157.4 million manat, and this is 23.9% more than previous year's

indicator. For the life insurance which is the part of this insurance product group this amount was 1 million manat and this indicator is also 2.2 times less than previous year's indicator. The collection indicators for compulsory insurance products in comparison with previous years has increased for 4% and were 21,84 million manat. In 2008 in non-life insurance products group's structure insurance of automobiles took an important place. For the last reporting year this indicator was 56.9 million manat. In non-life insurance products group's structure for the volume of collections fire insurance holds the next places. The amount of collections for this product in 2008 was 18,5 million manat. In 2008 the amount of collections for medical insurance was 19,2 million manat.

Diagram 5. Dynamics of Insurance Categories



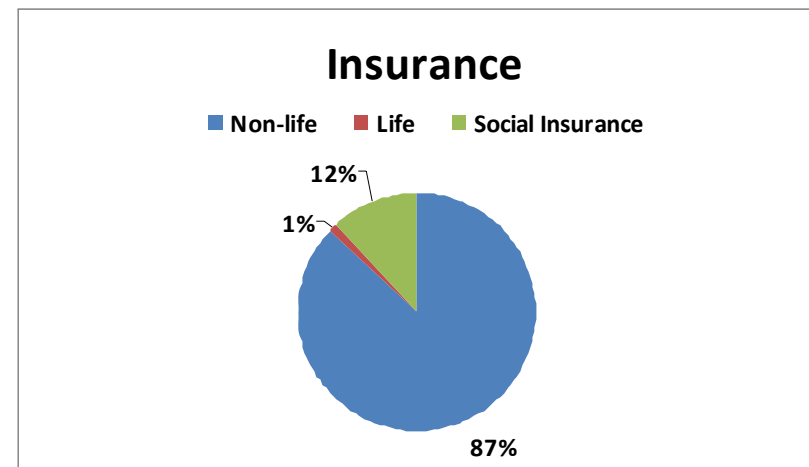
Source; Ministry of Finance, Azerbaijan, 2009

Country's insurance market's more dynamically developing products belong to the non-life insurance products group. During the last reporting periods the dynamic development of this insurance product group is one of the specific tendencies of the country's insurance market. For that reason, studying the structure of this product group, development features of its internal elements is important for identifying the existing tendencies in insurance market. During the

last reporting periods, the structure of the products which belong to the non-life insurance products group have been exposed to changes.

In 2006, the accident insurance had a very important share in this insurance group's structure; it was 57%. In 2006 this product type besides having big special weight, also showed 15% increase. Another product from this structure which has a important special weight is fire insurance. In 2006, the fire insurance product was 17% of non-life insurance, and it showed 16% increase in comparison with the level in 2006. One more product in non-life insurance products group of the same years which had an important special weight was medical insurance. In 2007 this product had only 12% share in non-life insurance products structure.

Diagram 7. Insurance Categories



Source; Ministry of Finance, Azerbaijan, 2009

During the past two years the structure of non-life insurance products group some changes have been made. This has to do with specific development tendency of the insurance market's element. The creation of number of new products has affected to the change in special weight division within the group. During these years country's insurance market has started to take usage of civil responsibility insurance, property insurance and freight insurance products of this group. In 2008 these products' sales reached

up to 21% of the non-life insurance group's total volume of sales. Even though during that period new insurance products such as mortgage and credit insurances came out in insurance market; their low annual volume limited the indication chances with important special weight.

The study on non-life insurance group products showed that during the last reporting period there is a changing dynamics on number of the product.

During the last reporting years medical insurance which is one of the non-life insurance products showed dynamic increase. The volume of this insurance products during the last three years was 9,67 million manat and it has increased 9,83 million manat (101,7%) and rose up 19.5 million manat. As the increase speed of medical insurance product was the same as total non-life products group's increase dynamics its special weight in 2006 and 2008 years did not change and was 12%. Obviously this insurance product also is connected to insurance market's, generally society's development.

It belongs to the products group demanded by population and business groups. At the same time cooperative management standards and business environment development in business subyektləri gives reason for the future potential perspective of this product.

Legislative Base on Medical Insurance

This law identifies the organizational, legislative and economic bases of population's medical insurance, regulates the relations between the parties of the medical insurance. According to the law, medical insurance is being implemented in the form of contracts signed between the parties. The form and contracting rules of the medical insurance contract and the rules on different kinds of medical insurance and categories of people, whom compulsory medical insurance do not concern, are being identified by executive organs.

Besides, with the aim to provide stable function medical insurance organizations are allowed to create reserve fund based on Azerbaijan Republic's legislation. The health care entities, regardless of the type of organization, functioning in accordance with the rules identified in the legislation, and individuals who are practicing medicine individually have a right to provide medical services within the medical insurance system. The main goal is to provide services to insured people. Also according to the legislation no payments should be requested from the citizens with medical insurance. Tariffs for medical services provided through medical insurance is set up based on agreement between the insurance organizations and health care entities which provided these services. As mentioned in legislation, in case service providing health care entities or a person practicing medicine individually breaks the conditions of the contract the medical insurance organization have a right to partly or fully not pay for the provided medical services. medical insurance organization carries out a responsibility in front of insured person

or insurer for implementation of the medical insurance contract conditions.

The main features of social medical insurance are the following:

- Relationship between incomes and the volume of insurance payments in accordance with unified and changing tariffs;
- Being compulsory for everyone or majority of the population;
- Sharing the responsibility for insurance payment between the employer and the employee or between different agents;
- Paying to one unified fund or to several funds;
- Appointed membership or choosing insurer;
- Existence of the highest and the lowest limits for the payers.
- The kinds of voluntary medical insurance are listed below:
- Substitutive, concluding or additional;
- Commercial or non-commercial insurers;

- Payment of the service by the individual or his/her employer;
- Registering the individual risks on area or group principles.

Private medical insurance also has several types. Private medical insurance can be person's only insurance payment form (substitutive insurance), services separate from state health care system can be fully or partly paid (concluding insurance), and finally, consumer's choice opportunities can be widened and access to the treatment improved.

In the area of protecting people's health the relations between the citizens and state bodies, thus the relations between the state and non-state health care entities and organizations are being regulated by the law of Azerbaijan Republic on "Protecting People's Health" (26 June, 1997). According to the law, the main principles of protecting people's health are:

- State guaranty on human and civil rights which are focused on the protection of

people's health and responsibility of legal and physical persons on this guaranty;

- Implementation of preventive measures for protecting people's health;
- Accessibility of social-medical aid for everyone;
- Social protection for citizens in case of lose of health.

In general, the health care system in Azerbaijan still keeps the features left from very centralized and inefficient planning system of Soviets time.

One of the distinguishing features of Soviet health care system was its comprehensive coverage of medical services. The USSR was the first country which indicated the right of all citizens to receive medical services free of charge in its Constitution. Obviously, citizens were not able to take full advantage of this right which was indicated in the Constitution: citizens had to pay themselves for separate expenses (for example, expenses for purchasing medicine and medical stuff) during the

treatment, but there were some concession groups (for example, children, pensioners, pregnant women, disabled people, veterans of war) identified and those groups were free of such kind of expenses. But in reality citizens still paid some un-official payments all the time.

Information on the scale and size of the unofficial payments is limited. As this payments are forbidden by law and are being paid illegally, its registration is very difficult task. Lack of transparency in this area doesn't allow the practical evaluation of its role in financial system. The legalization of unofficial payments requires some concession by the health care entities which will face the partial losses in their income and public support. The practices of the countries with low life standarts show that, the practical application opportunities of such initiatives depends on the national government's ability to regulate the health care and identify its priorities or limiting the scale of services provided.

Besides, the measures within the State Program on Social-economic Development of the Regions of Azerbaijan Republic for the 2009-2013 years to be implemented within the health care system, should guarantee the protection of population's health, the improvment on the quality of health care services and establishment of modern health care system in Azerbaijan. The main aim of state policy in the health care system consists of the following: to improve people's health, to prolong average life period, and to provide all layers of the population with quality health care services. In order to reach these goals, the main directions of the state policy on health care system are listed below:

- To widen and to improve the quality of free health care services, within the framework of state's financial resources;
- To prepare and implement action system for providing health care services to the part of the population with social disadvantages;

- To improve the maintenance of mothers' and childrens' nourishment and micro-nutritions;
- To improve the scale and the quality of medical-preventive measures;
- To plan the medical personnel training and to train family doctors in accordance with the demands of the health care sector;
- With the aim to improve the medicine and equipment supply of health care entities to establish medical industrial entities and to provide state support to their function;
- To build new health care entities in the regions;
- To establish geographical information system of health care sector for the whole country.

Insurance fees and payments in Azerbaijan

Insurance fees collected for the first half of 2009 totaled up to 79.89 million manat (table 2). But insurance payments were 24.65 million manat. Also for the first half of the 2009 insurance fees and payments were as following: life insurance fees 397.99 thousand manat, insurance payments 261.77 thousand manat; insurance fees for personal insurance 15,692.99 thousand manat, insurance payments 7 463,24 (medical insurance fees 12,805.82 thousand manat, insurance payments 6,171.84 thousand manat); compulsory insurance fees 14,354.47 thousand manat, insurance payments 5,772.65 thousand manat; property insurance fees 49,444.88 thousand manat, insurance payments 11,150.55 thousand manat; credit insurance fees 364.01 thousand manat, insurance payments 213.35 thousand manat; mixed financial risks insurance fees 5.23 thousand manat, insurance payments 0.00 manat; civil responsibility insurance fees 7,580.31

thousand manat, insurance payments 173.64 thousand manat. But in general, total insurance fees for 2008 were 179.26 million manat, insurance payments were 49.81 million manat. Insurance fees for medical insurance in 2008 year were 19,167.29 thousand manat, insurance payments were 11,143.17 thousand manat.

For the months January-February, 2009 medical insurance fees were 4,520.78 thousand manat, insurance payments were 1,739.72 thousand manat.

Table 2. Dynamics of Insurance Payments, million AZN

<i>Insurance types</i>	<i>2006</i>	<i>2007</i>	<i>growth, %</i>	<i>2008</i>	<i>growth, %</i>
Life Insurance	0.39	2.23	471.00	1.00	-55.15
Other Types	81.35	124.76	53.36	156.41	25.36
Social Insurance	6.59	21.01	218.81	21.84	3.80
Total	88.33	148.00	67.55	179.25	21.11

Source; Ministry of Finance, Azerbaijan, 2009

Let's look at the legal side of insurance-taxation relations. Insurance is a profitable type of business and in insurance process both insurance organization and insured person (both physical and legal persons) gains some income. Besides, insurance organization spends some amount for the reserve insurance funds and this belongs to regulation issues of the expenses deducted from the income according to the taxation legislation. One of the sides of this matter is to specify the income and identify to which income type it belongs to while insurance process. From other side, according to the Tax Code and international practice, drawing the insurance issue to the taxation and taxation abatement requires careful legal approach.

The taxation legislation is different for insurers from insured people. According to the article 99 of the Tax Code, the difference between the insurance payments and the payment paid by the insured on life saving insurance, or the insurance fees paid on behalf of that person is considered an income from non-paid or non- entrepreneurial activities. This income is taxable at the rate of 10% at the source of payment, according to the article 123 of the Tax Code.

For example, let's say insured person paid 2 million manat insurance fee to the insurance organization (insurer). Due to some kind of accident insured person has 3 million manat loss. According to the contract, insurer has accepted a responsibility of paying 5,5 million manat to the insured person. Insured person as a result of insurance payment gains 500 thousand manat of income. From that amount the organization which provides the insurance service, should deduct 50 thousand manat of tax and ensure its transfer to the budget.

The amount paid as a cash or in a natural form in case of insurance incident to substitute for the harm to the insurer's life, property and property benefits is free of income tax. Besides the appointed amount of insurance incident's harm, the received additional insurance payments are also free of profit tax. Obviously, to free the difference between the insurance payments and insurance fees from taxation has not been considered. As was mentioned earlier, that difference is subjected to taxation at the point of payment.

The national insurance market of Azerbaijan has started to develop since 1992. Before the insurance actions were under state monopoly and insurance issues were implemented only through one organization – State Insurance Agency. After becoming independent, in 1991 State Insurance Control was established near Azerbaijan Cabinet of Ministers. At the present time, many private local and foreign insurance companies are functioning in Azerbaijan. Their function is being regulated by the “Law on Insurance”. Before touching taxation issues let's review civil-legal aspects of insurance. In the Civil Code generally 2 forms of insurance are being mentioned: injury insurance and individual accident (life) insurance. Insurance contract is signed corresponding to the insurance object's main point. According to the damage insurance contract insurer takes a responsibility to pay for the damage to the property based on insurance fee within the agreed limit. According to the life insurance contract, in case becoming certain age, death, injuries or other insurance cases takes place with the insured person or other person mentioned in the contract insurer

takes a responsibility to pay this kind of payment at once or periodically.

In some systems' the right of using social medical insurance depends on the size of employment or membership fees. This might limit the access of unemployed people, elders, and also people with financial dependence to the medical services. That means that the income base of the social medical insurance depends on the membership fee's of the employed people. Therefore, the income for insurance is very limited in the countries with low employment. Not having social medical insurance as compulsory for all groups of employed population might have a negative effect on employers. Employers may employ at the rate below the minimum, or delegate this recruitment function to subcontractors that create vacancies in the shadow sector. This kind of practice is characteristic for Central and Eastern European and the Former USSR countries where social the medical insurance has just recently been applied. The employers who face with ineffective economical environment, deliberately decrease the salaries in an attempt of avoiding the social medical insurance fees.

Conclusion

The compulsory medical insurance system started in 1992, but the implementation is still not possible. The reason is not only the imperfect legislative base of compulsory medical insurance system. At the same time there is a high need for institutional improvements in this field. According to the analysis held above, the factors which prevent the application of compulsory medical insurance can be classified as below:

1. Incomplete legislative base. Even though law on medical insurance has been adopted in 1999 in Azerbaijan, there still are gaps in the legislation. The issues on how and by which entity compulsory medical insurance payments should be implemented, especially for unemployed citizens, have not yet been agreed upon.
2. One of the factors which affected the delays in the implementation of the reform is the presence of competition between the Ministry of Health Care and the Ministry of

Employment and Social Protection over the control of the Compulsory Medical Insurance System. Even though both of the state entities were trying to achieve the establishment of the State Agency on Compulsory Medical Insurance under their management, the agency was formed as a separate entity near the Cabinet of the Ministers and after that the support by the Ministry of Health Care to this reform sharply decreased.

3. Coordination of the policy on payments for health care services in the country. According to the decision of the Ministry of Health Care on February 1, 2008, in state hospitals medical service is free of charge. Besides, there are efforts on applying compulsory medical insurance in Azerbaijan. It is clear that, in the country where health care services are free of charge justifying the importance of compulsory medical insurance is not that easy.

4. Not being able to restore the function of Compulsory Medical Insurance Agency near the Cabinet of Ministers. Even though almost 2 years has passed since the signing of the document, but its statute has not been approved yet. Practically it is impossible for a agency which doesn't have a statute to control the insurance reforms.
5. Private insurance companies are not interested to work with medical insurance. At the present time, life insurance consists only small part of insurance contracts for whole country. Even though one of the main reasons for that is the low usage of life insurance among the population, another reason is that insurance companies are not interested to work with this type of insurance service. This has to do with that service's less profitability in Azerbaijan.
6. High corruption rate. High level of corruption and bribes in the hospitals does not allow the function of insurance reforms. In some cases, the hospitals do not accept

insurance documents and require illegal payments.

7. Hospitals are against of the application of compulsory medical insurance. The surveys held by the Center for Economic and Social Development (CESD) show that, majority of the doctors are not interested in the application of compulsory medical insurance and their main concern is that after the application of the mentioned reform the level of bribes will decrease and that means decrease in their income.
8. No relations between the medical insurance companies and hospitals. Still the relations between the insurance companies and state hospitals are not built up in a civilized level. Problems on acceptance of insurance documents at the hospitals are still present.
9. Absence of systematic reforms in this field. Despite the publicity given by the government on application of compulsory medical insurance system, the implementation of this issue is not observed.

This is due to lack of interest in application of compulsory medical insurance by some government entities.

10. Population's low information level on insurance service. Delays in the process are linked to the government's being cautious that the lack of public awareness may cause problems with implementation after the application of compulsory medical insurance.

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