



## Twinning Fiche

**Project title:** Strengthening mandatory health insurance mechanisms in Azerbaijan (Phase 2)

**Beneficiary administration:** State Agency on Mandatory Health Insurance (SAMHI), Republic of Azerbaijan

**Twinning Reference:** AZ/19/ENI/HE/01/21(AZ 58)

**Publication notice reference:** EuropeAid/173301/DD/ACT/AZ

**EU funded project**

***TWINNING TOOL***

## **1. Basic Information**

- 1.1 Programme:** Annual Action Programme 2019-2020 for Azerbaijan, Partnership Priorities Facility  
- CRIS number: ENI/2019/041 -968 – direct management

For UK applicants: Please be aware that following the entry into force of the EU-UK Withdrawal Agreement<sup>1</sup> on 1 February 2020 and in particular Articles 127(6), 137 and 138, the references to natural or legal persons residing or established in a Member State of the European Union and to goods originating from an eligible country, as defined under Regulation (EU) No 236/2014<sup>2</sup> and Annex IV of the ACP-EU Partnership Agreement<sup>3</sup>, are to be understood as including natural or legal persons residing or established in, and to goods originating from, the United Kingdom<sup>4</sup>. Those persons and goods are therefore eligible under this call”.

### **1.2 Twinning Sector:** Health and consumer protection

### **1.3. EU funded budget:** EUR 1,500,000

### **1.4 Sustainable Development Goals (SDGs):** Goal 3. Ensure healthy lives and promote well-being for all at all ages.

## **2. Objectives**

### **2.1 Overall Objective(s):**

To contribute to strengthening resilience of the national health sector in Azerbaijan.

### **2.2 Specific objective:**

To support the Government of Azerbaijan in improving quality, equality, efficiency and accessibility of health services in line with European best practices.

### **2.3 The elements targeted in strategic documents i.e. National Development Plan/Cooperation agreement/Association Agreement/Sector reform strategy and related Action Plans**

#### **EU-Azerbaijan Partnership and Cooperation Agreement (PCA) - Partnership Priorities**

The EU cooperates with Azerbaijan in the framework of the European Neighbourhood Policy (ENP) and its eastern regional dimension, the Eastern Partnership.

The framework for EU-Azerbaijan relations is based on the Partnership and Cooperation Agreement (PCA) in force since 1999. The EU-Azerbaijan Partnership and Cooperation Agreement enables gradual approximation of Azerbaijan's legislation and procedures with EU and international trade-related laws and standards. In February 2017, the EU and Azerbaijan began negotiations on a new framework agreement with Azerbaijan designed to give new impetus to political dialogue and mutually beneficial cooperation.

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<sup>1</sup> Agreement on the withdrawal of the United Kingdom of Great Britain and Northern Ireland from the European Union and the European Atomic Energy Community.

<sup>2</sup> Regulation (EU) No 236/2014 of the European Parliament and of the Council of 11 March 2014 laying down common rules and procedures for the implementation of the Union's instruments for financing external action.

<sup>3</sup> Annex IV to the ACP-EU Partnership Agreement, as revised by Decision 1/2014 of the ACP-EU Council of Ministers (OJ L196/40, 3.7.2014).

<sup>4</sup> Including the Overseas Countries and Territories having special relations with the United Kingdom, as laid down in Part Four and Annex II of the TFEU.

EU-Azerbaijan Partnership Priorities, which aim to focus cooperation on commonly identified shared objectives, have been endorsed by both sides on 28 September 2018. EU cooperation with Azerbaijan supports the country's reform agenda in particular in the areas of economic diversification, sustainable growth and social development, good governance and rule of law, and its connection with the EU through enhanced connectivity, mobility and people-to-people contacts.

Azerbaijan and the EU are committed to promote good governance and continuously improve the Azerbaijani public administration, including public service. The parties shall continue their efforts for the reform of public administration at all levels of government, including local authorities as well as public finance management. The cooperation aims to reinforce the accountability and effectiveness of aforementioned institutions as well as the transparency and efficiency of public service delivery based on best practices and by means that include widespread use of e-government.

### **EU – Azerbaijan Cooperation**

EU assistance to Azerbaijan aims at improving the quality of life of citizens from Azerbaijan in a tangible and visible manner, by supporting the policy objectives outlined in the Partnership Priorities. EU support is funded through the **European Neighbourhood Instrument (ENI)** for the period 2014-2020. The **Single Support Framework (SSF)** for EU support to Azerbaijan (2014-2017 and 2018 -2020) stipulates: “(...) despite progress made by the country in reducing poverty levels and advancing the reform agenda, social protection, education and health reforms must be continued to unlock Azerbaijan's full growth potential. Besides the "hardware", Azerbaijan needs to resolutely engage in the "software", i.e. human capital development.”

The objectives pursued by the **Multiannual Action Programme 2019-2020** to be financed under the ENI are to support Azerbaijan in the implementation of the recently concluded EU-Azerbaijan Partnership Priorities, a facility is setup allowing the EU to accompany the reform efforts undertaken by Azerbaijan in the four broad priority sectors. In particular priority 1. Stronger Economy stands for: promoting non-oil sector development and the country's economic diversification through trade facilitation, tourism and Small and Medium-Sized Enterprises (SME) development, support to the digital, green and circular economy, **promoting social protection systems.**

### **Azerbaijan 2030: National Priorities for socio-economic development**

“Azerbaijan 2030: National Priorities for socio-economic development” approved by the Order of the President of the Republic of Azerbaijan dated February 2, 2021, highlights the healthy lifestyle of citizens as one of the main priorities for the country development in its paragraph 3.3: “**the longevity and healthy lifestyle of citizens** must be ensured. This is important for increasing the productive activity and social welfare of citizens. Health and longevity will depend directly on **the quality of the healthcare system** in the country. The share of quality healthcare services in the generation of national income should be increased by achieving high results in **the introduction of modern innovations in health**”.

### **Concept for Health Financing Reform and Introduction of Mandatory Health Insurance**

The Concept was approved by the Decree of the President of the Republic of Azerbaijan of 10 January 2008. The Concept identified the following main goals for health financing reform in the country:

- to create new economic principles for financing the health care system and improving population access to health care;
- to increase the quality of health care services through the more efficient use of public funds allocated to the health sector; and
- to improve population health and increase average life expectancy.

According to the Concept, the government is responsible for the free provision of services included in a state-guaranteed benefit package, while all other services have to be covered by citizens themselves.

### **EU COVID 19 Response**

Global events related to the COVID-19 pandemic have affected all countries in the world, with many experiencing signs of recession in late 2020. The forced quarantine regimes and economic downturns challenged or accelerated the downfall of governance systems, revealing long-standing structural problems.

The healthcare system was one of the hardest-hit areas. The year 2020 was supposed to be the year of significant reforms in the sector, with the government planning to move from the remnants of the Soviet financing system toward mandatory health insurance. For this purpose, the Administration of the Regional Medical Divisions (TABIB) was established under the State Agency for Mandatory Health Insurance (SAMHI), but plans were postponed to April 2021. The new emergency led to 35 hospitals being designated for treating COVID-19 cases. Despite the high capacity of beds (over 8000 of which 437 are in intensive care units with oxygen), by November of 2020, the number of infected reached over 300,000 people, which was far above available resources.

### **3. Description**

#### **3.1 Background and justification:**

All over the world countries are implementing pro-poor reforms to advance universal health coverage. The widespread trend to expand coverage resulted in the inclusion of the “achieving universal health coverage by 2030” target in the Sustainable Development Agenda.

During decades after gaining independence, the Azerbaijan health care system financing and organization used to continue to follow the Soviet Semashko model, a national-health-service-type system with centralized planning of resources and personnel, primarily public ownership of health care facilities, input-based allocation of funds, and no clear provider-purchaser split.

The healthcare system was highly centralized and main decisions were adopted at national level. The management of healthcare facilities was undertaken by the Ministry of Health until recently, when a new agency was established for administration of healthcare providers – the TABIB under the SAMHI, which inherited most administrative functions in the management of healthcare facilities at all levels of care. Local authorities and managers of healthcare facilities and institutions bear managerial responsibility for provision of health services at the subnational level. The current system generally consists of a set of primary, secondary and tertiary healthcare facilities. While tertiary level care is concentrated mainly in Baku, secondary level is located in all districts and cities across the country, and primary healthcare has the widest network, including medical/doctoral points in villages, ambulatories and polyclinics (child and adult). The substantial reduction in hospital care facilities and hospital beds, introduced in 2011-2012 as part of the optimization of healthcare infrastructure, immediately affected bed occupancy rates, which were significantly low before.

Thanks to growing oil revenues, Azerbaijan significantly increased public resources for health in the late 90's, resources that were used to renovate the health infrastructure and increase the number and availability of pharmaceutical products at no cost to the population. These efforts, however, had a limited impact on decreasing catastrophic health expenditure, and on improving access to health services.

Significant changes in the country's macroeconomic and fiscal environment allowed the Government to embark on reforms in the health care area and start to think about introducing a mandatory health insurance (MHI) scheme as a way to mobilize resources for the sector in a more efficient and equitable manner. The main objective for introducing a MHI scheme was to improve financial protection in case of illness and to provide access to quality healthcare services. This new MHI scheme could not only increase revenue collection, but also generate needed structural changes in the system by creating a single purchasing agency and by changing provider-payment mechanisms from line-item budgets to payments linked to outputs.

The Law on “Health Insurance” was adopted on 28 October 1999 (with last amendments dated 20 November 2020). Besides raising people's access to health care services, it also stipulated to prevent out-of-pocket payments within the system. But the successful transition into MHI highly depended on adequate mechanisms for the application of this new system, and these mechanisms had not been fully identified at the time of its adoption in 1999. These shortcomings resulted in the postponement of implementation of the law until 2005.

To facilitate reforms in this sector, a new public legal entity responsible for the development and implementation of the MHI scheme in Azerbaijan, the SAMHI was established by the Order of the President of the Republic of Azerbaijan dated 27 December 2007. The SAMHI changed its legal status to

become a public legal entity in accordance with Decree № 1125 dated 24 November 2016 of the President of the Republic of Azerbaijan.

The introduction of the MHI scheme required much preparation to ensure its success. Over a decade after its establishment, the SAMHI undertook preparatory works by building the legal and institutional foundation that would ensure the implementation of the MHI scheme. It was particularly important to define a package of services to which beneficiaries would be entitled and ensure that this package could be fully funded by the scheme. In the mid- 2010s, all preparatory works were completed. It was decided to test the MHI scheme in selected regions as a pilot project with the intention of gradually expanding the program throughout Azerbaijan. For the pilot project, an extensive list of services was included in the essential package to be financed by the MHI.

The pilot phase of the MHI scheme was been launched in two regions - Mingachevir and Yevlakh - in 2017 (Decree of the President of the Republic of Azerbaijan No. 1127 of 29 November 2016). A third pilot region – Aghdash – was added in 2018 (Decree of the President of the Republic of Azerbaijan No. 1830 of 16 February 2018). Up to 400 thousand people from the total of 10 million Azerbaijani residents were covered by the pilot.

It should be noted that the introduced MHI in the pilot regions did not foresee financing through health insurance contributions.

The preparation of the nationwide implementation of MHI in general and the piloting of the reform in particular received positive assessments from EU experts and officials as well as from other international development partners (WHO, WB). Positive pilot results together with the approval of a benefit package of medical services (specified below in the Annex 4) as well as a mandatory insurance premiums collection procedure (specified below) contributed to the start of the nationwide implementation of the MHI scheme.

In the first stage, implementation of MHI has been launched in 23 regions on 1 January 2020. In the second stage, 36 cities and regions joined the system on 1 January 2021. In the last stage, starting from 1 April 2021, the population of Baku, Sumgayit, Absheron, Khankendi, Gubadli, Zangilan and Shusha started to use a benefit package of MHI. Thus, since 2021 all insured persons who pay mandatory insurance premiums/ contributions have a right to use a benefit package of medical services.

### **State Agency for Mandatory Health Insurance (SAMHI)**

#### *Central Administration*

The State Agency for Mandatory Health Insurance is a public legal entity that implements MHI through accumulating revenues to finance medical services within the benefit package defined and acting as purchaser of these services. The Agency was established in accordance with Decree No. 1125 of the President of the Republic of Azerbaijan dated 24 November 2016. The Charter of the Agency was approved by with Decree No 1592 of 6 September 2017.

The Agency's goals are the following:

- To ensure implementation of the mandatory health insurance;
- To accumulate funds to finance medical services within the benefit package;
- To take measures to improve the quality of medical services and to ensure accessibility of these services to the public;
- To protect the rights and legal interests of the insured;
- To ensure the efficient spending of accumulated funds and making insurance payments on time.

The Agency key operating areas are the following:

- Participation in developing a single policy on MHI and ensuring implementation of this policy;
- Arranging MHI for the population and ensuring the financial sustainability of this MHI;
- Providing the population with equal conditions to use medical services as a part of MHI;
- Taking measures to improve the quality and efficiency of medical services in order to ensure accessibility of MHI for everyone and to protect the health of the population;
- Ensuring the further development of MHI.

To carry out its functions, the SAMHI is structured in a Central Administration consisting of 14 departments (see Annex 3), an Institution of Information Technologies and Innovations and 11 regional branches. Seven key departments at the SAMHI will be the main beneficiaries of this project (other departments will be indirect beneficiaries upon request):

- Finance Department;
- Strategic Analysis Department;
- Medical claims Department;
- Legal Department;
- IT and Innovations Office;
- International Cooperation Division;
- Marketing and PR Department.

### TABIB

The Administration of the Regional Medical Divisions (TABIB) under the SAMHI is a public legal entity established on 20 December 2018 (Decree of the President of the Republic of Azerbaijan No. 418). On 12 April 2019 the Cabinet of Ministers of the Republic of Azerbaijan adopted a decision to approve the list of healthcare facilities placed under the supervision of TABIB (see Annex 3). The decision became effective on 1 January 2020.

The main goal of TABIB is to ensure the provision of medical services at healthcare facilities placed under its supervision and to improve the quality of medical services. In general healthcare facilities have to comply with requirements of the MHI scheme.

### Regional Medical Divisions

The regional medical division is a group of medical facilities in the public health system subordinated to the TABIB in administrative territorial units.

Regional medical divisions have been approved by the SAMHI and classified by territorial administrative units on the basis of population size, geographical area, transport infrastructure, network and capabilities of medical facilities, the number of doctors and middle medical staff.

In total, 14 regional medical divisions have been established.

## **3.2 Ongoing reforms**

In recent years, Azerbaijan has taken many steps to improve its health sector, including enhancing the efficiency of healthcare, implementing infrastructure projects and applying effective policies aimed at increasing the transparency of the healthcare system in the country.

One of those projects is a transformation that will last over a decade. The MHI scheme which offers universal coverage and that is now being implemented nationwide, promises widespread change to the nation's administration of healthcare. Challenges remain, however, namely difficulties in accessing care, long waiting times, and shortages in staff, medicine and equipment – problems that have been exasperated amid the country's efforts to combat Covid-19.

As mentioned above, piloting of health financing reform in Azerbaijan started in 2017-2018 in three regions. For this reason, management and financing of central hospitals in pilot regions were transferred from the Ministry of Health (MoH) to SAMHI.

During the testing period, the following new tools were introduced:

- Financing of inpatient and specialized outpatient services according to the price list;
- Financing of primary health care per capita;
- Increase of public financing to cover actual costs of public health care provider;
- Zero tolerance to out of pocket payments;
- Program based financing of capital investment;
- Referral system for admissions and consultations of specialists;
- Increased autonomy of health care providers regarding HR management, public procurement, clinical protocols;
- Restructuring of small rural hospitals in to primary health care centres.

SAMHI took responsibility for the financing and strategic management of health care providers. At the same time, the following tools foreseen by the health financing reform strategy have not been tested during

the pilot phase:

- Health insurance contributions;
- Sizable legal co-payments;
- Integration of vertical (treatment of cancer, dialysis) programs into the mandatory health insurance scheme;
- Reimbursement of medicines provided by pharmacies.

The main results achieved in the pilot regions can be summarized as follows:

- Residents have almost no financial barriers to get services or receive a treatment in national health centers (e.g. invasive cardiology);
- The number of visits to doctors and admissions to hospitals increased by about 30 percent. The gap in consumption of services between Azerbaijan and standard levels in EU countries has been reduced;
- Productivity of health care personnel has significantly increased;
- Salaries of health care personnel in 2018 were almost two times higher than in 2016;
- The majority of the population in the pilot regions has trust in the health financing reform.

These positive results contributed to the start of discussions about the nationwide implementation of MHI in Azerbaijan. Intense consultations between SAMHI, MoH and the Ministry of Finance that had started in June 2018 continued until the end of November and culminated in the presidential decree of December 2018 on “Measures to Ensure Implementation of Mandatory Health Insurance in the Republic of Azerbaijan” and the decision of the Parliament to start the collection of MHI contributions on 1 January 2020.

The presidential decree stipulated that the SAMHI “will carry out preparatory works to ensure implementation of mandatory health insurance throughout the Republic of Azerbaijan from 2020” (according to the amendment dated 30 March 2020, “2020” has been replaced by “2021”). As noted above, the process actually started on 1 January 2020 in the first 23 regions with the nationwide implementation following as of 1 April 2021.

New health financing tools tested in the pilot regions were progressively implemented in all public healthcare providing facilities under TABIB.

Nationwide collection of MHI contributions started on 1 January 2021. Statistics show that in spite of all economic shortcomings (restrictions, partial lockdowns) due to Covid-19, collection levels of MHI contributions surpassed expectations. During the first quarter of 2021, the State Tax Service under the Ministry of Economy managed to collect AZN 112.3 million of MHI premiums (AZN 25.5 million higher than expected).

The Health Insurance Law of Azerbaijan was amended on 28 December 2018. The Law foresees universal coverage for all permanent residents of the country. Amendments to Article 4 of the Law of 3 March 2020 plan a phased application of MHI for the administrative-territorial units of the country in 2021.

### 3.3 Linked activities

#### EU Support

**The EU funded Twinning project ENPI 2017 /387-220 ‘Support to implementation of the mandatory health insurance system in Azerbaijan’** propagated good European practices on health care financing in Azerbaijan.

The duration of the project from 22 August 2017 to 21 August 2019 corresponded to the period of MHI piloting.

French, Lithuanian and Estonian short-term experts provided recommendations on health care policy development, contribution collection, basic benefit package, budgeting, pricing, contracting, reporting, remuneration of health care providers, and the development of IT systems. Recommendations of the project have contributed greatly to the quality of the design of the MHI system, the definition of the pilots, and the positive assessment of the health insurance reform by international organizations (especially WHO and UNICEF) and local stakeholders (e.g. medical universities).

The Twinning project was one of the factors that assured the decision of SAMHI to move from piloting

to the nationwide implementation of MHI.

**Support to the Government of Azerbaijan in the implementation of health financing reform and introduction of mandatory health insurance based on European best practices” SOCIEUX project (April –November 2016).**

SOCIEUX provided technical assistance to help Azerbaijan to create necessary conditions for introducing MHI and for implementing health financing reform.

**EU Resilience Facility for Azerbaijan Programme (AAP 2021)** foresees assistance to contribute to the modernisation of the primary health system in Azerbaijan, enhancing quality and access in line with European standards and practices. Expected result: National primary health system is aligned with World Health Organisation (WHO) recommendations and EU good practices. The Action will be indicatively implemented in 2023-2025.

Other donors

**The WB Health Sector Reform Project (2006 – 2012)** for Azerbaijan aimed to improve the overall stewardship and financing of Azerbaijan’s health care system and to enhance equitable access to the system. The quality of essential healthcare services in selected districts was to be improved in a fiscally responsible and sustainable manner.

As a result of the project, the government implemented the National Master Plan for rationalizing the health care network and the health care workforce across the country, improved the health care infrastructure in five selected pilot regions, developed key policy documents covering recommended reforms, improved medical education, established the certification of health care professionals, and undertook an initial assessment of health care financing and of introducing MHI. Some WB recommendations (e.g. performance-based remuneration of health care providers) have been integrated into the design of MHI piloting.

### **3.4 List of applicable *Union acquis*/standards/norms:**

The following EU legal texts are relevant to health insurance issues:

- Directive (EU) 2016/97 of the European Parliament and of the Council of 20 January 2016 on insurance distribution;
- Directive (EU) 2009/138/EC of the European Parliament and of the Council of 25 November 2009 on the taking-up and pursuit of the business of Insurance and Reinsurance (Solvency II);
- The ECJ Test-Achats decision outlawing premium differentiation based on gender (EC, 2011b) in the provision of insurance services;
- Directive 2011/24/EU on the application of patients’ rights in cross-border health care
- Commission Implementing Directive 2012/52/EU of 20 December 2012 laying down measures to facilitate the recognition of medical prescriptions issued in another Member State.

### **3.5 Components and results per component**

The Twinning project will build capacities and provide advisory assistance through activities structured under the following Mandatory Results:

**Mandatory Result 1: Legal and institutional frameworks of the MHI system are strengthened to ensure adequate, qualitative, preventive & curative health care to people**

**Sub-result 1.1** Institutional framework of MHI system improved to addresses the principles of universal coverage, solidarity, equity in provision of health care

**Sub-Result 1.2** Proposals for necessary amendments to the regulatory framework drafted and submitted for approval

**Sub-result 1.3:** Communication capacities improved

**Sub-result 1.4:** Operational capacities of the staff of SAMHI to implement MHI methodologies and procedures strengthened



**Short description:**

The nationwide implementation of the MHI scheme from 2021 has triggered a huge shift in the health care system. A number of legal and institutional novelties and tools has been implemented nationwide. The time needed for the well-functioning and perfection of these instruments according to good international practice is estimated at up to five years.

This component will improve legal and institutional capacities of SAMHI in enhancing policies based on principles of universal coverage, solidarity, and equity in provision of health care.

The legal and institutional framework was developed considering national experience, good international practice and advice of international experts. It is however difficult to foresee the full complexity of health care reform prior to nationwide rollout. The MHI system in Azerbaijan is going to evolve incrementally, thus analyzing fine tuning/upgrading of MHI primary and secondary legislation as well as strengthening institutional capacity of SAMHI will be needed.

Most of the secondary legislation was prepared to allow the implementation of MHI in 2020-2021. But there are some key issues not covered by the existing legislation. A number of secondary legislation acts will be amended/developed to solve/regulate the following issues (not exhausted list):

- requirements related to the benefit package;
- medicines coverage;
- multiple health insurance plans/double charge for health insurance;
- working/cooperation with private health providers;
- requirements for health institutions entitled to participate in MHI scheme.

This component will address the needs of SAMHI in building its capacity in financial management, upgrading its controlling system, management of health claims, budget formulation process at the national level as well as at hospital facilities, and in estimating the cost of healthcare services. A methodology for incremental upgrading of the Benefit Package will be developed according to financial, human and physical resources available in the country.

The capitation used for remunerating primary health care should incorporate the complexity of health care provision (single and group private practices, public polyclinics acting as legal entities and as units of public hospitals). Capitation methods will be developed reflecting a case mix of patients (e.g. age, health status, place of residency) and elements of performance-based remuneration, where promoting prevention would improve providers' performance.

The remuneration of provided MHI services has to contribute to an increase in cost-effectiveness, a reduction of inequalities in health, a reduction of poverty, and more transparency in the health sector. To achieve this, a system of strategic procurement of health care goods and services is to be developed and implemented. This component will assist SAMHI in defining the optimal scope and structure of contracted health services, and in negotiating annual and/or long-term contracts between SAMHI and providers.

Mechanisms to involve society as a third party to strengthen civil society organizations' (CSOs') monitoring of the nationwide implementation of the MHI system will be developed.

This component will also focus on developing a communication and outreach strategy defining communication activities within the SAMHI team, with mass media and community (beneficiaries), and with government, partners (medical institutions and health workers) and other stakeholders. The strategy should reflect the local context and identify relevant audiences. It should develop clear messages, communication channels, and foresee monitoring and budgeting.

Informing people about the implementation of MHI about its own activities are amongst main duties of SAMHI. In this context, strengthening the knowledge and skills of SAMHI's PR team in managing PR activities as well as in how to communicate on complex health insurance issues should be improved. Further support should be provided in how to define clear and effective communication messages, organizing PR events and in social media marketing. These activities are to contribute to greater transparency in the health and insurance sector, improve SAMHI reputation and provide trustworthy information on MHI to citizens.

## **Mandatory Result 2: Risk management, financial and medical audits, monitoring and evaluation systems are modernised through enhanced data collection, processing, control and reporting**

### **Short description:**

This component will focus on the modernization of risk management, financial and medical audit, and the monitoring and evaluation system currently in use at SAMHI.

The list of health indicators currently monitored by SAMHI will be reviewed and tailored/expanded according to best international practices (WHO health indicators, the European Core Health Indicators (ECHI)). The reporting and data collection system for each of remuneration mechanism (capitation, FFS, DRG, global budgeting) as well as general financial reports (e.g. balance sheet, income and profit statement) will be upgraded.

Key performance indicators (KPIs) for health insurance will be tailored according to the main objectives of MHI (accessibility, productivity, quality, cost-efficiency, equity). KPI development will follow the SMART principle (specific, measurable, achievable, relevant and time-bound).

A data dictionary for KPIs will be drafted to foster consensus at national level regarding the objectives of health financing reform and provide a standard monitoring and assessment methodology to all MHI actors (health care providers, SAMHI, regional and national public authorities, patient and professional organisations).

Methodologies for IT and claims management monitoring systems will be designed.

## **Mandatory Result 3: New actuarial models and forecasting methods in health insurance provisioning are developed**

### **Short description:**

This component will focus on building the capacity of SAMHI in developing actuarial models and forecasting methods in line with European policies and best practice.

Within the component macroeconomic and microsimulation/actuarial/forecasting models for infrastructure planning, optimal allocation of resources, balancing of health resources with health care needs will be developed.

## **Mandatory Result 4: Digitalisation of the MHI system is facilitated**

### **Short description:**

This component will facilitate the digitalization process of the MHI system. Within this component, comprehensive proposals have to be developed to improve the digital health care system on a web based platform. Technical specifications and case models including software and hardware requirements are to be defined and a database to develop an Enquiry Management System designed. Technical specifications including domain and hosting names (SSL protection), coding platforms, user interface, web-based platform, input data and analysis are also to be developed.

### **3.6 Means/input from the EU Member State Partner Administration(s)\***

The project will be implemented in the form of a Twinning contract between the Beneficiary Country and EU Member State(s). The implementation of the project requires one Project Leader (PL) with responsibility for the overall coordination of project activities and one Resident Twinning Adviser (RTA) to manage implementation of project activities, Component Leaders (CL) and pool of short-term experts within the limits of the budget. It is essential that the team has sufficiently broad expertise to cover all areas included in the project description.

The RTA will be supported by an assistant that will handle administrative arrangements for conferences, training, seminars, etc. including provision of interpreters and the ensuring of translations.

A full-time interpreter/translator may also be recruited in Azerbaijan and funded by the project. (S)he will perform most of the required interpretation/translation services. Additional interpretation may be procured and funded by the project under special circumstances such as simultaneous interpretation.

Proposals submitted by Member State shall be concise and focused on the strategy and methodology and an indicative timetable underpinning this, the administrative model suggested, the quality of the expertise to be mobilised and clearly show the administrative structure and capacity of the Member State entities. Proposals shall be detailed enough to respond adequately to the Twinning Fiche, but are not expected to contain a fully elaborated project. They shall contain enough detail about the strategy and methodology and indicate the sequencing and mention key activities during the implementation of the project to ensure the achievement of overall and specific objectives and mandatory results/outputs.

**The interested Member State(s) shall include in their proposal the CVs of the designated Project Leader (PL) and the Resident Twinning Advisor (RTA), as well as the CVs of the potentially designated Component Leaders-(CLs).**

The Twinning project will be implemented by close co-operation between the partners aiming to achieve the mandatory results in sustainable manner.

The set of proposed activities will be further developed with the Twinning partners when drafting the initial work plan and successive rolling work plan every three months, keeping in mind that the final list of activities will be decided in cooperation with the Twinning partner. The components are closely inter-linked and need to be sequenced accordingly

### **3.6.1 Profile and tasks of the PL:**

The Project Leader is expected to be an official or assimilated agent with a sufficient rank to ensure an operational dialogue at political level.

*Basic Skill Requirements:*

- University degree in public administration, public health, health economics or other relevant discipline or equivalent professional experience of 8 years in public administration, public health or other sectors relevant for this twinning;
- Minimum 3 years of specific experience, at a senior management level, in health care/health insurance sector in EU MS relevant national or regional administration;
- Very good spoken and written English (at least level 2 on a scale of 1 [excellent] to 5 [basic]).

*Assets:*

- Experience in EU funded project management, preferably twinning;
- Specific professional experience in the implementation of health care reforms.

*Tasks to be completed:*

- To supervise and coordinate the overall project preparation;
- To supervise, guide and monitor project implementation towards the timely achievement of the project results;
- To liaise with the Beneficiary Counterpart (BC) administration at the political level;
- To ensure timely availability of the expertise;
- To prepare the project progress report with the support of the RTA;
- To co-chair the project steering committees.

### **3.6.2 Profile and tasks of the RTA:**

The Resident Twinning Adviser will be based in Azerbaijan to provide full-time input and advice to the project for its entire duration. She/he will be in charge of the day-to-day project implementation and coordination of project activities according to a predetermined work plan and liaise with the RTA counterpart in Azerbaijan. (S)he should co-ordinate the project and have a certain level of understanding of all the components.

*Basic Skill Requirements:*

- University degree in health economics, public health, public administration or other relevant discipline or equivalent professional experience of 8 years in public health sector;

- Minimum 3 years of specific experience in health systems financing, health insurance or strategic purchasing of health services;
- Very good spoken and written English (at least level 2 on a scale of 1 [excellent] to 5 [basic]).

*Assets:*

- Experience in project management, preferably twinning;
- Experience in implementation of relevant EU legislation and EU instruments related to the project components.

*Tasks:*

- To coordinate and assure project implementation and implementation of all project activities;
- To prepare the initial and subsequent work plans and project progress reports, together with the PL;
- To assure the coherence and continuity of the successive inputs and the on-going progress;
- To coordinate the activities of all team members in line with the work plan;
- To assess continuously project progress to assure its timely implementation;
- To prepare material for regular monitoring and reporting;
- To liaise with MS and BC PLs and maintain regular contact with the BC RTA;
- To provide technical advice, support and assistance to the Beneficiary institution in the areas specified in the work plan;
- To liaise with the EUD Project Manager;
- To liaise with other relevant institutions in Azerbaijan and with other relevant projects.

### **3.6.3 Profile and tasks of Component Leaders (component 1-4):**

The Component Leaders will work in close cooperation with the RTA and the Beneficiary administration in order to meet the mandatory results. Their main task is to plan and coordinate activities under their respective areas of responsibility in collaboration with the partner institutions.

*Basic Skill Requirements:*

- University degree in relevant discipline or equivalent professional experience of 8 years in a sector relevant to the component of the twinning for which the candidate is proposed;
- Minimum 3 years of professional experience at an operational level in relevant MS health or health insurance administration or mandated body in a field relevant to the component for which the candidate is proposed;
- Very good spoken and written English (at least level 2 on a scale of 1 [excellent] to 5 [basic]).

*Assets:*

- Experience in capacity building and ideally twinning projects;
- Azerbaijani, Turkish or Russian language skills.

*Tasks:*

- To provide component coordination, guidance and monitoring in close cooperation with the BC component leader, RTA and RTA counterpart;
- Preparation of Terms of Reference (ToR) for short term expert missions relevant to their component and overseeing the implementation of STE missions;
- Continually monitor the achievement of objectives related to their component and comparing actual progress with the specified benchmarks and time-frame;
- Support the RTA in preparing the interim, quarterly and final reports related to their component;
- To provide practical expertise and technical advice, as well as coaching to the relevant staff in the Beneficiary administration for the execution of activities relevant to their project components;
- To analyse policies and practices in the thematic area relevant to the respective component;
- To support the drafting of action plans, training plans, studies;
- To prepare and conduct training programs, to facilitate stakeholders' dialog;
- To draft technical documents relevant to their component's results in close cooperation with the BC counterparts;
- To suggest improvements of relevant procedures and systems.

### 3.6.4 Profile and tasks of other short-term experts:

The STEs should be identified by the Project Leader/RTA and will be agreed with the Beneficiary Administration during the negotiation phase of the Twinning contract and following these indicative (but not exclusive) areas: health insurance, health law, health finance, health monitoring and evaluation, healthcare actuary, health forecasting, health claims, IT database and software development, PR.

#### *Basic Skill Requirements:*

- University degree or equivalent professional experience of 8 years;
- At least 3 years of professional experience in a respective field related to the purpose of the mission foreseen in the work plan;
- Very good spoken and written English (at least level 2 on a scale of 1 [excellent] to 5 [basic]).

#### *Assets:*

- Experience in delivering capacity building activities;
- Experience in providing inputs to policy documents, methodological guides and/or handbooks.

#### *Tasks:*

- To provide advice, expertise and/or coaching to the relevant staff of the Beneficiary administration for the execution of specified project activities;
- To plan and deliver capacity building activities (workshops, study tours, trainings);
- To suggest improvements of relevant procedures and systems including suggestions to the revision of regulatory framework;
- To provide support in drafting action plans and roadmaps;
- To report on the results of the missions;
- To liaise with RTA and BC counterparts.

## 4. Budget

Maximum budget available for the Twinning Grant: **EUR 1,500,000.00**

## 5. Implementation Arrangements

### 5.1 Implementing Agency responsible for tendering, contracting and accounting (AO/CFCE/PAO/European Union Delegation/Office):

The Delegation of the European Union to the Republic of Azerbaijan (EUD) in Baku, Azerbaijan will be responsible for the tendering, contracting, payments and financial reporting. EUD will work in close co-operation with the Beneficiary.

Address: Landmark III, 11th Floor, 90A, Nizami str.

AZ 1010 Baku, Republic of Azerbaijan

<http://eeas.europa.eu/delegations/azerbaijan>

The persons in charge of the project at the EUD are:

#### **Mr Victor BOJKOV**

Head of Cooperation

Tel. +994 12 497 20 63 (ext. 853)

[Victor.Bojkov@eeas.europa.eu](mailto:Victor.Bojkov@eeas.europa.eu)

#### **Ms Lucia DI TROIA**

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## 5.2 Institutional framework

The State Agency for Mandatory Health Insurance (SAMHI) is the central counterpart and beneficiary of the Twinning Project. However, the project will also extend assistance to other institutions, as specified in this fiche. Other Azerbaijani stakeholders for the implementation of the MHI scheme:

- Ministry of Health;
- Ministry of Finance;
- State Tax Service under the Ministry of Economy.

## 5.3 Counterparts in the Beneficiary administration:

*The PL and RTA counterparts will be staff of the Beneficiary administration and will be actively involved in the management and coordination of the project.*

### 5.3.1 Contact person:

**Mrs. Asmar Karimli**

*Senior Advisor. International Cooperation Division*

*170, L.Tolstoy str., Baku, Azerbaijan, AZ1000*

*Tel.: (012) 310 07 70 (2503)*

*Mobile: (+99451) 360 45 65*

*E-mail: [akarimli@its.gov.az](mailto:akarimli@its.gov.az)*

### 5.3.2 PL counterpart

**Mr. Ruslan Abdullayev**

*Head of International Cooperation Division*

*170, L.Tolstoy str., Baku, Azerbaijan, AZ1000*

*Tel.: (012) 310 07 70 (2501)*

*Mobile: (+99450) 645 03 03*

*E-mail: [rabdullayev@its.gov.az](mailto:rabdullayev@its.gov.az)*

### 5.3.3 RTA counterpart

**Mrs. Asmar Karimli**

*Senior Advisor. International Cooperation Division*

*170, L.Tolstoy str., Baku, Azerbaijan, AZ1000*

*Tel.: (012) 310 07 70 (2503)*

*Mobile: (+99451) 360 45 65*

*E-mail: [akarimli@its.gov.az](mailto:akarimli@its.gov.az)*

## 6. Duration of the project

Execution period of the project shall be **27 months** (24 months of implementation + 3 months closure period).

## 7. Management and reporting

### 7.1 Language

The official language of the project is the one used as contract language under the instrument (English). All formal communications regarding the project, including interim and final reports, shall be produced in the language of the contract.

### 7.2 Project Steering Committee

A project steering committee (PSC) shall oversee the implementation of the project. The main duties of the PSC include verification of the progress and achievements vis-à-vis the mandatory results/outputs chain (from mandatory results/outputs per component to impact), ensuring good coordination among the actors, finalising the interim reports and discuss the updated work plan. Other details concerning the establishment and functioning of the PSC are described in the Twinning Manual.

### 7.3 Reporting

All reports shall have a narrative section and a financial section. They shall include as a minimum the information detailed in section 5.5.2 (interim reports) and 5.5.3 (final report) of the Twinning Manual. Reports need to go beyond activities and inputs. Two types of reports are foreseen in the framework of Twinning: interim quarterly reports and final report. An interim quarterly report shall be presented for discussion at each meeting of the PSC. The narrative part shall primarily take stock of the progress and achievements *via-à-vis* the mandatory results and provide precise recommendations and corrective measures to be decided by in order to ensure the further progress.

## 8. Sustainability

The sustainability of the achievement of this project will be assured by the adoption of best practices and solutions at the system level. New policy directions and practices will be proposed by the project. In their development a participatory and facilitative approach will be used in order to create ownership of the process and the results. Involvement of all relevant stakeholders will assure that the developed policy options have adequate acceptance among national partners. Mechanisms for communication and dialog between the agencies and ministries introduced by the project are meant to be a lasting contribution of the project to the health insurance policy development in Azerbaijan.

The sustainability of the project results is dependent on the commitment of the Beneficiary administration. Sufficient number of personnel from the Beneficiary administration will be assigned to work in the implementation of the project. Capacity building of the staff will be reinforced by the development of handbooks and guidelines which will be translated in the local language. The training materials will be at the Beneficiary's disposal to multiply and/or scale up the training and/or to update it, should the need arise. Project interventions are meant to reach the level of management practices in the relevant institutions and every-day procedures which should ensure that the results of the project last beyond the project's timeframe.

## 9. Crosscutting issues (*equal opportunity, environment, climate etc...*)

Equal opportunity in the project will be assured in accordance with EU standards and equal opportunity policies. Equal treatment of women and men will be observed in the project staffing, implementation and management. In particular, attention to the equality principle will be given to the selection of personnel for training and capacity building activities.

*Relevant project information and all communication and visibility materials must be updated and approved by the EU Delegation through the EU's project communication database 'EUDIGITOOL'. All visibility and communication material will be kept up to date throughout the lifetime of the project. The use of the 'EUDIGITOOL' approval system is a mandatory requirement.*

## 10. Conditionality and sequencing

There is no conditionality set for this project as the external conditions for achieving the results of this intervention are present - Beneficiary has demonstrated a commitment in the development of this project.

## 11. Indicators for performance measurement

The indicators for measuring success of the project implementation are linked to the Mandatory Result Components that have been outlined above in the Section 3.5. The logical framework, including the indicators, will be revisited during the inception period of the project. The workplan which will be composed in collaboration with the MS and the SAMHI will further specify the indicators.

*The indicators of achievement for **Result 1: Legal and institutional frameworks of the MHI system are strengthened to ensure adequate, qualitative, preventive & curative health care to people***

***Sub-result 1.1 Institutional framework of MHI system improved to address the principles of universal coverage, solidarity, equity in provision of health care:***

- Assessment report of the nationwide implementation of MHI policies and practices with the list of recommendations for their enhancement
- Number of policy papers/ methodologies on institutional framework drafted and put in use of MHI scheme
- Number of new medical services included to the Benefit Package of MHI drafted and put in use
- Number of mechanisms for involvement of society as a 3rd party to strengthen CSOs monitoring of nationwide implementation of MHI system
- New criteria for selection of private healthcare providers;

***Sub-Result 1.2 Proposals for necessary amendments to the regulatory framework drafted and submitted for approval:***

- Number of amendments of regulatory framework drafted and submitted for approval

***Sub-result 1.3: Communication capacities improved:***

- Availability of a communication and outreach strategy.

***Sub-result 1.4 Operational capacities of the staff of SAMHI to implement MHI methodologies and procedures strengthened:***

- Proportion of financial management staff of SAMHI trained on International Financial Reporting Standards and ready to train the remaining part of financial managers at national and local level according to the ToT approach;
- Proportion of PR staff of SAMHI trained on new multimedia tools as well as new management methods of PR activities;
- Proportion of relevant staff of SAMHI trained on new claims management methodologies.

***The indicators of achievement for Result 2: Risk management, financial and medical audits, monitoring and evaluation systems are modernised through enhanced data collection, processing, control and reporting:***

- Number of seminars obtain knowledge on European practices and elements of risk management, financial and medical audit, monitoring and evaluation systems;
- A gap analysis report on risk management, financial and medical audit, monitoring and evaluation systems currently in use;
- Number of policy papers/ methodologies/guidelines drafted and put in use;
- Number of new monitored health indicators in line with best practices (WHO health indicators, the European Core Health Indicators (ECHI)) drafted and put in use;
- Number of upgraded reporting and data collection systems for each of remuneration mechanisms (including capitation, FFS, DRG, global budgeting) as well as general financial reports (including balance sheet, income and profit statement) drafted and put in use;
- Number of new performance indicators tailored according to main objectives of MHI (accessibility, productivity, quality, cost-efficiency) drafted and put in use;
- Proportion of strategic planning and audit staff of SAMHI trained on new risk management, financial and medical audit, monitoring and evaluation methods.

***The indicators of achievement for Result 3: New actuarial models and forecasting methods in health insurance provisioning are developed:***

- Number of seminars to familiarize with European practices and elements of actuarial models and forecasting methods;
- Number of new macroeconomic models adapted to health care system of Azerbaijan drafted and put in use;
- Number of developed and tested mathematical and economic analysis methods in determination of benefit package drafted and put in use;
- Number of policy papers/ methodologies drafted and put in use;
- Proportion of strategic planning staff of SAMHI trained on new actuarial models and forecasting methods.

***The indicators of achievement for Result 4: Digitalisation of the MHI system is facilitated:***



- Number of seminars to obtain knowledge on European practices and elements of the IT solutions in the health insurance systems;
- A comprehensive proposal on how to improve the digitalization of the health care system on a web based platform;
- Number of policy papers/ methodologies on IT aspects of MHI scheme drafted and put in use;
- Number of new IT solutions in MHI scheme drafted and put in use;
- Proportion of IT staff of SAMHI trained on new IT solutions in MHI system.

## **12. Facilities available**

The Beneficiary commits itself to deliver the following facilities:

- Adequately equipped office space for the RTA and the RTA's assistants for the entire duration of the secondment;
- Supply of the office room including access to computer, telephone, internet, printer, photocopier;
- Adequate conditions for the STEs/MTEs to perform their work while on mission;
- Suitable venues for the meetings and training sessions that will be held under the project;

The Beneficiary will also guarantee the availability of staff who will be involved during the twinning project implementation;

Full coordination and transparency is expected among all key players involved.

## **ANNEXES TO PROJECT FICHE**

1. Simplified Logical Framework
2. List of existing legislation
3. SAMHI structure
4. MHI scheme in Azerbaijan

## Annex 1 Simplified Logical Framework

	Description	Indicators (with relevant baseline and target data)	Sources of verification	Risks	Assumptions (external to project)
<b>Overall Objective</b>	To contribute to strengthening resilience of the national health sector in Azerbaijan.	<ul style="list-style-type: none"> <li>• Number of people covered by health insurance or a public health system per 1,000 population [SDG 3.8.2] <b>Baseline:</b> N/A <b>Target:</b> All individuals (except prisoners and mandatory military servicemen) 2025</li> <li>• Coverage of essential health services/ Universal health coverage service index [SDG 3.8.1] <b>Baseline:</b> 65 (2017) <b>Target:</b> 75 (2025)</li> </ul>	<ul style="list-style-type: none"> <li>• World Bank Global Monitoring reports</li> <li>• WHO statistics</li> <li>• National statistics</li> <li>• Annual reporting of SAMHI</li> </ul>		
<b>Specific (Project) Objective(s)</b>	To support the Government of Azerbaijan in improvement quality, equality, efficiency and accessibility of health services in line with European best practices.	<ul style="list-style-type: none"> <li>• Proportion of total government spending on health <b>Baseline: 2018</b> 26% of all healthcare expenditure covered by state budget; 86% by people (out of pocket payments) <b>Target: 2025</b> 45% of all healthcare expenditure covered by state budget; 55% by</li> </ul>	<ul style="list-style-type: none"> <li>• World Bank Global Monitoring reports</li> <li>• WHO statistics</li> <li>• National statistics</li> <li>• Annual reporting of SAMHI</li> </ul>	<p>Resistance among providers/ recipients to the introduction of MHI scheme</p> <p>Financial and human Resources allocated by SAMHI insufficient to develop the foreseen</p>	<p>The Government remains committed to nationwide implementation of MHI scheme</p> <p>Adequate financial and human resources made available to SAMHI for nationwide implementation of MHI scheme</p> <p>Possible institutional</p>

		<p>people (out of pocket payment)</p> <ul style="list-style-type: none"> <li>•Number of targeted individuals newly registered as participant in the health insurance system</li> </ul> <p><b>Baseline:</b> N/A (2019)  <b>Target:</b> All the individuals meeting criteria for MHI (2025)</p> <ul style="list-style-type: none"> <li>•MHI contributions collection level (as % of expectations)</li> </ul> <p><b>Baseline:</b> N/A (2019)  <b>Target:</b> 75% (2025)</p> <ul style="list-style-type: none"> <li>•Staffing by area (nurses, general practitioners, specialists etc)</li> </ul> <p><b>Baseline: 2018</b></p> <ul style="list-style-type: none"> <li>•Number of doctors per 1,000 people - 3.3</li> <li>•Number of nurses per 1,000 people - 5.6</li> </ul> <p><b>Target: 2025</b></p> <ul style="list-style-type: none"> <li>•Number of doctors per 1,000 people - 4.5</li> <li>•Number of nurses per 1,000 people - 6.8</li> </ul> <ul style="list-style-type: none"> <li>•Indicators on health care resources (hospital beds, occupancy rates, length of</li> </ul>		<p>activities</p> <p>Lack of commitment from the managers/high level decision-making of the beneficiary institutions and relevant personnel to participate in the activities of the project</p> <p>Difficulty in mobilizing project's RTA and short-term experts due to COVID pandemic</p> <p>Slower processes as a result of Working From Home (WFH) measures</p>	<p>changes do not affect the existing roles and responsibilities of related institutions</p> <p>SAMHI retains its key staff who possess relevant knowledge, competences and skills to continue working on the MHI system</p> <p>Capacity of beneficiary is sufficient to absorb the projects results</p>
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		stay) in levels and per capita <b>Baseline: 2018</b> - Hospital beds per 1,000 people - 4.5 - Bed occupancy rate 45% - Average length of stay 10 days <b>Target: 2025</b> - 5 beds per 1,000 people - bed occupancy rate 75% - Average length of stay 7.5 days			
Mandatory results	<b>Result 1: Legal and institutional frameworks of the MHI system are strengthened to ensure adequate, qualitative, preventive &amp; curative health care to people</b>				
	Sub-result 1.1 Institutional framework of MHI system improved to addresses the principles of universal coverage, solidarity, equity in provision of health care	<ul style="list-style-type: none"> <li>Assessment report of the nationwide implementation of MHI policies and practices with the list of recommendations for their enhancement</li> </ul> <b>Baseline:</b> non-available <b>Target:</b> assessment report developed <ul style="list-style-type: none"> <li>Number of policy papers/ methodologies on institutional framework drafted and put in use of MHI scheme</li> </ul> <b>Baseline:</b> 0 <b>Target:</b> At least 5 documents <ul style="list-style-type: none"> <li>Number of new medical services included to the Benefit Package of MHI drafted (at least 450) and put in use</li> </ul>	<ul style="list-style-type: none"> <li>Assessment report</li> <li>Policy documents</li> <li>Updated Benefit Package</li> <li>List and description of new mechanisms and criteria</li> <li>Mission reports</li> </ul>	Lack of commitment from the managers/ high level decision-making of the beneficiary institutions and relevant personnel to participate in the activities of the project  Unavailability of qualified staff and funds for the implementation of the proposal may jeopardize the job done by the experts  Change of SAMHI	Commitment of SAMHI and involvement of all relevant stakeholders in the process  SAMHI establishes appropriate cooperation and information exchange links with other relevant institutions (e.g. Ministry of Health, State Tax Service, private healthcare providers, etc.)  Strong involvement and commitment of SAMHI staff at all levels

		<p><b>Baseline:</b> 2,550 (2019) <b>Target:</b> 3,000 services (2025)</p> <ul style="list-style-type: none"> <li>•Number of mechanisms for involvement of society as a 3rd party to strengthen CSOs monitoring of nationwide implementation of MHI system <b>Baseline:</b> 0 <b>Target:</b> Minimum 1 mechanism</li> <li>•New criteria for selection of private healthcare providers <b>Baseline:</b> 0 <b>Target:</b> Minimum 1 criterion</li> </ul>		<p>staffing (loss of staff, or high staff turnover)</p>	<p>Sufficient staff at SAMHI in terms of qualification, quantity and availability</p> <p>Coordination between departments and institutions connected with the Project is ensured</p> <p>Access to indispensable information and documents is ensured</p> <p>Required data are available</p>
	<p>Sub-Result 1.2 Proposals for necessary amendments to the regulatory framework drafted and submitted for approval</p>	<ul style="list-style-type: none"> <li>•Number of amendments of regulatory framework drafted and submitted for approval <b>Baseline:</b> 0 <b>Target:</b> Minimum 5 amendments</li> </ul>	<ul style="list-style-type: none"> <li>• List and text of regulatory amendments</li> <li>• Mission reports</li> </ul>	<p>Lack of commitment from the managers/ high level decision-making of the beneficiary institutions and relevant personnel to participate in the activities of the project</p> <p>Unavailability of qualified staff and funds for the implementation of the proposal may jeopardize the job done by the experts</p>	<p>Commitment from lawmakers to reviewing and improving legislation to enable direct support measures to be adopted</p> <p>Access to indispensable information and documents is ensured</p> <p>Required data are available</p>

				Change of SAMHI staffing (loss of staff, or high staff turnover)	
	Sub-result 1.3: Communication capacities improved	<ul style="list-style-type: none"> <li>• Availability of a communication and outreach strategy</li> </ul> <p><b>Baseline:</b> non-available <b>Target:</b> communication and outreach strategy developed</p>	<ul style="list-style-type: none"> <li>• Strategy paper</li> <li>• Mission reports</li> </ul>	<p>Lack of commitment from the managers/ high level decision-making of the beneficiary institutions and relevant personnel to participate in the activities of the project</p> <p>Unavailability of qualified staff and funds for the implementation of the proposal may jeopardize the job done by the experts</p>	<p>Capacity of beneficiary is sufficient to absorb the projects results</p> <p>Access to indispensable information and documents is ensured</p> <p>Required data are available</p>
	Sub-result 1.4 Operational capacities of the staff of SAMHI to implement MHI methodologies and procedures strengthened	<ul style="list-style-type: none"> <li>• Proportion of financial management staff of SAMHI trained on International Financial Reporting Standards and ready to train the remaining part of financial managers at national and local level according to the ToT approach</li> </ul> <p><b>Baseline:</b> 0 <b>Target:</b> 20% of financial management staff</p> <ul style="list-style-type: none"> <li>• Proportion of PR staff of SAMHI trained on new multimedia tools as well as new management methods of PR activities</li> </ul>	<ul style="list-style-type: none"> <li>• Training programs, training materials, attendance lists and reports</li> <li>• Mission reports</li> </ul>	<p>Difficulties in implementing training programmes</p> <p>Unavailability of qualified staff and funds for the implementation of the proposal may jeopardize the job done by the experts</p>	<p>Capacity of beneficiary is sufficient to absorb the training materials</p> <p>Access to indispensable information and documents is ensured</p> <p>Required data are available</p>

		<p><b>Baseline:</b> 0 <b>Target:</b> 75% of PR staff</p> <ul style="list-style-type: none"> <li>Proportion of relevant staff of SAMHI trained on new claims management methodologies</li> </ul> <p><b>Baseline:</b> 0 <b>Target:</b> 75% of relevant staff of SAMHI</p>			
	<p><b>Result 2: Risk management, financial and medical audits, monitoring and evaluation systems are modernised through enhanced data collection, processing, control and reporting</b></p>	<ul style="list-style-type: none"> <li>Number of seminars to obtain knowledge on European practices and elements of risk management, financial and medical audit, monitoring and evaluation systems</li> </ul> <p><b>Baseline:</b> 0 <b>Target:</b> Minimum 2 seminars</p> <ul style="list-style-type: none"> <li>A gap analysis report on risk management, financial and medical audit, monitoring and evaluation systems currently in use</li> </ul> <p><b>Baseline:</b> non-available <b>Target:</b> gap analysis report developed</p> <ul style="list-style-type: none"> <li>Number of policy papers/ methodologies/guidelines drafted and put in use</li> </ul> <p><b>Baseline:</b> 0 <b>Target:</b> minimum 3 documents</p> <ul style="list-style-type: none"> <li>Number of new monitored health indicators in line with best practices (WHO health indicators, the European Core Health Indicators (ECHI)) drafted and put in use</li> </ul> <p><b>Baseline:</b> 0 <b>Target:</b> minimum 10 new indicators</p>	<ul style="list-style-type: none"> <li>Gap analysis report</li> <li>Policy documents</li> <li>List of new health indicators</li> <li>List of new performance indicators</li> <li>List of new upgraded reporting and data collection systems and financial reports</li> <li>Mission reports</li> </ul>	<p>Lack of commitment from the managers/ high level decision-making of the beneficiary institutions and relevant personnel to participate in the activities of the project</p> <p>Unavailability of qualified staff and funds for the implementation of the proposal may jeopardize the job done by the experts</p> <p>Change of SAMHI staffing (loss of staff, or high staff turnover)</p> <p>Difficulties in implementing training programmes</p>	<p>Commitment of SAMHI and involvement of all relevant stakeholders in the process</p> <p>Adequate resources made available to SAMHI to develop and implement new monitoring methods/plans</p> <p>Capacity of beneficiary is sufficient to absorb the projects results</p> <p>SAMHI establishes appropriate cooperation and information exchange links with other relevant institutions (e.g. Ministry of Health, State Tax Service, private health care providers, etc.)</p>

		<ul style="list-style-type: none"> <li>• Number of upgraded reporting and data collection systems for each of remuneration mechanisms (including capitation, FFS, DRG, global budgeting) as well as general financial reports (including balance sheet, income and profit statement) drafted and put in use <b>Baseline:</b> 0 <b>Target:</b> minimum 6 systems</li> <li>• Number of new performance indicators tailored according to main objectives of MHI (accessibility, productivity, quality, cost-efficiency) drafted and put in use <b>Baseline:</b> 0 <b>Target:</b> minimum 10 indicators</li> <li>• Proportion of strategic planning and audit staff of SAMHI trained on new risk management, financial and medical audit, monitoring and evaluation methods <b>Baseline:</b> 0 <b>Target:</b> 75% of strategic planning and audit staff</li> </ul>		Difficulties in implementing study tours	<p>Strong involvement and commitment of SAMHI staff at all levels</p> <p>Sufficient staff at SAMHI in terms of qualification, quantity and availability</p> <p>Coordination between departments and institutions connected with the Project is ensured</p> <p>Access to indispensable information and documents is ensured</p> <p>Required data are available</p>
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	<p><b><u>Result 3: New actuarial models and forecasting methods in health insurance provisioning are developed</u></b></p>	<ul style="list-style-type: none"> <li>• Number of seminars to obtain knowledge on European practices and elements of actuarial models and forecasting methods <b>Baseline:</b> 0 <b>Target:</b> Minimum 2 seminars</li> <li>• Number of new macroeconomic models adapted to health care system of Azerbaijan drafted and put in use <b>Baseline:</b> 0 <b>Target:</b> Minimum 2 models</li> <li>• Number of developed and tested mathematical and economic analysis methods in determination of benefit package drafted and put in use <b>Baseline:</b> 0 <b>Target:</b> Minimum 2 methods</li> <li>• Number of policy papers/ methodologies drafted and put in use <b>Baseline:</b> 0 <b>Target:</b> Minimum 3 documents</li> <li>• Proportion of strategic planning staff of SAMHI trained on new actuarial models and forecasting methods <b>Baseline:</b> 0 <b>Target:</b> 75% of strategic planning staff</li> </ul>	<ul style="list-style-type: none"> <li>• List of new macroeconomic models</li> <li>• List of new mathematical and economic analysis methods</li> <li>• Policy paper</li> <li>• Training programs, attendance lists and reports</li> <li>• Mission reports</li> </ul>	<p>Lack of commitment from the managers/ high level decision-making of the beneficiary institutions and relevant personnel to participate in the activities of the project</p> <p>Unavailability of qualified staff and funds for the implementation of the proposal may jeopardize the job done by the experts</p> <p>Change of SAMHI staffing (loss of staff, or high staff turnover)</p> <p>Difficulties in implementing training programmes</p> <p>Difficulties in implementing study tours</p>	<p>Commitment of SAMHI and involvement of all relevant stakeholders in the process</p> <p>Adequate resources made available to SAMHI to develop and implement new actuarial models and forecasting methods</p> <p>Capacity of beneficiary is sufficient to absorb the projects results</p> <p>SAMHI establishes appropriate cooperation and information exchange links with other relevant institutions (e.g. Ministry of Health, State Tax Service, private health care providers, etc.)</p> <p>Strong involvement and commitment of SAMHI staff at all levels</p> <p>Sufficient staff at SAMHI in terms of qualification, quantity and availability</p> <p>Coordination between departments and</p>
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					<p>institutions connected with the Project is ensured</p> <p>Access to indispensable information and documents is ensured</p> <p>Required data are available</p>
	<p><b>Result 4:</b> <b>Digitalisation of the MHI system is facilitated</b></p>	<ul style="list-style-type: none"> <li>• Number of seminars on best European practices on improvement of PACS and Emergency Medical Care in the Health Insurance System. <b>Baseline:</b> 0 <b>Target:</b> Minimum 5 seminars</li> <li>• A comprehensive proposal on how to improve the digitalization of the health care system on a web based platform <b>Baseline:</b> non-available <b>Target:</b> comprehensive proposal developed</li> <li>• Number of policy papers/ methodologies on IT aspects of MHI scheme drafted and put in use <b>Baseline:</b> 0 <b>Target:</b> Minimum 3 documents</li> <li>• Number of new IT solutions in MHI scheme drafted and put in use <b>Baseline:</b> 0 <b>Target:</b> Minimum 3 solutions</li> </ul>	<ul style="list-style-type: none"> <li>• Comprehensive proposal on digitalization</li> <li>• Policy documents</li> <li>• List of new IT solutions</li> <li>• Training programs, attendance lists and reports</li> <li>• Mission reports</li> </ul>	<p>Lack of commitment from the managers/ high level decision-making of the beneficiary institutions and relevant personnel to participate in the activities of the project</p> <p>Unavailability of qualified staff and funds for the implementation of the proposal may jeopardize the job done by the experts</p> <p>Change of SAMHI staffing (loss of staff, or high staff turnover)</p> <p>Difficulties in</p>	<p>Commitment of SAMHI and involvement of all relevant stakeholders in the process</p> <p>Adequate resources made available to SAMHI to implement new IT solutions</p> <p>Capacity of beneficiary is sufficient to absorb the projects results</p> <p>SAMHI establishes appropriate cooperation and information exchange links with other relevant institutions (e.g. Ministry of Health, State Tax Agency, private health care providers, etc.)</p>

		<ul style="list-style-type: none"> <li>• Proportion of IT staff of SAMHI trained on new IT solutions in MHI system and European practice in the field of IT Governance</li> </ul> <p><b>Baseline:</b> 0  <b>Target:</b> 75% of IT staff</p>		implementing training programmes	<p>Strong involvement and commitment of SAMHI staff at all levels</p> <p>Sufficient staff at SAMHI in terms of qualification, quantity and availability</p> <p>Coordination between departments and institutions connected with the Project is ensured</p> <p>Access to indispensable information and documents is ensured</p> <p>Required data are available</p>
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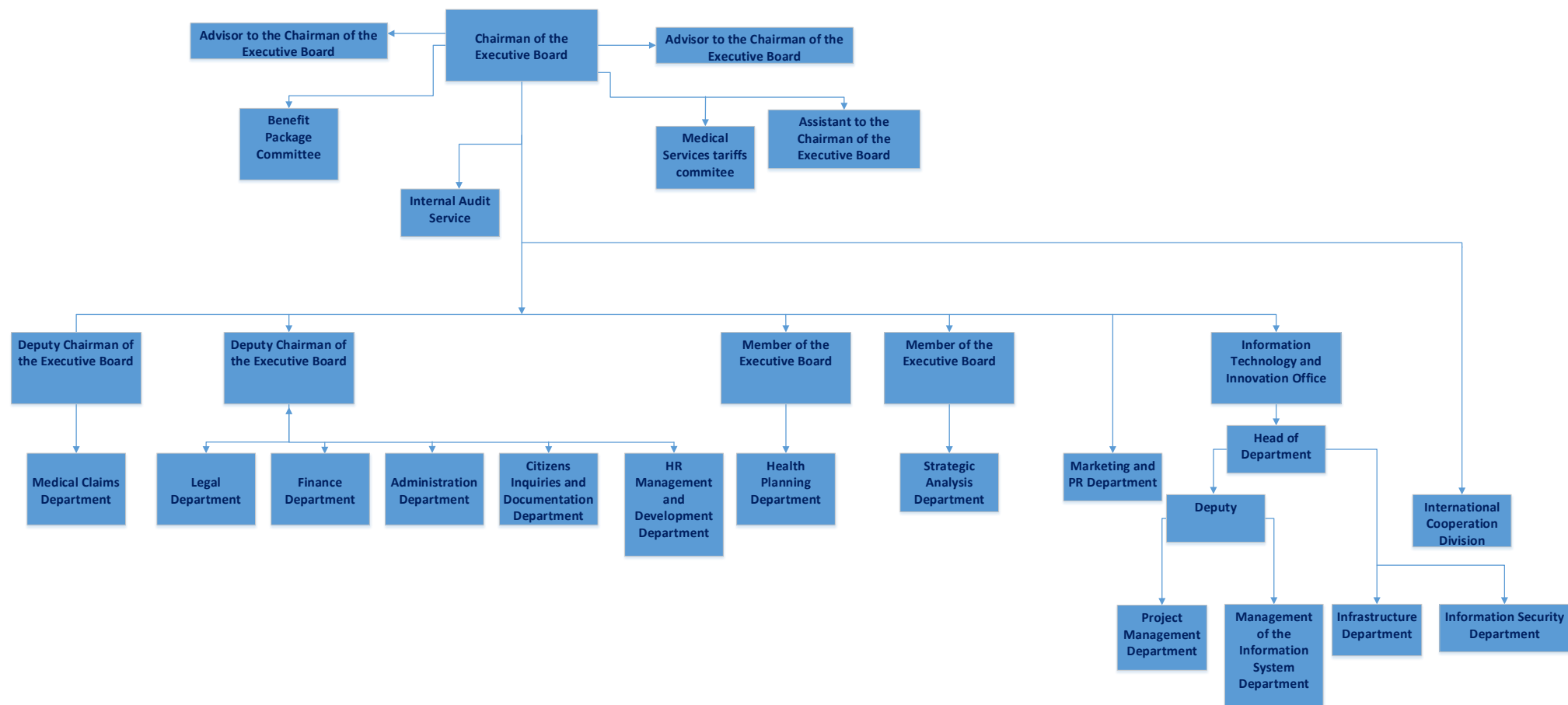


## **Annex 2: List of existing legislation**

There is substantial legal framework existing in Azerbaijan in the field of mandatory health insurance developed during 1999-2020. The main laws and by-laws adopted to regulate the sector are:

- “Law on Health insurance” of the Republic of Azerbaijan dated 28<sup>th</sup> October 1999. Last time amended on 20<sup>th</sup> November 2020;
- Order of the President of the Republic of Azerbaijan on “Establishing the State Agency on Mandatory Health Insurance under the Cabinet of Ministers of the Republic of Azerbaijan” dated 27<sup>th</sup> December 2007;
- Order of the President of the Republic of Azerbaijan on “Concept for Health Financing Reform and Introduction of Mandatory Health Insurance” dated 10<sup>th</sup> January 2008;
- Decision of the Cabinet of Ministers of the Republic of Azerbaijan on “Action plan for the implementation of the Concept for Health Financing Reform and Introduction of Mandatory Health Insurance for 2008-2012” dated 11<sup>th</sup> August 2008;
- Decree of the President of the Republic of Azerbaijan on “Approval of the Statute of the State Agency on Mandatory Health Insurance under the Republic of Azerbaijan and its structure” dated 15<sup>th</sup> February 2016.
- Decree of the President of the Republic of Azerbaijan on “Measures on implementation of mandatory health insurance as pilot project in the administrative regions of Yevlakh, Mingachevir and Aghdash” dated 29 November 2016. Last time amended on 10<sup>th</sup> May 2018.
- Decree of the President of the Republic of Azerbaijan on “Additional measures on implementation of mandatory health insurance as pilot project in the administrative regions of Yevlakh, Mingachevir and Aghdash” dated 28 December 2016. Last time amended on 10<sup>th</sup> May 2018.
- “Statute of the State Agency for Mandatory Health Insurance” approved by the Decree of the President of the Republic of Azerbaijan dated 6<sup>th</sup> September 2017. Last time amended on 7<sup>th</sup> February 2019
- Decree of the President of the Republic of Azerbaijan “Measures to Ensure Implementation of Mandatory Health Insurance in the Republic of Azerbaijan” dated 20<sup>th</sup> December 2020
- Decision of the Cabinet of Ministers of the Republic of Azerbaijan on “Approval of a benefit package” dated 10<sup>th</sup> January, 2020
- Resolution of the Cabinet of Ministers of the Republic of Azerbaijan "On approval of the Procedures of payment of insurance premiums in 2020 and in 2021 from the state budget for mandatory health insurance" dated 17<sup>th</sup> March, 2020

**Annex 3: SAMHI structure**



#### ***Annex 4: MHI scheme in Azerbaijan***

##### ***How to apply for medical services covered by the MHI scheme***

To apply for medical services covered by the MHI fund, insured persons (except for emergency medical care cases) should contact family doctors at their place of registration or residence. A family doctor gives a citizen a referral to a medical institution subordinated to TABIB under SAMHI where, after the necessary examination, the necessary treatment will be provided.

If medical services according to a medical indication comprised within the Service Package cannot be provided in medical institutions subordinated to the TABIB, these services can be provided on the basis of a referral in other medical institutions with whom SAMHI entered into a contractual relation.

If a citizen applies to a medical institution at the place of registration or residence for outpatient services without a family doctor's referral, he/she will have to pay AZN 5 (EUR 2.4) for each insured medical case.

If a citizen applies to a medical institution located outside the medical territorial department where he/she is registered for outpatient services without a family doctor's referral, he/she must pay AZN 15 (EUR 7.3) for each insured case.

If a citizen applies without a referral from a medical institution at the place of registration or residence for inpatient services to a medical institution located in another administrative territory, but inside a medical territorial department, for each insurance case the cost of which exceeds AZN 100 (EUR 48.8), he/she will have to pay AZN 30 (EUR 14.6).

If a citizen applies without a referral from a medical institution at the place of registration or residence for in-patient services to a medical institution located outside the medical territorial department, the cost of which exceeds AZN 100 (EUR 48.8), he/she will have to pay AZN 90 (EUR 43.9).

##### **Mandatory health insurance contribution payment scheme**

As part of state social insurance, the MHI system established certain obligations related to the payment of insurance fees and the submission of reports.

Categories of citizens obliged to pay health insurance fees include:

- Employees;
- Employers;
- physical persons engaged in entrepreneurial activity/individuals who are registered as taxpayers;
- physical persons implementing works (services) under civil-law contracts.

The amount to be paid as mandatory insurance premium was determined at different rates for different categories of taxpayers. Pursuant to the Law of the Republic of Azerbaijan “On Health Insurance”, from 1 January 2021, MHI premiums started to be collected from the above-mentioned category of citizens as follows:

- Two percent of the monthly payroll bill up to AZN 8,000 (EUR 3,902.4) and 0.5 percent of the monthly payroll bill over AZN 8,000 shall be paid by employers and employees.  
It should be noted that until 1 January 2022, a 50 percent discount is applied to the amount of insurance premiums to be paid by employers and employees working in the non-public and non-oil sectors with monthly salaries of up to AZN 8,000 (EUR 3,902.4).
- Four percent of the minimum monthly wage for individuals (individual entrepreneurs, private notaries, members of the Bar Association) registered as taxpayers under the Tax Code, except in cases of temporary suspension of entrepreneurial activity or other taxable operations. Currently the monthly minimum wage in the country is AZN 250 (EUR 122), therefore the monthly contributions for MHI makes up AZN 10 (EUR 4.9).
- Two percent of the monthly income up to AZN 8,000 (EUR 3,902.4) and one percent of the monthly income over AZN 8,000 for individuals performing works (services) on the basis of civil-law contracts.

MHI for the privileged segments of the population is paid from the state budget. Thus, the following groups of the population are exempt from paying mandatory health insurance if they do not work under a labour or civil law contract and are not engaged in entrepreneurial activities:

- persons under 18 years of age;
- persons under the age of 23 receiving vocational education, secondary special education or full-time education in higher education institutions;
- retired persons;
- unemployed persons
- persons entitled to receive social allowances;
- members of families receiving targeted state social assistance;
- pregnant women registered in territorial polyclinics and women's clinics, as well as women within 42 days after delivery, women on partially-paid social leave in accordance with the Labour Code.

Only citizens of the Republic of Azerbaijan have the right to receive these benefits.

It is expected that as of 1 January 2024 the retirees and unemployed persons will pay MHI premiums for the use of the MHI package. The relevant legal acts and mechanisms are to be developed and approved.

According to Resolution No. 98 of the Cabinet of Ministers of the Republic of Azerbaijan of 17 March 2020, "On approval of the Procedures of payment of insurance premiums in 2020 and in 2021 from the state budget for mandatory health insurance", MHI premiums will be paid from the state budget in 2020 and 2021.

The per capita amount of insurance premiums paid from the state budget is: AZN 90 (EUR 43.9) for administrative territorial units where mandatory health insurance has been introduced in January 2020; AZN 90 (EUR 43.9) + AZN 90 (EUR 43.9) multiplied by the consumer price index for administrative territorial units where MHI has been introduced since January 2021; and AZN 67.5 (EUR 32.9) + AZN 67.5 (EUR 32.9) multiplied by the consumer price index for administrative territorial units where MHI has been introduced since April 2021.

According to the Law of the Republic of Azerbaijan "On Health Insurance", the entire population is considered insured and has an equal right to use the medical services provided in the service package. The Law does not apply to:

- conscripts;
- accused persons in pre-trial detention centers;
- persons serving sentences in penitentiaries (excluding precinct-type penitentiaries);
- persons entering the country temporarily, residing temporarily and permanently in the country in accordance with the Migration Code, other than (i) foreigners and stateless persons who have received refugee status and are under the protection of the UN High Commissioner for Refugees in the Republic of Azerbaijan and (ii) foreign entrepreneurs or foreigners working in Azerbaijan under labour/civil law contracts paying mandatory health contributions.

MHI payments shall be made monthly and quarterly reports shall be submitted to the State Tax Service under the Ministry of Economy.

### ***Other sources of revenue collection for the MHI scheme***

Taxpayers engaged in the production and import of:

- gasoline, diesel fuel and liquefied gas have to pay MHI premiums equal to AZN 0.02 (EUR 0.01) per liter,
- alcoholic beverages, including beer (except for non-alcoholic beer) and other beer-containing beverages, cigars (thin cigars) and tobacco cigarettes and tobacco substitutes have to pay MHI premiums equal to certain percentage of the excise rate for 1000 units;
- energetic drinks have to pay MHI premiums equal to certain percentage of the excise rate for a liter.

### **Benefit package under the MHI system**

Decree No 5 of the Cabinet of Ministers of Azerbaijan dated 10 January 2020 defined the set of health services provided to insured person specifying the type, volume and conditions of service provision.

The package serves to improve health indicators of the population, increase the availability and quality of



medical services, increase the frequency of visits of the population to medical institutions and provide them with appropriate medical care for the early detection of diseases by strengthening primary health care (home examination, education on maintaining a healthy lifestyle, regularly collecting and rechecking data on the health status of the population).

The package of MHI services includes 2,550 different medical services such as:

- First aid and emergency medical care (including ambulance service);
- Primary healthcare (family physician/doctor);
- Outpatient services;
- Inpatient services (2550 services in total);
- Instrumental diagnostics and laboratory services (USI, CT, MRT, etc.);
- Physiotherapy;
- Pregnancy and delivery;
- Urgent vaccinations (anti-rabic, anti-tetanus, anti-snake venom, etc.);
- Child vaccinations;
- Surgeries (lifesaving and expensive medical services);
- Specialized continuing healthcare.

In addition, SAMHI has developed a proposal to amend the package of services to increase the number of medical services included in the package to 3,000.

Treatment of diseases widespread in the country with a high risk of disability and death is carried out through the provision of MHI. These services include therapeutic services for more than 3,500 diagnoses, such as myocardial infarction, stroke, coronary heart disease, heart failure and other cardiovascular diseases, gastrointestinal diseases, urological diseases, infectious and parasitic diseases, as well as injuries, burns, poisoning.

The package of services also covers more than 1,100 surgeries, including vital ones, which are of great importance for ensuring the health and material well-being of the population, such as cochlear implantation, joint replacement, coronary artery bypass grafting, replacement and repair of heart valves, aneurysm surgery, surgical treatment of congenital heart defects, and minimally invasive cardiac surgery (coronary stents). A wide range of expensive ophthalmic, trauma, urological, and neurosurgical surgeries are also included into the package.

Inpatient and emergency medications are also included in the package.

There are some exclusions not covered by the benefit package, such as for example medicines prescribed by a doctor for outpatient treatment not covered by the package.

To make the benefit package of MHI sustainable and fully funded by the scheme, a revision is to be carried out including (but not limited to) the development of a methodology for incremental upgrading of the package, defining criteria and procedures for inclusion and exclusion of medical services and medicine coverage in the package.

### General Indicators

One challenge facing the health sector is Azerbaijan's growing population which passed 10 million citizens in early 2019, and with a growth rate of 0.91 percent in 2020 Azerbaijan could see its population growing by another 1 million by 2036<sup>1</sup>.

According to the most recent World Bank data, in 2018 the average life expectancy in Azerbaijan is estimated at 72.9 years, or 75.3 years for women and 70.3 years for men. This constitutes an increase of almost two and half years from a decade prior. This means that along with a growing population, age-related diseases may become an increasing concern.

At the same time, both child and maternal mortality rates have decreased significantly over the last decade. The UN estimates that the infant mortality rate fell from 37 per 1000 live births in 2008 (11.4 by SSC) to 18.2 in 2019 (11 by SSC). Similarly, the maternal mortality rate per 100,000 live births dropped from 47 (37.6 by SSC) in 2000 to 26 in 2017 (14.9 in 2019 by SSC).

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<sup>1</sup> <https://worldpopulationreview.com/countries/azerbaijan-population>

### Total expenditures on healthcare

The table below illustrates the total government spending on healthcare during the 2017 to 2019 period. Private expenditure on healthcare is not included in these figures.

	2017	2018	2019
Total expenditures on healthcare	AZN 704.7 million	AZN 709.9 million	AZN 873.6 million
% of GDP	1	0.9	1.1
% of state budget	4	3.1	3.6

### Private health insurance

Private health insurance is voluntary in Azerbaijan, but it is nevertheless essential. Only a small percentage of Azerbaijanis purchase private health insurance. Typically, those who do work for major foreign enterprises, oil and gas or financial companies.

A passport or ID card is needed in support of an application. A health insurance package is usually valid for one year and covers both outpatient and inpatient services. The following treatments are usually covered depending on the package:

- Dental care;
- Hospital and ambulatory care;
- Maternity care;
- Medical emergency;
- Medicines;
- Occupational therapy.

A patient has a choice of doctors. An insurance company provides a list of private clinics and doctors as most private health insurance companies generally have contracts with private hospitals and clinics.

A doctor's prescription is needed to ensure that medicine will be covered by insurance. It is possible though to buy some medicines over-the-counter at pharmacies.

There is no legal framework or relevant mechanism to introduce multiple health insurance plans. This will be one of the challenges to be addressed by this project.