Evaluation of the Community Based Primary Health Care Programme in Azerbaijan

Full Report

Oxfam GB Programme Evaluation

August 2008

Commissioned by: Oxfam GB MEEECIS

Evaluators: Unknown

I Table of contents

Acknowledgements

We would like to thank very sincerely the staff at the Oxfam office in Azerbaijan and of the Care for Children/Healthy World NGO for their excellent support and counsel. We are particularly grateful to Sevinj, Ibrahim and Khumar for their insights and kind attention during the mission. Many thanks also to Gulnara and Marif for the outstanding logistic support.

II Executive summary

After the transition, Azerbaijan has suffered from decline in resources for health care and health outcomes. Despite the significant economic growth, the share of health expenditure from the total national budget dropped from 10% between 1995 and 2006. This resulted in a rapid decline in primary health care provision, in terms of access, coverage and quality. While staff numbers and facilities are comparable to the EU averages, rates of child and infant mortality are 16 times higher; and maternal mortality rates are 10 times higher than in the EU. The health care system in Azerbaijan remains highly centralised and characterized by inflexible management practices, ineffective financing mechanisms, poor health information and surveillance systems, and focused on curative services rather than primary care and prevention. There has been insufficient leadership and clear vision for the sector as well as corruption giving rise to informal practices. The current health sector reforms in Azerbaijan, implemented with the support of the World Bank, USAID, WHO and UNICEF, are aiming to decentralise the provision of health services to district level, but still do not reach poor rural remote communities. The government is designing a new health financing strategy involving the introduction of mandatory health insurance seeking to improve access to and the quality of health care.

Oxfam GB has been implementing the “Community based primary health care” programme in Central Azerbaijan since 2001 in partnership with Care for Children, currently covering 43 villages in Barda, Ter ter, Goranboy and Yevlakh districts, and funding is available until 2011. The programme seeks to improve the health of the population in rural communities through availability of first-line PHC at village level, and uses participatory approaches (management by Communities Health Committees). Members contribute US$1.20 per month, per family and receive out-patient consultations (including basic services as injections, blood pressure checks, simple blood and urine tests), PHC drugs and outreach activities. A total of 10% of community members, all pregnant women and children under one are exempted by the community on a rotational basis. Drug supplies come quarterly and are based on the health profile produced by each health post. The health posts are usually staffed by a doctor and a nurse who receive an incentive payment. Rehabilitation of the health post infra-structure and the supply of basic equipment are also part of the scheme activities. Funds are collected by

the appointed treasurer, and oversight of the funds at community level is performed by the village health committees. All 43 communities are represented in the Health Community Forum established in 2007 as a strategic management body. Currently funds contributed by members ($80,000) are not used to fund recurrent and capital items, before decisions on their most strategic use are taken. The rate of participation of the villages and their population is variable, dependant on context and their perception of what the benefits for their community are. The CBHI schemes can contribute to achieving the PRSP and MDGs, by informing advocacy and feeding into the agreed aims at national level, but this potential has been insufficiently realised.

Oxfam is considering further scaling-up of these schemes and linking it to the health financing reform led by the Ministry of Health and Azerbaijan Parliament. This evaluation aims to support this process by seeking to a) assess the role of key stakeholders in the schemes: community, government, NGOs, donors and others, and their interrelationships; explore how the CBHI can be scaled up in view of the national health system setup and what contextual factors could influence this process. It would also suggest a strategy for transition from local level small-scale financing and provision, to nation-wide engagement and advocacy. This case study included a review of relevant documents on community based health insurance and scaling up options; focus group discussions with community members (with and without insurance scheme); key informant interviews with a range of providers and stakeholders at local, district and national levels.

The study's findings suggest that there are a range of problems with financing and delivery of primary health care in rural Azerbaijan where there is a high proportion of internally displaced people including a lack of adequate infrastructure, appropriately trained, supervised and motivated staff, modern diagnostic equipment, laboratories, and drug supplies at community level. The services fail to address adequately both most prevalent chronic disease but also maternal, reproductive and child health, and preventive care. The problems of primary care reflected in the poorer than average health indicators are more severe than the norm for the former Soviet Union region, due to overall financing shortages, deprioritisation of rural areas and system inefficiencies e.g. poor resource allocation, misallocation and inefficient use of staff, lack of supervision and targeting of essential drugs.

Patients faced multiple barriers when seeking health care, including financial (unable to join the insurance schemes), information (lacks knowledge of what services are available/appropriate), poor quality (lack of drugs/tests), lack of trust in effectiveness of local services. The community financing schemes sought to primarily cover households for acute illness, and provide limited protection against the cost of prolonged chronic diseases. This results in patients seeking care for chronic conditions at district level at higher cost (transportation, fees, informal payments, gifts, voluntary official payments).

The unavailability and affordability of drugs at PHC level is a major problem as most government expenditure is for health workers salaries. Purchasing of drugs at district level subsidised by the state is not cost-effective due to inefficiencies and corruption. To cope with costs of care, users resorted to borrowing money, formal credit, selling essential assets such as livestock. Unaffordability of PHC is problematic given the high levels of poverty, deterring care or cutting expenditure on food and other basic items. Besides the decline in health care resources, there are structural health system inefficiencies including bias towards specialist and hospital care, resource allocation not matching the need, spending mainly on staff rather than other inputs such as drugs and equipment, inefficient use of highly-qualified staff, a lack of rational drug use. Hence, there is agreement that major reforms in the organisation and financing of PHC are needed.

There seemed to be good accountability of the CBHI model in terms of community involvement, acceptability and awareness of the main principles of CBHI. The schemes were also seen as transparent, flexible and responsive to local needs, while trust in the government institutions was low due to perceived corruption and inefficiency. At the community level, there is a strong preference for the schemes to remain voluntary, while at district and national levels the view is for a move towards compulsory insurance to improve risk pooling. The attitudes of different actors to the schemes very widely, with scheme members and community representatives being positive, and district level specialists being most hostile.

Factors reported by respondents to have influenced people's decision in taking part of the CBHI schemes ranged from economic status, the scope of benefits package (not catering sufficiently for chronic disease), availability of infrastructure, equipment and

drugs, and quality of PHC services, understanding of the benefits of insurance, not having to pay informal fees. Poor availability of drugs (e.g. for chronic conditions) is a major deterrent to participation in the scheme and cause high expenditure (for transport). Although there is a good level of satisfaction with the quality of the schemes, especially the care received, availability out of hours, limited availability of drugs and poor conditions in the facilities are problematic. Procedures for ensuring good quality care are often inadequate, and affected by poor system design, and poor collection and use of information about local needs, and clinical protocols are lacking. Increasing membership rates and PHC utilisation in rural areas would require investment in capacity, training, and change in population perceptions.

The CBHI schemes can be further developed in several areas according to the participants in the study: the benefit package should be expanded to cover chronic diseases (diabetes, asthma, cardio-vascular diseases, and mental health) reproductive/maternal health and selected secondary care interventions of high priority. There was also support for CBHI schemes offering choice of different levels of contribution and benefit packages, allowing some co-payments. Quality improvements (training, better infrastructure and drug supply outreach, improved scheme management) were seen as key to the scheme development. A key issue that is insufficiently recognised is the lack of clear guidelines and clinical protocols for treatment and prescribing, which reduce the opportunity to optimise care and shift tasks to lower-level cadres (e.g. standard protocols may enable an appropriately trained nurse to monitor diabetes patients at community level, with a regular review by a doctor, thus freeing up resources). The study authors identified the need for stronger linkages between the village health posts and higher levels of care in terms of diagnosis, referral systems, continuity of care, a shared care approach, particularly regarding the treatment of chronic illnesses. It was suggested that there is complementarity between the CBHI schemes run by Oxfam and the government reform plans, and Oxfam's experience could contribute to the design stage and piloting of the insurance model in the Northwest region.

Recommendations

Compatibility of CBPHC schemes with national plans for development of PHC and universal insurance

Our analysis identified a favourable context vis-à-vis the CBHI schemes and good scope for integrating or scaling up these with broader national plans. The current health financing reform and proposed implementation of social insurance in the context of economic growth presents a unique opportunity for Oxfam to promote the right of poor and vulnerable communities to essential health care and strengthen primary health, drawing on the lessons learned from the CBHI. Oxfam has a clear mandate by the communities (those choosing to have a CBHI scheme) and by the health professionals (those working in rural health posts) as a platform for advocacy around health financing systems that protect poor people. The study showed however that there is a lack of awareness at national level about the design and achievements of the Oxfam-supported financing model – such as ability to deliver essential first-line PHC and ensure basic drug distribution through accountable, locally managed and trusted insurance schemes, and encourage community participation, building local capacity and promoting solidarity. However, the low educational level of the population, economic vulnerability, the pervasive corruption and lack of trust in government institutions will present an obstacle to scaling up community financing.

Working towards this goal, we suggest that Oxfam should have a multi-faceted strategy of working at national, district and local levels, to build on the substantial experience amassed in supporting CBHI schemes, including:

- A major concern is expanding the benefits package to include chronic care, maternal and reproductive care and referrals to secondary care. Resources could be increased through expanding membership, attracting government subsidies (e.g. vertical disease programmes funds, or weighted per capita financing taking account of local needs), introducing a choice of different levels of contributions and respective packages. Another option is, to introduce direct payments for non-members, e.g. for drugs at the health post.
- Scaling up the CBHI schemes is dependent on improvements in quality of the services and the linkages between rural health posts and other levels of provision:

integrated care packages, shared care, patient follow-up. These require effective leadership and communication across the health system – this is an area where Oxfam can work with others to achieve progress in the medium and long-run. Oxfam could support evidence-based training of health care professionals jointly with national professional organisations and introduce incentives for implementing these.

- National advocacy by Oxfam and their partners can increase awareness of alternative financing models, increase support for the targeted subsidies for specific groups. Scaling up and improving sustainability of the CBHI schemes is a long-term objective, and in the short-term, subsidies by donors or governments are required.
- This should parallel activities at district level, that can involve working with individuals in key positions of power, such as head doctors and identifying 'change agents' that can bring up change.
- Oxfam should identify other donors and organisations supporting access to health care initiatives (including voluntary health insurance schemes), and initiate discussions on how to further develop such schemes in the context of health sector reform. One option is for the schemes to stay independent, providing an additional pillar of insurance (supplementary to the national insurance) or covering particular groups. This is consistent with the preference for a voluntary membership and retaining community ownership and accountability. Another option would be for the schemes to gradually form part of a national social insurance system seeking to cover informally employed and rural populations. The schemes can facilitate the financing reform, e.g. by creating a pluralistic provision, and allowing contracting out different types of providers. In any case, the CBHI scheme can be seen as a stepping stone rather than an aim in itself, to expand coverage through system-wide arrangements. In any case, CBHI schemes need to be coordinated with the rest of the official health system.
- Scaling-up the CBHI schemes should be balanced against maintaining local accountability. Mandatory membership may lead to an increased risk pooling and achieving efficiency gains, while voluntary membership and seeking to improve participation via other means (enhancing chronic care and maternal and child health service, creating several levels of contribution) appears to be popular in the short to medium term. However, as the implementation of the national mandatory health insurance proceeds and public perception change, there is a need for careful consideration as to whether membership remains voluntary. This would also depend

on whether the scheme will form part of the national social insurance model, or will remain independent from it.

- Developing the CBHI schemes require change in regulation, particularly with respect to the regulatory framework for purchasing and monitoring performance, task shifting and expand the role of the nurses and other auxiliary staff.
- Given the concerns about the governance and legitimacy of the government (lack of trust, perceptions of corruption and inefficiency etc.), a viable strategy would be to join or initiate coalitions, donor alliances around health sector improvement programmes, civil society forums around common aims (as in previous bullet). This would involve for example, participation in regular events and forums (donor coordination meetings/ annual conferences), publications in media.
- Advocacy at national level could be linked to health sector reform developments such as health financing reform, PRSP, reform of labour legislation, and broader strategies addressing poverty and vulnerability. The new health financing strategy could incorporate elements of the Oxfam's CBHI schemes, e.g. public control of public health spending and implementation of national insurance by community representatives. This requires proactive engagement with organisations and individuals that are working in these areas, e.g. the reform working groups.
- There should also be an effort to increase awareness internationally through publications, published reports, so that this can contribute to an external pressure on the government.
- Work at national level could be through a direct involvement in health sector reform processes, but also through promoting community development, accountability, good governance which would indirectly affect how health services are provided and financed. Oxfam could support a broader anti-corruption and good governance agenda with implications for the private sector – e.g. addressing informal payment for health care through improving local governance of the CBHI scheme (e.g. customer complaints procedures, sanctions etc.).
- Oxfam should also develop analysis of the political feasibility, and in case partnership between the government and voluntary sector is not feasible, it should link its 'right to health' advocacy to other, non-health political agendas.
- Opportunities to form public-private partnerships should be considered, especially to improve access to most needed and unaffordable drugs (determined in consultation with national level professional organisations, local practitioners, managers). This

can involve agreements with major state and private suppliers, working to improve procurements and distributions systems to achieve economies of scale and reduce drug costs. Contracting out of private suppliers through public institutions can also be explored. Cost savings can also be achieved through promoting rational drug prescribing and improved drug regulation. Oxfam can also lobby the government, donors, and the private sector to subside particular drugs for diseases that pose a high burden to the country, and improve drug regulation.

- There should be efforts to improve understanding of insurance, pathways to care, and patient rights among different population groups using a range of strategies.

Options for utilizing the accumulated funds

There are a range of views regarding the possible use of the accumulated funds since the set up of the scheme.

- Improving the infrastructure and the range of drugs available due to needs.
- Introduction of co-payments which was acceptable at community level, provided it ensures access to drugs that are high-demand and currently available only at district level.
- Providing loans or other means of payment for drugs (especially where income is seasonal) would improve availability.
- Non-members can be allowed to purchase drugs directly to the health post, and thus contribute to the resources available while having access to drugs that can be obtained at district level at a higher cost.
- Training of clinical staff and managers, in new skills, cost-effective and collaborative treatment models, and shared care models, which would improve quality and effectiveness of the schemes.
- Developing health prevention and promotion activities in the region, especially targeted to prevention of chronic diseases should be a key area of investment.
- Advocacy on PHC, for example lobbying for increases in funding levels. At sub-national levels (district and village stakeholders) it can be led by Health Community Forum, and at national level – by Oxfam and other organisations.
- The Health Community Forum can invest the money provided there is sufficient capacity and ensuring appropriate financial checks and balances are present to maintain trust and accountability. In the future, the functions of the forum can be

expanded, and it can become a regional umbrella organisation which manages the funds, purchases drugs, takes strategic decisions on scheme development, or can become an insurance fund within the national social insurance system.

- It would be beneficial to fund (or lobby for) in the long run improved standartisation of care – and focusing scarce resource on the most cost-effective, locally relevant treatment, using generic drugs. In the short run, updating and diversifying the skills of nurses and other mid-level providers (feldshers/ newly qualified doctors) to manage chronic illness (follow-up, supporting for self-care, appropriate referral), some maternal and reproductive health care should be prioritised.

We recommend that the question of sustainability needs to be discussed more broadly (as for how to expand PHC coverage, improve quality), as the CBHI schemes are one among many options for health care financing. Greater attention should be placed on rolling out the strengths of the schemes, such as community mobilisation, empowerment, and accountability, which should be built upon by the new health financing reform.

Strategy for CBHI transformation taking account of the contextual changes in Azerbaijan

There are several steps that can be taken in succession, or in parallel.

A. At a first stage the opportunities for development and scaling up of the schemes within the existing constraints should be explored. This may include efforts to expand the package of care in order to increase membership (outreach, referrals, better continuity of care between the primary and secondary care). This could be done through improved scheme design and implementation of effective information and communication at community level to increase awareness of the benefits of having insurance. Oxfam should conduct assessments of context and community attitudes to CBHI, prior to scheme expansion, implement campaigns and gain support of key people locally.

B. There is scope for improving the schemes per se. The schemes can benefit from a stronger accountability system, higher levels of community involvement, and a more flexible management approach. There are currently unrealistic expectation as to what care can be covered through the schemes. There should be a better awareness of community and stakeholders regarding the remit of CBHI operating through village

health posts, and its focus on primary health care, they do not have the capacity to deliver services beyond this level. However, given that chronic conditions such as diabetes and hypertension are highly prevalent and represent a significant burden, there should be effort to develop better linkages between the PHC services and the secondary and tertiary care services. This may include shared care approaches, involving strong referral systems, outreach visits of specialist and dispensing at village level of routine drugs for patients who require them, coordinated training of specialists working at different levels.

Increasing the scope of benefits provided under CBHI schemes and enhancing quality of care locally will require investment in human resources – in training, incentives, regulatory framework. There should be a shift from care provided by doctors, to care led by 'rural health teams' (mid-level staff, supervised by doctors). There should be formal evidence-based treatment and prescribing protocols. To develop effectively, the schemes will have to devise stable partnerships with district level government administration that could allow for these changes to be implemented, including providing support, improving capacity and joint activities.

C. Another stage would involve stepping up engagement at national level. As described above, Oxfam has a valuable contribution to make to the national agenda based on its grassroots experience. This includes the experience of running pro-poor cost effective PHC for vulnerable groups and ensuring meaningful community involvement and local accountability. The new health financing strategy led by the Government can incorporate elements of community mobilisation, participatory and flexible management, for example exercising public control through community participation and local monitoring of financial flows/expenditures. Health financing reform should take into account community views and attitudes, such as preference for voluntary rather than mandatory insurance, and resistance to risk pooling. Before initiating a more active engagement in policy, Oxfam needs to develop its vision for the health sector and choose a strategy which will guide all its interactions with other actors in the health sector. Oxfam also should engage with other donors to harmonise strategies and ensure that investment in systems is coordinated and strategic.

III. Background and methodology of the evaluation

1. Introduction and background

Azerbaijan is among the five countries in the world with the smallest annual expenditure on health as 4.2% of total government expenditure. Despite the significant economic growth, per capita public expenditure on health is $8, far below the required WHO standards[1]. It is smaller than per capita public expenditure on health in Sudan, Uzbekistan and Mali. Although, during the period 1995-2006 the absolute amount of health expenditure increased, its ratio as a percentage of the total national budget dropped from 10% in 1995 to 4.2% in 2006[2] resulting in a rapid decline in primary health care provision, in terms of access, coverage and quality.

Although per capita number of doctors and nurses in Azerbaijan is comparable to the average number in the EU, rates of child and infant mortality are 16 times higher; and maternal mortality rates are 10 times higher than the EU average[3]. (Statistics of the WHO Regional Office for Europe on Azerbaijan: Infant mortality rate (per 1 000 live births), 74.0 (2005); Under-5 mortality per 1000 live births, 91(2004); Maternal mortality ratio (per 100 000 live births), 94 (2005))

The health care system in Azerbaijan is characterised by a highly centralised and inflexible management culture, overstaffing, weak financial mechanisms, poor health information and surveillance and an excessive focus on hospitalisation and curative services rather than outpatient and preventive care. The current health sector reforms in Azerbaijan, implemented with the support of the World Bank, USAID, WHO and UNICEF, are aiming to decentralise the provision of health services. While this is commendable, reforms do not go beyond district level restructuring and leave poor rural remote communities out.

Oxfam GB has been implementing the “Community based primary health care” programme in Central Azerbaijan since 2001 in partnership with Care for Children. It is aimed to advocate for the Oxfam supported existing CBPHC schemes as a start to a

[1] *The World Health Report*, WHO, 2006, p. 186-189
[2] *Study on Health Financing in Azerbaijan*, ERC, 2006
[3] ibid, p.2

village health insurance scheme. The overall objective of the project is to contribute to the national efforts to improve the health of the population in rural communities through improvements in the provision of PHC services, with a participatory and right-based approach as well as to contribute to achieving the PRSP and MDGs aims throughout the country. Currently the programme is covering 39 villages in Barda, Ter ter, Goranboy and Yevlakh districts. Funding has been secured until 2011 and this year four villages have been added and a further district as well. The main components of the programme are:

- Strengthening of management and delivery of village PHC packages via Community Based Primary Health Care schemes established in the targeted villages;
- Increasing capacity of Communities Health Committees to manage the schemes;
- Advocacy and lobbying work with key decision makers from Ministry of Health and Azerbaijan Parliament.

Oxfam GB intends to suggest to the Ministry of Health and the Azerbaijan Parliament that Community Based Primary Health Care Schemes should be introduced as a preliminary step towards establishing a village health insurance scheme. Cooperation with the Reform Centre under the Ministry of Health will facilitate the advocacy process.

2. Aims, objectives and methods of this assessment

The aim of the evaluation is to help Oxfam to engage in policy work in the Primary Health Care Reforms by providing a clear proposition backed by evidence on the role of CBPHC in the various communities to be studied as well as in the national health care reforms.

The evaluation objectives are:

1. To assess the role of key stakeholders in the schemes: community, government, NGOs, donors and others. The evaluation will explain how the CBPHC schemes developed by OGB and partner is supported by different stakeholders in order to provide the PHC services which are accessible and affordable to the poorest people in remote areas.

2. To provide an overview of the contextual factors that could potentially influence the operation of the CBPHC scheme and its scaling-up, such as economic environment, primary health care financing, primary health care reform process, existing legislation and policy frameworks, etc.
3. To explore how the CBPHC schemes can be used in the development of the national village insurance scheme. More specifically, the evaluation will assess how the CBPHC scheme must be developed in order to comply with a national insurance scheme. It will also consider how the schemes can link to secondary and tertiary referral levels.
4. To recommend options for utilizing the premium community funds being accumulated since the set up of the scheme.
5. To recommend on model transformation in terms of reflecting/responding on contextual changes in Azerbaijan as regards the future development of the schemes. / Suggesting a sound strategy for CBPHC model transformation within the next four years in order to achieve this aim.

The methods for this qualitative case study include a general review of relevant documents on community based health insurance and scaling up options; focus group discussions with community members (both members and non-members of the scheme); key informant interviews with health providers at health posts and stakeholders at district (e.g. physicians and chiefs of district health authorities) and national (e.g. MoH, international organisations and NGOs) levels.

III. Findings from the qualitative research

3.1 The status of primary health care services in Azerbaijan: what are the key issues?

3.1.1 Problems with the organisation and delivery of PHC in rural areas

Based on the accounts of focus group participants and key informants, the study found that the organisation and delivery of PHC services face a number of challenges. These include: lack of adequate infrastructure (or in need of major rehabilitation), modern diagnostic equipment, laboratories, and drug supplies at community level. While the overall number of staff seemed not to be a problem, health workers lacked training and supervision and their salaries were reported to be very low. The situation is made worse due to the high burden imposed on health services by the refugee population from the Nagorno-Karabach region.

For instance, Yevlach district counts with 26 health posts, but according to the chief health doctor, only eight of them are in a good condition, in terms of infrastructure, drug availability and staffing.

Among the problems identified by the study respondents and listed above, insufficient drug supplies was reported by all those interviewed as being the most important difficulty faced at PHC level. In some areas, health workers stated that drug supplies tended to be limited to those received through the Oxfam schemes. Community members and health workers also noted in particular the lack of drugs for the treatment of chronic diseases, which are increasingly prevalent among the Azeri population.

Based on the information collected, we can conclude that Azerbaijan faces many of the problems reported in the rest of the former Soviet Union, however in rural areas the situation is considerably more severe than the norm for the region. This is reflected also in the poorer than average health indicators. The main problems found are due not only to deprioritisation of rural areas and insufficient financing, but also to disbalances in the health system and inefficiencies resulting in poor resource allocation, misallocation and inefficient use of staff, systems to ensure appropriate technologies and drugs are

provided to the rural population in accessible and cost effective ways. This will influence significantly what strategies are going to be selected. For example, an area where significant results can be achieved within the current financial and political constraints, is in improving human resource management (training, supervision and motivation) of front-line staff. Another key area is setting up systems to ensure access to appropriate secondary level care. For example this may include providing access to specialist care through outreach, use of shared care (teams of doctors and nurses working in different configurations) and task shifting (where certain tasks that are traditionally performed by doctors can be delegated to nurses or another level of cadre).

However, it is clear that the money in the system is also limited – as reflected in extremely poor conditions at the primary care facilities (even by Former Soviet Union (FSU) standards). One option is to seek to engage with other donors and ensure that efforts to invest in systems are coordinated, as there may be cases of inefficient and short-sighted investments that undermine rather than enhance each other. Efforts to harmonise strategies should be either at regional, or at national level – depending on where decisions are made.

3.1.2 The burden of disease in rural communities and service availability

In Azerbaijan, according to the WHO representative, cardiovascular diseases contribute to 63% of all mortality (WHO Rep). Diabetes was often mentioned by various key informants as being one of the main health problems in the country. Mental health was another chronic condition reported to be a problem rarely addressed at PHC.

According to an independent public policy expert, services have been organised with a view of treating the main chronic diseases affecting the population. At the same time health promotion and prevention activities tended to be neglected. In addition, maternal, reproductive and child health remain extremely problematic in terms of what could be expected given the level of income and lacked adequate services at PHC level as noted by the focus group of health workers, and policy makers and implementers interviewees.

In one of the districts, a health worker reported gastro-intestinal diseases as related to poor sanitation to be a considerable problem.

From the examination of national health indicators, WHO statistics, and data from this study, we can conclude that Azerbaijan occupies an intermediary position in terms of epidemiological transition, with increasing burden of chronic diseases but still high-level of infectious diseases in pockets of vulnerable populations. However, it should be noted that community financing schemes sought to primarily cover one-off events (acute illness episodes) and enhance financial protection to households among particular occupational and community groups. In many settings they expanded to cover not only acute illness episodes but became a comprehensive social insurance models under the active encouragement of authorities and in line with accelerated socio-economic development (e.g. Germany, Japan, more recently Thailand). By its design, community financing can provide limited protection against the cost of prolonged chronic diseases and is not suited to the complexities involved at this level of care. For example, an insured person with diabetes can have access to a local health posts, have diagnostic tests, and have a prescription of insulin and/or drugs, and be followed up (if the doctor or nurse working at the post are trained to do these services). However, in many cases the patient once diagnosed may develop complications or need preventive checkups (for foot ulcers, sight test, etc.) by specialists at hospital level – which may not be covered by the insurance scheme. Furthermore, the lack of linkages and information sharing between the primary care services (under the CBHI) and district-based primary or secondary care may complicate patient follow-up, may involve duplications of tests and services, increasing the cost to the patient and reduce adherence to treatment.

In summary, community-based financing schemes require re-evaluation in terms of fostering linkages and working within the rest of the official health system, rather than in parallel. Again, this requires negotiating procedures and systems of health care, flexible use of human resources to respond to need. It is also an option that the CBHI schemes can be expanded vertically – e.g. funding referrals for certain prevalent conditions, outreach by specialists, and other forms of collaboration with the mainstream health system. If the legal framework allows, it is possible to consider the use of ‘community health workers’ with a basic medical training (variant of nurses/ fedshers) that can provide simple monitoring, health education (for chronic and other diseases) and advise the patients on how to navigate the system and seek appropriate care. These are seen to improve outcomes in many low-income settings.

3.1.3 Barriers to accessing health care and coping strategies in rural Azerbaijan

As noted by the respondent groups, patients faced a number of barriers when attempting to access health care in the studied areas. The lack of appropriate services at PHC level compels patients to seek care at district hospitals. Yet, this represents additional costs for the patient or his/her family, mainly related to incurring transport costs to reach urban or peri-urban facilities.

Most interviewees reported lack of drugs as being one of the main reasons driving patients to seek care at district level. This was said to be because there are not sufficient stocks at health posts and often no pharmacy / drug stores at village level. Diagnostic tests and informal payments constitute other potential costs patients tend to incur when accessing care at district level.

The above represent concrete geographical and financial barriers to many patients who cannot afford these additional costs. For instance, as reported by a health worker, a patient usually pays 10 manats for transport to the district town to buy drugs which costs about 3 manats. This is a particular burden for the elders and refugees living in the area.

Patients attempting to access health care in rural Azerbaijan employed a number of coping strategies in order to pay for the costs of care they needed (focus groups respondents and key informants – mainly at district level and implementing agency). These included borrowing money from relatives, friends or neighbours; taking credits in financial institutions; selling essential assets such as livestock. These practices would take place not only for major health problems (e.g. a surgery) but also to purchase drugs for less serious conditions.

Various respondents described the lack of affordability for health care as a major problem given the high levels of poverty within the studied communities. According to community members and health workers many patients have either to forego health care or decrease expenditure on basic items such as food in order to pay for health services (often drugs). This contributes to a worsening of the economic status and or health condition of those affected.

Here, it is important to emphasise that barriers to effective care are multiple. While respondents referred mainly to geographical and financial barriers, our analysis showed that there are also barriers related to poor quality of care available in rural areas and information barriers (not knowing what services are appropriate for what conditions leading to overuse or underuse). Often there is also a lack of trust among the population in the skills of the local providers and their ability to provide effective treatment – as rural PHC providers have been traditionally bypassed, and people preferred to seek care at district level for all but the most basic services.

3.1.4 Financing of rural PHC in Azerbaijan

Historically PHC has been under-funded as resource allocation focused on secondary and tertiary levels (key informants). In certain districts the funding problem has worsened due to the presence of a sizeable refugee population. According to the chief health doctor of Barda, there are 40,000 registered refugees in the district and an equal number of unregistered ones.

Officially (as reported by key informants), budget allocations at district level are based on:

a) population size
b) number of beds
c) disease burden

However, as noted by some interviewees (implementing agency) when districts allocate funds to village health posts, they do not seem to take into account the burden of disease and the number of poor and vulnerable people within villages.

Government funding for PHC tended to cover mainly staff salaries. Other necessary inputs (e.g. drug supplies, rehabilitation, technical equipment) were reported to be severely under-funded (various key informants and focus group participants).

Informal out-of-pocket payments were reported to be a frequent practice in the country (various key informants and focus group respondents). However, since February 2008 a new directive from the MoH prohibited any charges for medical services in public facilities. Given that this evaluation took place in March 2008, it was difficult to assess any clear impact related to this new policy.

Many community members and doctors referred to these payments as gifts, as a sign of respect for the services provided. Health workers usually emphasised that they did not force patients to pay. They also highlighted that when they accepted the gifts offered by their patients this was justifiable in view of the very low salaries they received from government.

Most respondents tended to describe the practice of informal payments as a tradition in the country and less as corruption. Doctors tended to be particularly defensive about the use of the word corruption. Other respondents recognised the problem more openly, such as those involved in policy advice and implementation. One informant said: “It is a difficult problem to solve as this is seen as being part of the norm, of being the culture.”

In the villages where we conducted focus group discussions with community members and health workers there tended to be agreement that no patients were charged informal fees for health services - even though patients would voluntarily pay as a sign of their gratitude. Villages where the CBHI schemes are not being implemented may show a different result.

At hospital level, there were reports that patients were asked by doctors and nurses to pay informal fees. But at times community members described these payments as being voluntary.

The situation found is typical across the FSU region – with the shortage of funding compounded by inefficient resource allocation, e.g. a lack of weighted per capita allocation for health care, to take into account vulnerable and IDP population. There is also inefficient staff use – with a good number of highly-qualified staff rendering simple services that could be easily performed by a nurse or mid-level staff (after training).

Underfunding of drugs is endemic in the FSU region, and studies have shown a lack of rational drug use (e.g. preference for branded drugs), high mark-ups for commercial companies. Even the use of essential drug lists to restock the posts in the CBHI schemes is not a guarantee that the drugs will be appropriate to need or prescribed rationally. A study in Georgia and Armenia showed that in many cases drugs prescribed were duplicated and inappropriate to the diagnosis due to vested interests in the pharmaceutical sector. More work can be done on the creation of a short version of essential drug list (by professional associations, WHO – preferably agreed nationally), that can include drugs based on their effectiveness and realistic cost. One major area where CBHI can address to reduce costs drastically (as shown in the Armenia work and work in other countries) is on procurement and distribution of drugs – e.g. linking to national distributors in the public sector, providing training on rational drug use to staff working under the CBHI schemes, and campaigning for better drug regulation nationally.

Informal practices (informal payments, gifts, exchange of services) and their impact on the CBHI operation is not well understood. Clearly they may create perverse incentives – specialists at district level reluctant to 'lose' customers who can be treated locally, and such specialists may hamper the development of local PHC services. Short-term solutions are unlikely to work, as these are related to cultural expectation, traditional relationships between client and service provider, and it is very difficult to distinguish between solicited and unsolicited payments. Some authors have suggested that the existence of such practices does not relate to the way health services are financed and organised but to the governance in the wider society, namely whether there are explicit rules against corruption and whether these are enforced. Therefore, one option is to improve local governance of the CBHI scheme (e.g. customer complaints procedures for informal payments at local and district level, peer-review of treatment by professional bodies, sanctions for taking informal payments, or public advisory services where patients can take their cases and seek redress).

3.1.6 Quality of PHC

Members of the scheme and of the community (participating in the focus groups discussions) tended to be satisfied with the quality of PHC. The main areas of

satisfaction related to the care received from the health workers, including their availability out of hours for any emergency. In their view, the main barriers to quality improvements were the lack of drugs and the poor conditions of health facilities.

Quality within the CBHI schemes is monitored by the medical advisor (key informants – implementing agency). This includes reviewing patients' notes from all health posts and interviewing patients to assess quality of care and whether patients received the prescribed drugs.

Quality of care at village health posts is monitored through district hospital delegations (health workers participants in the focus group discussions). These usually take place two to three times a year. These delegations are meant to review documents, supervise care provided by health workers and identify the needs of health providers. However, as reported by some health workers, these visits tended to be very brief and often formal, without conducting in-depth evaluations.

Village health posts also provide monthly reports to central district hospitals on their health information (health workers participants in the focus group discussions). These include: number of pregnancies, births, deaths, chronic diseases, attendances and socio economic data.

However, according to a key informant, the health information system is not reliable. This is particularly the case for hospital data as funds are allocated on the basis of number and occupancy of beds. There is thus a tendency to manipulate statistics to increase bed occupancy and length of stay. Other statistics also vary considerably. For example there was said to be a nine times difference for child and maternal mortality data between the figures from the MoH and those from WHO (independent public policy expert).

Our analysis showed that many of the problems with quality, are related to a lack of consistent clinical protocols and logarithms, leading to considerable variability. This makes it difficult to monitor the quality of care. As in other parts of the region, provider practice is determined by what is learned during training, with very little further training or on-the-job support by senior level practitioners. A related issue is that of responsiveness

to users, monitoring local need and demand, and providing services in line with these. One area that can provide valuable improvement is to fund (or lobby for) in the long run improved standartisation of care – and focusing scarce resource on the most cost-effective, locally relevant treatment, using generic drugs. In the short run, updating and diversifying the skills of nurses and other mid-level providers (feldshers/ just qualified doctors) to manage chronic illness (follow-up of patients diagnosed with hypertension, supporting patients to monitor blood sugar, appropriate referral to prevent major complications), some maternal and reproductive health care (e.g. some of the ante-natal care visits). Again care can be provided in close cooperation with specialists – e.g. under shared care or triage schemes (e.g. district-based doctors working with nurses in health posts, providing support or authorising treatments by telephone, and reviewing personally particular cases or similar models).

3.1.7 Drug supply, procurement and regulation

Implementers, health workers, and patients consider the lack of drug supplies as one of the major problems in PHC. For instance, even though the government maintains a list of diabetic patients who are meant to receive regular supplies of insulin, this list is not sufficiently comprehensive to encompass all patients in need (various respondents). The cost of drugs is thus rationed by limiting the package of drugs sent to health posts.

As explained by the implementing agency and chief health doctors, drug procurement and purchasing takes place at district level. Districts subsequently distribute drug supplies to village health posts.

According to a key informant, purchased drugs are approximately 2 ½ times more expensive than needed. This is said to be due to inefficiencies and corruption. The same informant stated that about 50% of funds allocated to districts for the purchase of drugs like insulin are misused.

Our analysis show that there may be scope for greater participation of the private sector in procurement and distribution of drugs, for example, at village level. Drug availability as noted above was raised as a major problem for accessing health care by village and

district level informants. Patients not participating in the schemes or in need of drugs not available at the village health post have to travel long distances to purchase these. A question however is whether there would be sufficient market to attract private retailers to villages in rural areas of the country. Perhaps an area to be explored is public contracting of private providers, who are specialising in drug supply and may be able to achieve efficiency savings.

See also comments on page 15.

3.2 PHC reform

3.2.1 Need for PHC reform

The majority of respondents suggested that further reform of the organisation and financing of PHC were needed. These reforms would address a number of key problems as described below (based on the views of some national level key informants):

- The current system has been inherited from the soviet era and lacks clear policies, appropriate financing mechanisms and organisation aimed at PHC. While the health system was structured along rigid hierarchical lines of accountability, these were not always complied with in reality.
- At the national level there has been insufficient leadership and clear vision for the sector as a whole. Various organisations within government run their own health services as it was the case for the oil companies and the Ministry of Defence thus leading to a fragmented system.
- When the Soviet Union collapsed these problems were exacerbated as public funding for the health sector decreased and institutional linkages have been disrupted. Due to scarcity of resources, health workers salary consumed about 90% of the government budget, and the remaining 10% covered drugs, equipment and rehabilitation (independent public policy expert). Yet, health workers salaries tended to be two times lower than the average salary of state officials / civil servants often giving rise to informal practices to increase provider income. Lack of financial resources for PHC was also related to the misuse of funds allocated from the MoF through the ex-coms at the different levels (regional, district and municipal). According to a key informant about 2/3 of the budget was lost through corrupt practices. Access to PHC services was affected by these problems, most severely in

rural areas. In this context, physicians opted for jobs in district towns; patients self-referred themselves to districts due to low quality of services at village posts and or delayed seeking care.

3.2.2 The impact of recent PHC reform

Since independence although there were two large loans from the World Bank for health sector reforms, little changes seemed to have been seen at the frontline level of service. As put by a doctor in one of the districts, “I have not seen any health reforms in the past 20 years”. Community representatives also concurred to this in that they have not benefited from any changes at village and district levels.

3.2.3 Current PHC reform process

At present another health system reform project is ongoing (national level key informants). The government with the support of a large group of donors [World Bank, USAID (these two provide financial support), WHO, UNICEF, UNFPA (these three provide technical support)] is leading the process (national level key informants). Improvements in PHC are seen as one of the priority areas by the MoH (MoH official).

The government started a consultative process with key stakeholders’ (e.g. with the ministries of social and legal affairs) with a view of designing a new health financing strategy which includes the introduction of mandatory health insurance (various interviewees). The main goals of this new strategy include[4]: improving access to health care and the quality of health services and increasing allocative efficiency of public funds to the health sector.

A national insurance agency is to be established which will operate as the single purchaser of medical services on a contractual basis; and will also pool the major sources of funding for health (government budget, health insurance payments and other revenues) (MoH and WHO officials). This is in contrast to the current situation where approximately 25% of the budget is held by the Ministry of Health and 75% by the

[4] MoH, 2008. Concept for Health Care Reform in the Republic of Azerbaijan. Baku: Ministry of Health.

Ministry of Finance - each of these ministries allocates funds to the districts (MoH and WHO officials). After the reform, it is envisaged that the MoH will focus on the policy, stewardship and regulatory functions and the management of vertical programmes (e.g. GAVI, GFATM) (MoH and WHO officials).

The implementation timeline of this new strategy is a medium to long term one – five to ten years and therefore, a step by step approach is planned (MoH and WHO officials). District health authorities are participating in training workshops to get familiarised with the concept of health insurance (various key informants). The model will be tested first in one district and in the second phase it will be rolled out to the Northwest region encompassing five districts (MoH, WHO and World Bank officials).

Further elements of the new strategy include (MoH and WHO officials):

- The health budget allocation is to be based on a per capita system which include the following elements: demographic, epidemiological, socio-economic and etc (e.g. cost of service provision in remote areas).
- The benefit package to be offered by the mandatory health insurance scheme will be finalised upon completion of costing studies and the piloting in selected districts.

However, our analysis suggests that no in depth and large scale studies to investigate patterns of access and service utilisation, attitude towards health insurance, possible impact on informal strategies and other coping strategies, and related feasibility issues seemed to have been conducted or planned. This does not allow monitoring of change over time, and assessing the impact of reform on the health and socio-economic status of different groups.

Given the current reform objectives and identifying PHC and health care financing reform as priorities, it is essential that Oxfam has a proactive participation and increased visibility at national level. Oxfam should use the CBHI experience and the clear mandate by the communities (those choosing to have a CBHI scheme) and by the health professionals (those working in rural health posts and supporting the CBHI) as a platform for advocacy around health financing systems protect the poor people. There could be several steps towards increased participation at the national level:

- Oxfam should seek to increase awareness of the Oxfam experience in running community financing schemes with an empasis on the achievements such as increasing coverage, good level of local participation, responsiveness and locally valued services. (current awareness is low at national level).
- Oxfam may consider seeking alliances with other partners involved in supporting CBHI and health sector improvement programmes (government officials that are favourable, international agencies providing technical assistance, civil society organisations), to maximise the chances of progress. This can be done through attendance of relevant meetings at national level, presentation of CBHI data on use, expenditure, active liaison with individuals at national and district government services, organising seminars on community financing and inviting a wide range of actors, and disseminating publications etc.
- Options for integration with the national insurance strategy should be explored – one options is to create a regional umbrella organisation which manages the funds, purchases drugs, takes strategic decisions on investment and scheme development (as in Armenia) This organisation can then be transformed into a regional social insurance fund within the framework of the national system – but for this it is key to gather political support and to ensure that the schemes if integrated into the social insurance fund do not lose their appeal to the communities (being responsive and accountable)

3.2.4 Current context and policy environment for PHC reform

The overall context for this reform is one of strong economic growth and political stability on the positive side which has allowed for the readiness from the Ministry of Finance to increase the health budget and reform the way the health system is financed introducing social insurance (various national level key informants).

With respect to the role of donors in this process, due to the oil boom, donors are less active in the country, and government less willing to accept their support (some national level key informants). Thus, while financial aid plays a smaller role in the reforms, the government still requires technical support to design and implement complex health care financing transformation (some national level key informants).

On the political side (internal politics), the accountability procedures of the new health insurance agency has been the subject of some intense debate, according to some national level key informants:

- At the time of this review, the agency was to act as a quasi-independent body accountable directly to the cabinet and so operate independently from the ministries of health and finance. As in other central and eastern European countries, this is aiming to safequard the funds from changing political priorities and interference.;
- However, the Ministry of Health is less motivated to participate in the reform process since this decision took place. As the agency is not going to be under its jurisdiction, this was perceived to involve a significant loss of power over the functioning of the health system and the multiple actors involved.

Another problem refers to a conflict between the ministries of health and finance concerning the devolution of powers within government. According to a government official, the MoF would like to introduce more market economy elements within government administration and increase flexibility in the way funds are managed at local level; while the MoH does not share these views. This leads to problems of how to obtain efficiency gains, given the limited scope for local flexibility / management (WHO official).

Related to the above problem of conflicting views within government there is also a lack of clarity as to what and how exactly it wants to achieve through the envisaged reform process. This was reported by various key informants at national level, including government officials. While the new health financing strategy covers the concept of health insurance, within government it is not always clear what are the different possible meanings (for example insurance will differ at national and local level) and implementation strategies. Ideas around community involvement and local accountability are new concepts for the government which need further understanding on how best to build on these (WHO official).

Our interpretation of the situation is that given the rivalry between the actors within and outside government, and dynamic reform process which may lead to frequent changes of policies and regulations and staff turnover, Oxfam should engage with a variety of

actors, coalitions, and networks. This should be an approach of long-term engagement, from the start of the health sector financing reform process. This may help achieve a better leverage.

3.3 Community-based health insurance schemes in Azerbaijan – perspectives on their objectives and design relevant to scaling up and integration

3.3.1 Description of the schemes

This section describes the community-based health insurance schemes supported by Oxfam in Azerbaijan and is based on the review of documents, interview data and to a larger extent on briefing information provided by Oxfam officials. Currently the schemes run in 43 villages in five districts of the country. The process of selecting village health posts into the schemes is undertaken jointly by the implementing agency and the district health authorities, after obtaining a formal consent of the municipality. However, the rate of participation of the villages and their population is mainly dependant on their awareness of how the insurance model operates and what the benefits for their community are, and on where respected community members (including municipality leaders) supported introduction of the scheme or not.

Oxfam's support towards the community-based health insurance schemes involves a capacity building element for the staff involved in the project. Doctors and nurses based at the selected health posts by the scheme receive an incentive payment to be part of the scheme. The health posts are usually staffed by at least one doctor and a nurse. Rehabilitation of the health post infra-structure and the supply of basic equipment are also part of the scheme activities. Drug supplies come on a quarterly basis and are based on the health profile produced by each health post.

Membership is set at US$1.20 per month, per family (average of about four to five individuals per household). The costs of the membership cover individuals for out-patient consultations (including basic services as injections, blood pressure checks, simple blood and urine tests), PHC drugs and outreach activities. Approximately 10% of community members are exempted on a rotational basis. These members are chosen by the community based on their assessment of their poverty status. In addition pregnant women and children up to one year old are exempted.

Funds are collected by the appointed treasurer within the health post, usually a nurse. Oversight of the funds at community level is performed by the village health committees which are constituted by a group of five to six elected members within the community. The committee meets on a quarterly basis.

All 43 communities are represented in the Health Community Forum which was established in July 2007. The main purpose of this forum is to serve as a representation and strategic management body for community health committees. It should also play a leadership role in the promotion of policy and advocacy work on PHC. It is envisaged that in the long run this Forum will manage the CBHI model independently by overseeing the Community Health Fund which encompasses the individual contributions of all schemes at a higher up level. The total value of the individual's contribution into the scheme amounts at present to $80,000. For sustainability purposes of the scheme, funds contributed by members are still not used to fund recurrent and capital items, before decisions on their most strategic use are taken.

3.3.2 Determinants of membership

The first issue to be considered as a determinant of membership in the schemes is the understanding of the concept of health insurance.

Overall respondents considered the population to be aware of the concept of health insurance. For instance, some community members (women in particular) reported to have sufficient information about insurance in general and for health care. They thought it is a good way of spreading risks and protecting themselves in the future.

However most respondents also thought that there is insufficient understanding of what exactly health insurance mean for their lives and more information should be provided – for example on the benefits of the memberships. Members of the CBHI schemes tended to feel better informed about the concept of insurance and non-members were less informed. According to a key informant the understanding of the concept of health insurance has increased in urban areas due to the recent economic growth – mainly connected with the oil industry. This has led to an increase in the uptake of private

insurance (WHO official). In contrast, in rural areas, people's understanding of the concept of insurance was said to be still poor.

The understanding of the concept of health insurance and people's attitude towards the CBHI was also said to be dependant on educational levels, which was a common view among community representatives, health workers and chief doctors. For the more educated people insurance was acceptable and for the less educated ones, they tended to have greater misconceptions.

Other factors reported by respondents to have influenced people's decision in taking part of the CBHI schemes ranged from economic status, levels of coverage, availability of inputs and quality of PHC services.

However, there is no full agreement on which factor is most important. Some respondents reported high levels of poverty within communities as a determinant of participation in the schemes (according to implementing agency, chief doctors, physicians, community members). However some other respondents disagreed with this as they considered the monthly contribution required to participate in the schemes to be low. They thought that a more important determinant was the level of benefits (according to implementing agency, health workers, community members and representatives). A benefit package that would include coverage for the treatment of chronic illnesses, in particular drugs dispensed at village level was seen as crucial determinant of participation.

Some health workers noted that many people spend substantive amounts of money seeking care for chronic conditions at district hospitals. They felt that extending the scope of the current package to include chronic diseases (e.g. hypertension, diabetes), reproductive and maternal health, could lead to an uptake of memberships to the schemes. They also recognised that this would require considerable improvements in the capacity of health posts to provide the additional services. Another issue they reported was that often the quality of hospital care is perceived as better than PHC and people may bypass the health post even if an extended package for the treatment of chronic illnesses was available.

In the view of some community members and representatives the incentives that motivated people to join the CBHI schemes included: not having to pay informal fees; improvement of services at health post (rehabilitation and drugs); and rich people in the community taking part in the schemes (others in the village see them as role models).

Based on our analysis, we can conclude that membership of health insurance schemes seems to be constrained by an environment where the population does not fully understand what health insurance means and thus, may not be sufficiently motivated to participate. Given that the understanding among the population of what health insurance entails is dependant on educational levels and whether they live in urban or rural areas, the government will need to device different strategies to reach and inform different groups, through different information channels, and community organisation, in order to expand coverage of the social insurance system. However, research on similar schemes in Armenia suggests that often there is a threshold of affordability to participation in the scheme. For example, there is a section within communities for which the scheme do not represent value for money (as they have to spend considerable amount for seeking care for chronic disease and maternal and child health at district level). Yet, there are people who are simply too poor to join under any arrangements (e.g. or do not have continuous income), but would like to participate.

Data suggest that the government is in an initial phase of reform and lacks clarity on how to implement the new financing strategy involving a move to a health insurance model (e.g. what the role of key stakeholders like the employers would be, as reported by an independent public policy expert). This presents a unique opportunity for Oxfam to scale up its abvocacy work at national level, building on the CBHI and other community development experiences in Barda.

3.3.3 Desirability

Schemes accountability and community participation

There seemed to be good accountability of the model in terms of community involvement, acceptability and awareness of the main principles of CBHI. Members of

the scheme (participating in the focus group discussions) felt they were well informed about the way the schemes are managed. They reported to be aware of the financial flows and services provided. They also showed awareness of the existing sustainability plans for the schemes (to use the existing contributions to cover the scheme costs when donor funding ceases). They felt they were sufficiently involved in the process of managing the schemes. Even non-members of the schemes interviewed during this evaluation reported to be aware of how the schemes are managed.

Besides the strong community involvement in the way the schemes are run, another characteristic of the CBHI schemes described by a number of respondents was the flexibility in the management. This allowed the schemes to be more in tune with the local level needs of the population thus helping them feel ownership of the services (chief doctor Barda).

The community participation and the emphasis on accountability of the CBHI schemes supported by Oxfam seemed to be clear benefits of the model. The schemes can be further strengthened, in the view of a key informant, by inclusion in the new health financing strategy with a view of improving health services and outcomes (WHO official).

See our comment and recommendations in the previous section.

Perceptions of trust in government institutions and solidarity within the community

While some community representatives reported to trust the government generally and in particular with regard to financial matters, this view was not shared by the majority of other respondents. They believed there were problems of endemic corruption and inefficiency within government institutions and ineffective ways of working. For instance a key informant reported that the last minister of health had been charged with corruption. Health workers and community representatives as well as community members reported to see no problems of corruption at village level (including at health posts). Some community members (women) noted that they felt they could trust their health workers, their leaders and their own community. However, the majority of respondents at village level agreed that corruption was a widespread problem in the official health system, both at lower and higher levels.

In line with the above, a number of respondents indicated that people do not trust the government to provide accessible and appropriate services. This also applied to the quality of services as well. As put by a community representative, “why insure my health if I get no services for it*”.* Quality needs to improve before people feel they can trust government institutions and join a state insurance scheme (community representatives).

Related to the above, another problem reported in Azerbaijan was that the population do not perceive public funds as ‘being theirs’ or spent on services that benefit them directly. (‘they don’t show consideration towards it’, independent public policy expert). In contrast, when they contribute financially to earmarked funds, they were seen to have more interest and care; they tended to trust private institutions that are locally known and seen to bring public benefits. Based on the experience of the CBHI model, a health worker noted that people believe that by paying a fee they are able to get better quality care. They seem more willing to participate when they can see tangible improvements (e.g. if they can see that their contribution goes towards improvements within their own communities/villages) (independent public policy expert). In addition, it was reported, a payment into a specific trusted fund is seen to improve incentives of health care providers to deliver PHC services.

Most respondents concurred with the view that there is a considerable community solidarity. In particular community members emphasised that solidarity is very strong. They noted that people know each other well in the villages, they trust each other including regarding financial issues and they help one another – even the rich vis-à-vis the poor (e.g. driving them to a hospital or lending money for the purchase of drugs when necessary).

The findings of this study show that there is an agreement among respondents that there is considerable solidarity within the communities and ownership of the community based financing schemes, while at the same time trust in government and local administration (including those involved in the health sector) is low. This shows that a reliance on community organisations and CBHI (or an umbrella organisation) to drive change may be productive in expanding coverage through implementation of social insurance. Even if the insurance scheme are not integrated (initially) in the national insurance model, they

have the potential to offer an enabling environment for implementation of financing reform (e.g. by creating a pluralistic system of provision, and allowing contracting out of a range of different types of providers, by building public confidence in insurers, especially where they are quasi-independent).

3.3.4 Feasibility considerations

When considering how feasible the scaling-up of the CBHI schemes and increase in the risk pooling were, we investigated whether respondents preferred membership to be compulsory or voluntary.

In the view of those living and working at community level the schemes should be voluntary. The physicians interviewed at district level shared this opinion. Respondents argued that people may not be able to afford therefore they can not be forced to join the schemes; or they may not want to take part because the schemes coverage is limited to PHC. In addition, the voluntary option was said to be better because it creates trust in the schemes, people feel no obligations (implementing agency).

In contrast, policy makers and advisors at district and national levels thought that insurance should be compulsory. As claimed by most respondents in this group, the main benefit from making insurance schemes mandatory is that it allows for risks to be pooled across the population and greater results to be achieved. The chief doctor in Yvelach pointed that during the soviet time “we had outreach visits of doctors to companies, but people did not come to see the doctors since it was voluntary”.

Another benefit of making health insurance contribution mandatory is that people are likely to feel empowered - since they will be paying for health services, they will demand higher quality (WHO official). The government plan for the districts where health insurance will be piloted to introduce it as a compulsory measure (WHO, MoH and World Bank officials).

The feasibility of scaling-up of the CBHI schemes is constrained by their local embeddedness (responding to local need, local management), and their expansion and creation of regional umbrella organisations that can handle funds needs to proceed with

care, as it may damage the trust in these institutions. However, increasing the risk pooling and the scope of benefits provided under the scheme, as well as achieving efficiency gains requires a large membership mass. Keeping the schemes voluntary and seeking to improve participation rates via other means (enhancing chronic care and maternal and child health service, creating several levels of contribution) may be the only option in the short to medium term. However, as the implementation of the national mandatory health insurance model proceeds and public perception change, there is a need for careful consideration and debate as to whether membership remains voluntary. This would also depend on whether the scheme will form part of the national social insurance model, or will remain independent from it.

3.3.5 Equity considerations

With regard to equity, we asked interviewees as to whether they considered acceptable that non-members of the CBHI schemes had access to health posts. Most respondents agreed that non-members should use the posts provided that they paid for the drugs prescribed. Some also thought that non-members should pay consultations fees as well (district physician and some community members). According to a community member (woman) this would help non-members to access drugs at village level where they need them and it would benefit the poor.

Establishing a two-tier schedule (free access to members and certain payment for non-members) has to be designed carefully and financial transactions occurring at the level of the health post have to be carefully monitored to prevent abuse and informal payments.

3.4 Integrating and scaling up CBHI nationally – perspectives related to the way forward

3.4.1 Defining a benefits package

According to community members and leaders, the CBHI schemes should cover a wider range of services than it currently does. The benefit package should include: chronic diseases (including mental health), reproductive/maternal health and hospital treatment. One community group (women) highlighted that in particular drugs for chronic diseases

should be part of the benefit package. They noted that only a limited number of people are able to be covered by the government register for free provision of these drugs and this creates a heavy burden for their families.

Similarly, in the view of health workers based at village level the benefit package should also be expanded to cover chronic diseases (diabetes, asthma, cardio-vascular diseases, and mental health) as well as hospital care and drugs for chronic conditions. District level chief doctors, physicians and the implementing agency were in agreement with the above view. They noted the package should focus on the treatment of the most prevalent chronic diseases, i.e. diabetes and hypertension, and prevention of complications, and emphasised the need for patients to receive the respective drugs as part of the schemes.

However, as reported by a national level key informant, in spite of the oil boom, the country is unlikely to be able to afford to cover all health care needs of the population. In order for the new health insurance scheme to cover the entire population of the country, the benefit package will have to be a small one, encompassing PHC services and some selected secondary care interventions (independent public policy expert).

In our view, there are several options to deal with this situation. One strategy is to expand the membership mass and increase cross-subsidisation, that may ultimately increase the resources available. Another is to introduce several different levels of contributions and different prices, so people could choose a package that suits the need of the households. Oxfam can lobby the government to channel subsidies towards the poor people with chronic diseases who cannot afford to pay for an extended package – either directly to them or via per capita financing taking account of the level of local need.
Another option is, as noted above to discuss the introduction of direct payments for non-members– so that they are able to avoid payment for transportation to district facilities. However, the range of drugs available at the health posts as well as specialist advise and prescribing should be adequate so as to motivate non-members to purchase their drugs there.

3.4.2 Changes in financial arrangements

Benefits package

Initial estimates suggest the new insurance package is likely to cost around US$80-100 per year, per person (MoH official). This is a much higher figure then the US$1.20 currently paid by members in the CBHI. Clearly a subsidy policy will be needed. Therefore, we were particularly interested in understanding who would benefit from such subsidies – as envisaged in government plans and reflected in the opinions of key stakeholders.

National level key informants and some at district level tended to support the view that subsidies to be provided by the government should target the poor. As part of the development strategy of the new financing strategy, numerous options are being considered on how to target the poor. Among them one that has somewhat broad support is to provide the poor with vouchers so they can choose facilities and providers of care (WHO official). Independent of which option is chosen, the beneficiaries shall be determined on the basis of their income and this will require the involvement of and collaboration with the Ministry of Social Protection (World Bank official).

This group of informants also recognised that there are likely to be various management and organisational difficulties concerning the process of identifying and targeting the poor. These include: lack of management capacity (WHO official); need of improved databases (there are considerable differences between social and health registers according to the chief doctor Yevlach); and scope for corruption (WHO and World Bank officials and chief doctor Barda).

In view of the kinds of problems listed above, district and community level respondents argued that there should be no targeting of subsidies to the poor. They also noted that because the majority of the people living in rural areas in Azerbaijan are poor, this would be unnecessary. Instead they would favour a system that focused on the provision of high priority services for all, indirectly benefiting the poorest groups (e.g. reproductive and maternal health and chronic diseases).

Some district based physicians and health workers based at village level supported the provision of not only high priority services but also that focus should be placed on groups at risk (pregnant mothers, children, etc.). Some community members thought that targeting should be on specific groups at risk and not necessarily on the poor.

Level of contribution and mode of payment

Most respondents at community and district levels (including health workers and the implementing agency) thought that the CBHI schemes should offer differentiated packages - a basic package and an extended one. The level of contribution would be in line with the benefit package and people would choose according to need and affordability. For instance, those willing to have chronic disease coverage should pay more and those who prefer to opt out of an extended package would pay less.

In one community however there was disagreement with the above view. A women's group argued that all members of the scheme should pay more and everyone would have access as needed, including chronic patients.

We were also interested in identifying the extent to which the community accepted the idea of co-payments (where people pay a small portion of the total cost). In line with the previous finding - that when people contribute financially they tended to have more interest/ownership – the idea of co-payments was an acceptable one for the community. This view was shared by most health workers at village level, community members and physicians at district level.

A final point regarding financial arrangements refers to the sustainability of the CBHI. As described earlier for sustainability purposes, funds contributed by scheme members cannot be currently spent by the community. At present the total value of the accumulated contributions to the scheme amounts to $80,000. According to some community members these accumulated funds should be used to pay for infrastructure development and the purchase of drugs, as this would improve quality, providers motivation and participation rate.

See our comment on differential packages on page 31.Given the high opportunity cost of obtaining care and drugs (at disctrict level), small co-payments may be an option. However, this is subject to consideration under strict financial controls available in relation to transactions at the health post.

3.4.3 Further development of the CBHI schemes in key areas: Linkages between rural health post and other levels of provision

Quality improvements were said to involve primarily the enhancement of infrastructure (as well as a decrease in the number of facilities according to the chief doctor Barda); and of drug supplies (various respondents). These were said to be likely to lead to greater trust in the schemes by the population and eventually a higher enrolment rate (implementing agency).

Further improvements would encompass outreach visits by specialist doctors on the basis of need to village health posts (physicians at district level and health workers at community level). Respondents pointed out that such activities should also carry an in-service training component (community representatives, physicians at district level, health workers).

Further capacity building was noted as another area where considerable improvements will be required (chief doctor Barda, physicians at district level, health workers and community representatives Gyunbinasi). Respondents said that there should be more space for discussions, to share experiences, more meetings, exchange visits of health workers and opportunities to attend refresher courses and conferences/seminars. Currently it was stated that there is very limited support from the government with respect to these activities. As reported by an interviewee, at the time of the Soviet Union, doctors had to take part in yearly compulsory seminars and undergo performance assessments. These routines are no longer in place and medical staff lack training and refresher opportunities (implementing agency).

Further problems in the area of human resources that were reported by national level key informants, in the context of the health systems reforms and scaling up, include the need to: promote the concepts of general practice and family medicine; work with training institutions in order to change existing curriculum (under way); introduce training

in evidence based medicine. A key issue is the lack of clear guidelines and clinical protocols for treatment and prescribing, which reduce the opportunity to optimise care and shift tasks for lower-level of cadre (e.g. standard protocols may enable an appropriately trained nurse to monitor diabetes patients at community level, with a regular review by a doctor, thus freeing up resources). These were reported to be long term strategies and no results could be expected in the short term.

Another capacity constraint to be addressed as the schemes are scaled up relates to management strengthening. Again, the lack of qualified human resources in the area of health management / public administration represents a crucial limitation (WHO official). An additional problem is the lack of a reliable health and management information system (chief doctor Barda). Accreditation of health workers is a further challenge that will have to be dealt with by the insurance agency (independent public policy expert).

Scaling up of the CBHI schemes is also confronted with the problem of weak linkages between the village health posts and higher levels of care, particularly regarding the treatment of chronic illnesses. This problem was a particular concern among community members and health workers. They considered that chronic illnesses strongly affect their quality of life and would like to have greater access to secondary level care at village level as part of the CBHI schemes. However according to the chief doctor in Barda, there are insufficient members in the scheme to include some secondary care in the package of care at village level at present. With the increase in membership, this may become possible and should be planned for.

Areas that could be further strengthened with a view of improving the links between PHC and secondary care are: laboratory capacity, referral systems, continuity of care, a shared care approach (with a strong link to district hospitals) (health workers, implementing agency, chief doctor Barda).

In our view, given the existing capacity constraints, any efforts towards integration of the CBHI schemes and scaling up will require improvements in both the overall quality of the services and the linkages between rural health posts and other levels of provision. There are many possible linkages with the secondary care and many of these are clearly identified by the respondents (both at policy level and frontline provision) – these include

subsidised referral, financing diagnostic tests at secondary level, improved information system (can be paper-based). However, the common underlying factor is the improved cooperation between PHC (and the CBHI) and secondary care involving better communication between primary and secondary care, integrated care packages for many chronic diseases, better patient follow-up, shared care, clear responsibility for different aspects of care. All of this requires effective leadership at district level and ability to enforce rule – this is an area where Oxfam can work with others to achieve progress in the medium and long-run.

Changing medical practice and education systems will take a long time, but Oxfam should explore every possibility for targeted training of health care professionals involved in the programme, to ensure that some evidence-based standards are observed and quality is monitored (ideally by an external/professional/ or accreditation body if such). This may simply be short training courses in managing particular conditions, agreement on consistent protocols and use of drugs among the CBHI providers – achieving this would require developing linkages with national professional organisations. There can be bonuses for good practice around agreed indicators. Experience from elsewhere of use of community health workers to perform simple tasks, educate and support population in terms of prevention and access to treatment can be effective (if the legislation allows such roles). Research has shown that more efficient care locally (with quick access to higher levels of care in case of clear need) can improve outcomes, prevent complications, and achieve savings of financial resources.

3.4.4 Enabling legislation and regulation

The current legislative arrangement allows Oxfam to pay financial incentives to health workers (Oxfam representative). However, the new directive (February 2008) that established that all health services in the country should be free, may represent a problem, if members' contribution is to be used to pay incentives to health workers (national level key informants). Regulatory capacity is another problem for the new financing strategy, according to a key informant (WHO official).

Our analysis shows that this is an area requiring specific attention as it directly affects how the schemes operate and how they can be further developed. Improvements in this

area will be needed particularly with respect to the regulatory framework for purchasing and monitoring. For instance, the adoption of a case-based system of reimbursement requires improvements in the health information systems. Another aspect is the possibility to expand the scope of responsibilities of the nurses and other auxiliary staff (enabling them to prescribe and perform a wider range of duties). For example, in the UK and Canada, nurses and other mid-level cadre (doctors, assistant/junior doctors, below the level of a fully-qualified doctor) essentially manage the majority of diabetes and hypertension after the diagnosis is set by a doctor, following strict guidelines and making referral for occurring complications. The outcomes are seen to be better than in coutries where care is predominantly led by doctors (the USA, most of the former Soviet Union, etc.).

3.4.5 Actors positions vis-à-vis CBHI: supportive, opposing; neutral

The view of community leaders, health workers, some chief district doctors and the implementing agency is that many key actors at community level are supportive of the CBHI schemes. These actors are: those well-off, the executive committee of the CBHI schemes / municipality, school teachers, doctors, the elders. These tend to correspond to the more educated groups within the community and they are seen as role-models that influence the opinion and behaviour of the wider population (implementing agency).

However as one interviewee pointed out, this is likely to be the case within those villages/areas where the CBHI schemes are already in operation; it is not clear if these groups would have similar views and promote implementation of CBHI (or a wider insurance system) in areas not covered by the scheme (implementing agency). Yet, in communities where the schemes are running successfully, these groups have proved to be instrumental in encouraging the involvement of the population and enhancing transparency (community representatives). In view of this, our recommendation is that these groups should be involved in efforts to scaling up the schemes.

In terms of groups who oppose the CBHI, district hospital physicians were mentioned (independent public policy expert and implementing agency). This was said to be the case - even if not all physicians share this position - because they lose income through patients' informal payments. However as argued by this group of informants, physicians

are not sufficiently powerful to strongly influence the scaling up of CBHI if the government is determined to support it. They said this is also linked to the hierarchical nature of government management systems in the country. Yet, government itself may not be supportive.

Some parts of the population were said to oppose CBHI schemes. According to the implementing agency this is because of low educational levels and lack of understanding of the concept of insurance. In the view of the chief doctor of Yvelach and a national level government official, the poor and vulnerable are not supportive of the schemes because they cannot afford them, they are concerned about the costs involved.

Regarding the introduction of a national health insurance scheme (within the context of the new financing strategy), some respondents thought that donors (mainly WHO, World Bank, USAID) and some parts of the government (at national – particularly cabinet and the justice department - and district levels) are supportive (chief doctor of Yvelach, government official).

However, some parts of the government are not entirely supportive. According to a MoH official, CBHI should not be a priority area for Azerbaijan; that it should not even be considered an option for financing health care in the country. S/he argued that it is too difficult to make the schemes sustainable because of low wages among the population. Other reasons for this lack of support is the lack of clarity within government as to its understanding of the new financing strategy (independent public expert). According to this key informant:

- The MoH has a leading role in the reform process - by preparing the strategy, submitting it to the president, who then passes to the MoF for implementation;
- The MoF needs a clear plan and needs to be persuaded that it is a feasible strategy;
- However the lack of clarity within the MoH regarding the strategy hinders its ability to harness the support of the MoF which controls the allocation of resources within government.

The situation described above paints a complex picture, requiring a more in-depth stakeholder analysis identifying positions, views and likely actions of each group, that is beyond the scope of this study. Also, these positions are fluid, they tend to change over

time as the reform progresses, they are susceptible to lobbying, and to other influences. As in the case of specialists at district level hospitals, although they cannot overtly influence the reform process, through their actions they can obstruct the actual implementation (for example if service package is expanded at village level, they may be resentful of 'losing clients' and fail to provide support to the local practitioners or demand more frequent referrals than needed). In this sense, although not politically powerful, cooperation with this group is essential.

A strategy that can be taken by Oxfam is to direct efforts both at national level, district and local level – in agreement with a clear organisational health strategy identifying priorities that may lead to different implications. These priorities can include enhancing access to care (in this case, it can involve liaison at national level to work within the emerging financing strategy and lobby for subsidies for the poorest or other vulnerable groups, in parallel with running the CBHI schemes. Or the priority can be focusing on particular services that are neglected or inaccessible, rather than seeking to expand the current CBHI model.

As mentioned in an earlier, it is important to identify individuals at key positions within institutions and work with them over time, and identify 'change agents' (institutions or individuals that can help to influence the agenda-setting process as well as stimulate debate or instigate a process of small-scale change that can gather momentum).

3.4.6 Communication and consensus building

As part of the efforts towards integrating and scaling up the CBHI schemes, various respondents stated the need for more information to be provided to the population about what health insurance is and how the schemes operate. Education campaigns at community level would help to raise awareness of the population (implementing agency). These campaigns should take the form of meetings, brochures, and home visits (community representatives).

At the same time, the government was urged to seek clarification within its structures as to what it seeks to achieve through the current health sector reform agenda and the new financing strategy (government official). Once this is in place, and if consensus is built

around the adoption of a national health insurance scheme, this should be introduced gradually, through careful planning (chief doctor Barda).

A number of interviewees at national level noted that there is scope for complementarity between the CBHI schemes run by Oxfam and the government reform plans. As argued by a key informant (independent public policy expert) the new financing strategy should incorporate elements used by Oxfam of public control, through community participation (establishment of village health committees, with clear tasks with regard to monitoring financial flows/expenditures).

The timing for closer interaction between the government and Oxfam with a view of sharing its experience with the schemes is seen as particularly opportune since the government plans are still under development (WHO official). It was said that Oxfam's experience could contribute to the design stage and piloting of the insurance model in the Northwest region. The main channel for Oxfam to share its experience and influence the policy making process are the reform working groups (particularly the one that focuses on the funding mechanism) (WHO official).

We have commented on some of these issues in previous sections. This includes the need for a careful preparation for the implementation of social insurance, national debate around health priorities and implementation issues, as well as the role of the different actors. For example the community-based committees involved in running the CBHI could be given the authority and power to hold government to account and influence budget allocations at local level, as well as monitor the implementation of the national insurance scheme after trained to acquire the necessary skills. The public will need to be sensitised as to the importance of participation, provided with subsidies and other non-financial incentives (e.g. free specialist outreach, access to preventive screening etc.).

As mentioned earlier, Oxfam's involvement in health sector reform at all levels and providing a platform for raising frontline concerns to national level will be extremely valuable.

4. Conclusion and recommendations around the specific evaluation objectives

This report examined shortcomings of the primary health care in Azerbaijan, focusing on financing and delivery of primary health care services at village level, some issues related to scheme design and operation, and some options for further scheme development and integration into the official services. The field work sought to cover a wide range of topics (as seen in the data collection instruments), but given the small-scale field work, this represents just a snapshot of the major issues found. Further work in each of the main areas is required to provide a more in-depth analysis (we conducted a series of studies in Armenia over a period of 3 years). Therefore, this may limit the conclusions that can be drawn and the recommendations.

Our analysis identified a favourable context vis-à-vis the CBHI schemes and good scope for integrating or scaling up these with broader national plans. The new financing strategy offers an opportunity to strengthen PHC which was greatly neglected in the past. Regarding structural factors, the availability of resources and the recent economic growth (thanks mainly to the oil boom) as well as the political stability add to the favourable scenario. In addition, at the global level, the international community is supportive of health systems strengthening initiatives, including the development of initiatives to scale up interventions with a view of achieving universal coverage. A challenge however will be the low educational level of the population and economic vulnerability. Additionally, the pervasive corruption and lack of trust in government institutions will present an obstacle to scaling up community financing. This still hinders a more widespread and in-depth awareness of insurance schemes at the community level.

Generally the CBHI schemes benefit from a favourable environment in terms of social values and attitudes. There were reports of trust in non-governmental organisations; willingness to contribute financially to obtain services; a strong sense of solidarity within communities. These elements encourage the scaling up of CBHI schemes. However it is not clear if this situation is similar in areas not covered by the CBHI schemes.

The recommendations will be organised around particular objectives:

4.1. To explore how the CBPHC schemes can be used in the development of the national village insurance scheme. More specifically, the evaluation will assess how the CBPHC scheme must be developed in order to comply with a national insurance scheme. It will also consider how the schemes can link to secondary and tertiary referral levels.

A major conclusion is that the current policy developments around health financing reform (implementation of a national social insurance system) presents a unique opportunity for Oxfam to actively promote the right of poor and vulnerable communities to basic (and other essential) health care. Advocacy efforts should be firmly grounded in the significant work happening at community level, and lessons learned should be presented to a wider audience. The study showed that there lack of awareness at national level about the design and achievements of the CBHI funded and supported by Oxfam – e.g. ability to deliver PHC and ensure basic drug distribution through simple cost-effective measures through accountable and locally managed insurance schemes; while encouraging a good community participation and buy-in of the process.

Working towards this goal, we suggest that Oxfam should have a multi-faceted strategy of working at national, district and local levels, to build on the substantial experience amassed in the process of running CBHI schemes. Running sustainable CBHI schemes is not realistic as shown by the experience in many settings; subsidies are always required either by donors or governments. This is the case even where there are social insurance systems but there is a shortfall financed by the governments or funded by supplementary voluntary insurance (France, Netherlands, Germany). In our view, engaging in national advocacy is important – in order to increase awareness of alternative financing models, increase support for the targeted subsidies (poor people, specific groups such as mothers and children etc.)

There are also issues about the process of engagement in health sector reform in Azerbaijan. It is clear that given the concerns about the governance and legitimacy of the government (lack of trust, perceptions of corruption and inefficiency etc.), the most viable strategy would be to join coalitions, donor alliances around specific issues, civil society forums. This would involve for example, participation in regular events and forums (donor coordination meetings/ annual conferences). Advocacy at national level could be linked to health sector reform developments such as PRSP, sectoral reform development, reform of labour legislation. This requires proactive engagement with

organisations and individuals that are working in these areas. There should also be an effort to increase awareness internationally through publications, published reports, so that this can contribute to an external pressure on the government. CBHI could also be linked to broader strategies addressing poverty and vulnerability.

Oxfam should identify other donors or organisation running (or funding) voluntary health insurance schemes or supporting access to health care initiatives, and initiate discussions to further such schemes under the forthcoming reform – and possibly work towards a common position. One option for discussion is for the schemes to stay independent, providing an additional pillar of insurance (in addition to the national insurance) or targeting particular groups (poor people, rural residents, IDPs, as in Thailand) or provide supplementary coverage to the package covered under social insurance. This is consistence with the preference for a voluntary membership and retaining community ownership and accountability.

Another option would be ultimately for the schemes to form part of a national social insurance system. Such systems usually aim to cover the whole population – with those formally employed and their employers making insurance contributions, and those not working to be covered by the municipalities. However, experience from many countries has shown that covering informally employed and rural populations is extremely problematic. This represents a niche for Oxfam – to work with communities (through the CBHI schemes or otherwise) to expand coverage.

It is also recognised by many authors that CBHI schemes are often an intermediary option – where countries move towards more formal arrangements that are linked to national systems that are stable over time. Therefore, the CBHI scheme can be seen as a stepping stone rather than an aim in itself, to expand coverage. However, moving from the current situation to a fully functioning health insurance system may take a long time, and therefore the current scheme could be sustained to fill the gaps in the short and medium term but then cease to exist.

Work at national level could be through a direct involvement in health sector reform, but also indirectly, through promoting community development, accountability, good governance which would indirectly affect how health services are provided and financed.

Oxfam should also develop analysis of the political feasibility, and in case partnership between the government and voluntary sector is not feasible (as in many other countries), it should link its 'right to health' agenda to the political process.

This should parallel activities at district level, that can involve working with individuals in key positions of power, such as head doctors and identifying 'change agents' that can bring up change.

4.2. To recommend options for utilizing the premium community funds being accumulated since the set up of the scheme.

With respect to the sustainability of the CBHI schemes, a question that this evaluation has sought to address is how to utilize the premium community funds being accumulated since the set up of the scheme. There was not a majority view among the respondents who replied to this question, but some members of the community suggested using the accumulated funds for improving the infrastructure and the range of drugs available. Although spending the accumulated funds to cover running and capital costs in the medium term cannot be sustained, however this is an area where there is clearly a major need. Therefore one option for Oxfam is to consider the possibility of entering negotiations with major state and private suppliers or partnerships at national level, and seek to obtain key drugs (from the essential drug list of the country) that are currently most needed and relatively unaffordable. The range of drugs can be determined in consultation with national level professional organisations and local health care professionals, managers, distributors of pharmaceuticals. There is evidence that improved (often centralised) procurement and distribution of drugs through linkages with major pharmaceutical distributors within the public sector, can help achieve economies of scale and significantly reduce drug costs. Cost savings can also be achieved through promoting rational drug prescribing, better drug regulation, and use of cheaper generic drugs. There are also possibilities to lobby pharmaceutical companies to provide subsidies or preferential conditions (e.g. Novo Nordisk has been instrumental in securing subsidised insulin in some FSU countries, and to link to donors such as DANIDA which has prioritising stocking diabetes drugs in central Asia. Entering partnerships may be beneficial for controlling drug costs over time. Oxfam can also lobby the government to

provide for free, or subside (for some groups or for all) particular drugs for diseases that pose a high burden to the country.

Introduction of direct co-payments is also a possibility which was seen as acceptable at community level, provided it ensures access to drugs that are high-demand and currently available only at district level. Currently members' contributions to the schemes correspond to a 'symbolic' fee, far from covering the actual costs. Providing loans for payment for drugs (especially where income is seasonal) would ensure increased availability. Additionally, non-members can pay for (lower-cost) drugs directly to the health post, and thus contribute to the resources available.

Another option for spending a part of the amassed resources is for training of health professionals (clinical staff and managers), in new skills, cost-effective and collaborative treatment models, and shared care models (as discussed earlier in this report).

Accumulated funds could also be used for advocacy activities on PHC (including lobbying for increases in funding levels) at sub-national levels (district and village stakeholders) under the leadership of the Health Community Forum, and at national level under Oxfam's leadership. We recommend that the question of sustainability needs to be discussed more broadly (as for the PHC in Azerbaijan as a whole), with a lesser focus on the existing financial resources accumulated within the CBHI schemes. Greater attention should be placed on rolling out the strengths of the schemes, such as community mobilisation, empowerment, and accountability, which have contributed to the trust in the model and should be built upon by the new health financing reform. Therefore, sustainability should be addressed by influencing the health policy environment. This should include efforts to achieve universal coverage and improvements in the quality of services provided.

The money can also be invested by the Health Community Forum. However, this is subject to capacity building, and ensuring appropriate financial checks and balances are present to maintain trust and accountability. Furthermore, the Forum can diversity its functions and act as an insurance fund within the national social insurance system.

4.3. To recommend on model transformation in terms of reflecting/responding on contextual changes in Azerbaijan as regards the future development of the schemes. / Suggesting a sound strategy for CBPHC model transformation within the next four years in order to achieve this aim.

There are several steps that can be taken in succession, or in parallel.

A. At a first stage the opportunities for further development and scaling up of the schemes within the existing constraints should be explored. This may include efforts to expand the package of care in order to increase membership (outreach, referrals, better continuity of care between the primary and secondary care). There should be an emphasis on increased awareness of what health insurance means and the benefits of the schemes that can mobilise communities. This could be done through design and implementation of effective information and communication programmes at community level. As a part of a scaling up process, Oxfam should conduct assessments of levels of social capital and community attitudes to CBHI, prior to introduction of a scheme in a new area, in order to address preconceptions through campaigns and gain support of key people within the communities.

B. There is scope for improving the schemes per se. The schemes can benefit from a stronger accountability system, higher levels of community mobilisation, and a more flexible management approach. These characteristics bring the schemes closer to the communities and enhance the scope for understanding the schemes. For example, there can be improvements in the way the schemes are managed, e.g. the treasurer can be another community representative rather than the nurse, to improve transparency.

A crucial problem identified through this evaluation was the high expectations of community members and some other stakeholders in regard to the level of coverage to be provided through the schemes. There is a need of further clarification that the CBHI schemes, and also village health posts in general, are not meant to provide secondary level care. The remit of the schemes according to their design is focused on the provision of PHC. Therefore they currently do not have the capacity to deliver services beyond this level. Hence, our recommendation is to raise awareness of community and stakeholders regarding the remit of CBHI and its focus on primary health care (services

that can be provided at village level) and the remit of higher level services to be provided by government (at secondary/tertiary levels).

However, since chronic conditions such as diabetes and hypertension are highly prevalent in the areas studied, and represent a significant burden for patients and families, the schemes need to develop better linkages with the secondary care services. There should be a shared care approach, involving strong referral systems, outreach visits of specialist and dispensing at village level of routine drugs for patients who require them.

Increasing the scope of benefits provided under CBHI schemes and enhancing quality of care locally will require investment in human resources – in training, embedding incentives, change in the regulatory framework. There should be a shift from care provided by doctors, to care led mostly by nurses and mid-level staff, working under the supervision of doctors and as a part of 'rural health teams' consisting of different level of specialists cooperating to provide integrated care. There should be more precise evidence-based treatment and prescribing protocols appropriate to rural realities, developed by professional bodies and endorsed by the local government as obligatory norms. These guidelines can be used for monitoring quality, accreditation, or benchmarking.

To this end, the schemes will have to devise strong collaborative arrangements and stable partnership with district level government administration that could allow for these linkages to be improved. In some districts where government authorities are more committed this will be easier than in other districts. In addition, much greater efforts should be placed at improving health prevention and promotion activities in the region, especially targeted to prevention of chronic diseases. Efforts can be linked to providing support to the local administration and improve capacity (maybe some officials can be subsidised to attend training courses or multi-actor meetings at national level, joint activities at regional level, or other incentives).

C. Another stage would involve stepping up engagement at national level. As described above, Oxfam has a valuable contribution to make to the national agenda based on its grassroots experience. This include the experience of running pro-poor cost

effective PHC for vulnerable groups (and building on experience in other countries), and ensuring meaningful community involvement and local accountability. As suggested by a key informant, the benefits inherent in the Oxfam CBHI schemes should be built upon when the government develops and implements the new health financing strategy. Thus the Government can incorporate elements of community mobilisation and participatory and flexible management in the new health financing strategy, for example exercising public control through community participation (establishment of village health committees, with clear tasks with regard to monitoring financial flows/expenditures within the CBHI and the public sector in general).

As the government progresses with its plans to introduce a national health insurance scheme, the mandatory nature of it will have to be thoroughly discussed with the community who currently would prefer voluntary-based schemes. The benefits of both options should be clearly explained, as for example the possibility to expand the package of care locally if the risk pool is increased (mandatory participation).

However, Oxfam first needs to develop its organisational vision for the health sector (what are the goals, and policy and practice changes it would like to see?), and choose a strategy (what are the routes that it wants to pursue? where are its key competencies and what other areas have to be developed?). The strategy and organisational vision will determined what methods are used.

Annex I - List of the key informants interviewed

[List Removed]

Annex II - Data Collection Instruments

Focus Group Discussion Participation Criteria

GENERAL OUTLINE

1. There will be focus group discussions, in high participation rate villages and low participation rate villages.
2. In each village there will be separate discussion groups for members and non-members.
3. In each village there will be separate discussion groups for women and men
4. That makes a total of eight focus group discussions all together.

SPECIFIC CRITERIA

The groups will need to be balanced in terms of:

1. Socio-economic status: we are particularly interested in having poor and relatively well off people participate in the groups (since they are the groups that commonly elect not to become members of the schemes).
2. It would be good to have some people with a chronic disease sufferer in their family, as well as people who do not.

EXCLUSION CRITERIA

Exclusion criteria will include:

- Being a member of the village council.
- Being a member of the health facility committee.
- Being a health professional.
- Already having had a friend, neighbour or relative selected for the focus group.

It should be noted that the opinions of the members of the village council, health professionals, and members of the health facility committee will be accessed via specific key informant interviews at the village and district level.

Focus Group discussion guide for Azerbaijan CBHI study
(with members and non-members)

INTRODUCTION

We would like to find out what you think about the current scheme, especially what sort of care you think should be covered by the scheme. We also want to find out more about why some people join the scheme and others don't.

GENERAL DISCUSSION TOPICS

ACCESS TO HEALTH CARE IN THIS VILLAGE

Where do you or your family usually go for treatment when you get sick, and why do you go there?

Are there any problems that make it hard for you to get the treatment that you or your family need?

Are you able to get treatment in the hospital if you need it?

Are there any problems that make it hard for you to get treatment at the hospital?

PAYMENTS FOR ACCESSING HEALTH CARE

What do people have to pay for at health posts or polyclinics?

Can they afford to pay for these things?

Is treatment at the hospital affordable?

Informal payments for access to care

In many parts of the world it is considered normal to bring a gift with you as sign of respect when you have to consult an important person for any reason.

Is there tradition of such gifts in Azerbaijan?

In Azerbaijan in general are such payments to doctors and nurses common?

Are under the table payments to doctors or nurses common in your district?

If informal payments are occurring commonly:

Does the fact that people can get treatment from doctors or nurses by paying under the table make joining the CBHI scheme in your village less attractive to people?

How do people pay for health care?

What do people if they have to pay for health care; how do they raise the money?

Do you know people who have not been able to get the health care they need because they cannot pay the costs?

Do you know people who have had to borrow money to pay for health care?

Are there any other things that people do to raise money to pay for health care? (For example do they sell things, or do they offer to work in exchange for the money to pay for health care?)

How has borrowing the money or selling things affected these people's lives?

VOLUNTARY OR COMPULSORY MEMBERSHIP

What do you think about the idea of making CBHI compulsory?

What might the problems be with making the schemes compulsory?

BENEFIT PACKAGES AND RELATED ISSUES

Setting premiums, fees, and co-payments

A generous package of benefits, which might include hospital treatment, is obviously more attractive to people, but it would mean that people would have to pay more to join the scheme. Some people may not be able to afford to join at all. One way to deal with these issues is offer people a choice between paying a small amount for limited benefits and paying more for more benefits.

What do you think of this idea?

What do you think about the idea of letting people who are not members of the CBHI schemes use the health post provided that they pay for treatment?

Do you think that co-payments, where people using health services pay a small amount of the total cost, would be acceptable in Azerbaijan?

Chronic Disease Care

In your village, where do people who require daily treatment for chronic disease go for their health care?

How do they get the drugs that they need?

Who do you think should be responsible for the cost of providing daily drugs and check ups for people with chronic disease?

To what extent are people with chronic diseases a burden on their families?

What do you think should be done for people with chronic diseases?

Do you think that CBHI should cover the care of chronic diseases?

Should everyone pay more to enable the scheme to provide people with drugs for their chronic diseases?

Should people with chronic diseases pay more to have their medications covered?

Coverage of Hospital-Based Health Care
Do people in this village have problems getting treatment in hospital if they need it?
In Azerbaijan do you think that the CBHI schemes be moving towards covering hospital treatment such as emergency caesarean sections?
Should they cover non -medical costs such as transportation to hospitals?

Care for Non-Members
In your village, how do people who are not covered by the CBHI schemes get treatment when they are sick?

Have you heard of cases where non-members of the CBHI scheme use the health post when they are sick?

What do you think of the idea that non-members should be able to use the village health posts on condition that they have to pay for their consultation and the drugs that they are given?

THE DETERMINANTS OF PARTICIPATION RATES

Open Question about Explanations for Participation Rates
Why do some families join the schemes and others do not?

Geographical access factors
Is the Oxfam health post easy to get to?

Are alternative clinics, health posts, or sources of drugs easy to get to?

How important is the closeness of the health post compared to other treatment options in people's decisions to join the scheme?

Poverty and affordability
How important is poverty in influencing people's decision to join the CBHI schemes? Are there people in this village who cannot afford to join the schemes?

Quality of care and value for money issues
Do you think that the quality of health care at your village health post is good?

Do you think that the quality of care available from alternatives to the health post is good? (Prompt: *Examples of alternatives include the polyclinic, government health posts, and treating yourself with drugs that you buy at a pharmacy*).

Which alternative do you think offers better quality of care?

Which alternative offers the best value for money?

How important do you think that the issues of quality of care and value for money are for people when they are thinking about whether or not to join the CBHI scheme?

USES FOR THE ACCUMULATED FUNDS– question for Members
Are you aware of what happens to your contributions?

What should the accumulated funds be used for? Paying for drugs, for administration of the scheme, for health care, for additional benefits like secondary care (hospital / specialist care), for infrastructure improvements etc?

Social capital or trust issues
Can people who live in this village/neighbourhood be trusted?

Are people in this village/neighbourhood willing to help each other if there is a need to?
In this village/neighbourhood, do people generally trust each other in matters of lending and borrowing money?

Understanding of risk and familiarity with insurance
Are you familiar with insurance for cars or houses?

Are you familiar with insurance for health care?

In some parts of the world families or expended families help each other in times of need. This help can be very like insurance: if someone needs money for truck repairs or because they need to go to see the doctor, they can borrow money from their family.

Do people in your village deal with unexpected demands for money in this way?

Does it affect people's decision to join the CBHI scheme or not?

How do you think that the CBHI in your village could be changed to get more people to join?

THE FUTURE FOR CBHI IN AZERBAIJAN

Has the CBHI scheme here been a good thing for your village?

Do you think that having similar schemes in other rural areas of Azerbaijan would be a good idea?

Questions for Key Informants at the Village level
(providers, representative of community health committees)

1. PHC AND HEALTH POLICY OBJECTIVES IN AZERBAIJAN

CURRENT SITUATION IN RURAL PRIMARY HEALTH CARE IN AZERBAIJAN

Organisation of PHC and access to health care in this village

- What do you see as the major health problems in your village?
- Where do you or people in your village usually go for treatment when they get sick, and why do they go there?
- Are there any problems that make it hard for people to get the treatment that they need?
- Are people able to get treatment in the hospital if they need it?
- Are there any problems that make it hard for people to get treatment at the hospital?
- What health services are most needed by the rural population in your village?

Out-of-pocket expenditure on health and catastrophic expenditure

- What do people have to pay for at health posts or polyclinics?
- Can they afford to pay for these things?
- Is treatment at the hospital affordable?

In many parts of the world it is considered normal to bring a gift with you as sign of respect when you have to consult an important person for any reason.

- Is there tradition of such gifts in your village?

Doctors and nurses may have to charge people for treatment, even if health care is supposed to be free.

- Do people in your village have to make such payments to doctors and nurses?

If informal payments are occurring commonly:

- Does the fact that people can get treatment from doctors or nurses by paying under the table make joining the CBHI scheme in your village less attractive to people?
- How do people pay for health care?
- What do people do if they have to pay for health care; how do they raise the money?
- Do you know people who have not been able to get the health care they need because they cannot pay the costs?
- Do you know people who have had to borrow money to pay for health care?
- Are there any other things that people do to raise money to pay for health care? (For example do they sell things, or do they offer to work in exchange for the money to pay for health care?)
- How has borrowing the money or selling things affected these people's lives?

Quality of care

- Are there quality related incentives or penalties at the primary health care level? in your village for example
- Who is responsible for monitoring and evaluation of PHC quality?

Health Information Systems

- Who send data to whom?
- Do you collect socio-economic and health data, or other in your area?
- To whom do you send it?

PHC REFORM

Assessment of PHC reform and desirability of alternative options

- How have the reforms of the Azerbaijann health system affected PHC services in your village?
- Are there issues relating to PHC services in your village that have to be addressed? [Probe: planning, organization and financing of PHC in rural areas] How? [probes: economic or community development; health sector reform; social support system reform]
- What are the priorities for further reform of rural primary health care services in your village? [Probe: More revenue; improving equity among different groups; etc.]
- To what extent are the problems of rural PHC related to the way that the health system is financed? [Probe: Discuss pros and cons of financing based on general taxation; on social insurance tax; community prepayment/insurance; out-of-pocket payments; etc.]

Community financing for rural PHC

- What is the role of CBHI schemes in the delivery of PHC services in your village compared to other forms of provision (dispensary, policlinic, pharmacies)
- To what extent is community-based health insurance (prepayment to a fund in return for guaranteed future access to a defined package of health care) acceptable to people in your village? [Probe: Is it too big a change from previous ways of financing health care? Is it compatible with Azerbaijan's culture, and values?
- Are such schemes helpful given the current circumstances of your village?
- What is the purpose of the CBHI schemes currently existing in your village? [Prompts: raising revenue; improving access to care; improving quality of PHC; as a stepping stone towards universal compulsory health insurance; etc.]
- Could you please outline some of the advantages and disadvantages of the CBHI schemes in your village?

Public preferences/ shared values / social capital

- How strong is the support for public provision of health care in your village?
- In general terms, how willing are people in your village willing to help each other financially and in other ways? [Across communities; social networks]
- Within your village, what are the attitudes to the poor and socially disadvantaged? Do people see them as deserving of assistance? Is there support for exemptions or subsidies for these groups?

- Are there any others groups that people in your village regard as deserving of support or subsidy to enable them to access medical care (e.g. people suffering from chronic diseases)?
- In your village, to what extent is healthcare seen as a personal responsibility, a community responsibility, or a government responsibility? Are perceptions of responsibility changing?
- In your village, to what extent is there trust in public and private institutions (incl. the government)? Why?
- In your village, to what extent is corruption an issue within the health?

2. DESIGN OF HEALTH INSURANCE SCHEMES

POPULATION COVERAGE

An important issue when designing CBHI schemes is deciding who the scheme should be aimed at.

- What population is the scheme supposed to serve?
- Who should be covering the rest of the population? (the ones not mentioned above)

VOLUNTARY OR COMPULSORY MEMBERSHIP

Oxfam's CBHI schemes are currently voluntary, and only about a certain percentage of people in all the villages with schemes have joined them. This is a problem because if more people join CBHI schemes they would be able to raise more money and offer more benefits. With more members schemes are better able to subsidise the poor and the sick. One way to ensure more members of the schemes would be to make membership of the schemes compulsory.

However this may not be acceptable to people, and it can be difficult to get people to pay if they do not earn regular incomes or if people are simply too poor.

- What do you think about the idea of making CBHI compulsory?
- What might the problems be with making the schemes compulsory in your village?
- Would compulsory membership of locally managed schemes be acceptable in your village? Why/ why not? What would people's reaction to that be?
- Would it be feasible in the current circumstances? [Probes: Administrative burden; difficulty collecting compulsory contributions; corruption etc ...]

BENEFIT PACKAGES AND RELATED ISSUES

Setting premiums, fees, and co-payments

It can be very difficult to make a CBHI scheme both attractive to join and affordable. If the benefits offered are limited, the contributions required to fund the CBHI can be small, and more people can afford to join; however some people may decide that a limited package of benefits is not worth paying for. A generous package of benefits, which might include hospital treatment, is obviously more attractive to people, but it would mean that people would have to pay more to join the scheme. Some people may not be able to afford to join at all. One way to deal with these issues is offer people a choice between paying a small amount for limited benefits and paying more for more benefits.

- What do you think of this idea?

- What do you think about the idea of letting people who are not members of the CBHI schemes use the health post provided that they pay for treatment?
- Do you think that co-payments, where people using health services pay a small amount of the total cost, would be acceptable in your village?

One of the key questions in every insurance scheme, national or local, is about what conditions and services to be covered. This has implication for the willingness of population to participate and for scheme sustainability.

- What type of services do you think should be covered: [**Probes**:
  - **a.** Primary health care/ first aid
  - **b.** Reproductive health care/ maternal care/ contraception
  - **c.** Chronic diseases (hypertension; diabetes; asthma; cardio-vascular diseases)
  - **d.** Mental health services
  - **e.** (Re)emerging diseases (TB/ HIV)
  - **f.** Diseases leading to catastrophic expenditure at the hospital level (cancer, stroke, etc.)]
- How important is that the community based schemes in your village cover hospital care and care leading to catastrophic expenditure and poverty? If not, who should fund it? Do you think that the insurance schemes should aim to cover acute secondary level care e.g. emergency caesarean section, in the long run?
- Should insurance cover non -medical costs such as transportation to hospitals?

Level of contribution and mode of payment

- Do you think that it is a good idea that community based health insurance offers different packages of care at different prices so that people could have choice? Or should all people joining CBHI schemes pay the same?
- Do you think that it would be acceptable in your village different models of payment for using the health posts were introduce for different groups or services? For example if some people had to insure themselves, while others had their insurance subsidized by the state, and others paid out-of-pocket for some services?
- Do you think that it would be acceptable in your village for scheme members has to make a co-payment (a small percent of the total cost) when using the health post, in order to prevent them overusing the services? (the poorest could be exempted)
- Do you think that it is a good idea that people with chronic illnesses enrol in pre-payment or savings schemes to help them budget for their medical expenses? Is there a better alternative?

Chronic Disease Care

Chronic diseases like diabetes, high blood pressure and heart disease are responsible for an increasing amount of sickness and death in Azerbaijan. Currently the CBHI scheme in your village does not cover the cost of drugs that must be taken every day for the long term treatment of chronic diseases like high blood pressure and diabetes. The main reason for this is that if it were to cover chronic conditions, the cost of providing care at the health posts would increase, and the contributions demanded to join the scheme would have to be higher; this might discourage people from joining the scheme.

There is interest in developing options for improving the care that people with chronic disease receive.

- In your village, where do people who require daily treatment for chronic disease go for their health care?
- How do they get the drugs that they need?
- Who do you think should be responsible for the cost of providing daily drugs and check ups for people with chronic disease?
- To what extent are people with chronic diseases a burden on their families?
- What do you think should be done for people with chronic diseases?
- Do you think that CBHI should cover the care of chronic diseases?

If the CBHI scheme were to cover the cost of long term care for chronic diseases the cost of joining the scheme would have to be increased. If everyone paid the same contribution to join, this would mean that healthy people would be subsidising people with chronic diseases. This could be a problem if healthy people then decided not to join the scheme because they thought that it was no longer good value for money. The cost of joining the scheme might then have to go up even more because there would be fewer healthy members to subsidise people with chronic diseases.

There are a number of possible ways in which CBHI schemes could be changed to help people with chronic diseases:

1. The scheme could cover the cost of long term care of chronic diseases and everyone would have to pay more to join the schemes.

2. People could be given the choice of either not having long term chronic disease care covered and paying less to join the scheme or having their chronic disease care covered and paying more to join.

3. The scheme could remain the same as it is now, and would not cover the cost of drugs that must be taken every day for the long term treatment of chronic diseases. People with chronic diseases could be offered the chance to save for the costs of the drugs that they know they will need by paying a small amount of money to the CBHI fund regularly. (They could of course just decide to pay for their drugs when they need them under such an arrangement).

- Which of these options do you think would be best?

Coverage of hospital-based health care

- Do people in this village have problems getting treatment in hospital if they need it?

In many parts of the world where people have to pay to get treated in hospital, people who have to raise money to pay for this treatment can be tipped into long term poverty as a result. If CBHI schemes cover hospital treatment people are protected against this. But, schemes that cover hospital treatment have to charge people a lot more to join them. A lot of people may then be unable to join the scheme.

- In your village, do you think that the CBHI scheme should be moving towards covering hospital treatment such as emergency caesarean sections?
- Should they cover non -medical costs such as transportation to hospitals?

Care for non-members

Most of the studies of CBHI schemes have looked at whether CBHI schemes improve the ability of their members' to get treatment when they need it. An important question however, that should be considered, is if people who are not members of the CBHI schemes are able to get treatment if they are sick.

- In your village, how do people who are not covered by the CBHI schemes get treatment when they are sick?
- Have you heard of cases where non-members of the CBHI scheme use the health post when they are sick?
- What do you think of the idea that non-members should be able to use the village health posts on condition that they have to pay for their consultation and the drugs that they are given?

Subsidies

Schemes like the one in your village need substantial subsidies if they are to be sustainable.

- Assuming someone was going to provide the subsidies, how do you think the scheme could ensure that those most in need of subsidies get them?
  1. Linked to specific groups such as the very poor or otherwise disadvantaged?
  2. Linked to particular high priority services (e.g. pre- and post-natal care, chronic diseases that are the major cause of morbidity and mortality)?
- What groups should be subsidised?
  a. The poorest of the poor (the poorest 25%).
  b. Those who cannot afford to join insurance schemes but are not exempted
  c. Specific groups at risk (pregnant mothers, children, other) who may not be always poor.
  d. Other
- What are the challenges to that those most in need get the subsidies? (**Probes**: Weak administrative capacity/ seasonal variations in income/ difficulty assessing income due to the informal nature of much economic activity/ difficulty defining and identifying vulnerability/ corruption)
- Do you have any other suggestions as to how access for the poorest could be ensured

3. THE DETERMINANTS OF PARTICIPATION RATES

OPEN QUESTION ABOUT EXPLANATIONS FOR PARTICIPATION RATES

- Why do some families join the scheme in your village and others do not?

SPECIFIC QUESTIONS ABOUT THE DETERMINANTS OF PARTICIPATION

Geographical access factors

- Is the Oxfam health post easy to get to?
- Are alternative clinics, health posts, or sources of drugs easy to get to?
- How important is the closeness of the health post compared to other treatment options in people's decisions to join the scheme?

Poverty and affordability

- How important is poverty in influencing people's decision to join the CBHI schemes? Are there people in this village who cannot afford to join the schemes?

Quality of care and value for money issues

- Do you think that the quality of health care at your village health post is good?
- Do you think that the quality of care available from alternatives to the health post is good? (Prompt: Examples of alternatives include the polyclinic, government health posts, and treating yourself with drugs that you buy at a pharmacy).
- Which alternative do you think offers better quality of care?
- Which alternative offers the best value for money?
- How important do you think that the issues of quality of care and value for money are for people when they are thinking about whether or not to join the CBHI scheme?

Social capital or trust issues

Experience in other countries has shown that the level of trust within a community is one of the factors that can influence people's decision to join a CBHI. If people do not trust each other, if people do not trust the government or other institutions like banks, they are unlikely to trust that the money they pay to join CBHI will be safe.

In every community, some people get along with others and trust each other, while other people do not. I would like us to talk now about trust in your community, and the issue of solidarity, or the degree to which people are prepared to help each other in times of need.

- Can people who live in this village/neighbourhood be trusted?
- Are people in this village/neighbourhood willing to help each other if there is a need to?
- In this village/neighbourhood, do people generally trust each other in matters of lending and borrowing money?
- Do you think that over the last five years, the level of trust in this village has gotten better, worse, or stayed about the same?
- In your community, do you think that individuals would contribute time or money to a community project that will not benefit themselves directly, but will benefit many others in the village/neighbourhood?

Understanding of risk and familiarity with insurance

In other countries people buy insurance to protect themselves from possible but unlikely future problems. For example farmers can pay money to an insurance company so that if their crops fail and they get no money from their harvest the insurance company will pay them something. Another example would be a truck driver who insures his truck so that if he has an accident and damages his truck the insurance company will pay to have the truck fixed.

- Are people in your village familiar with insurance like this?
- Are they familiar with insurance for health care?

In some parts of the world families or expended families help each other in times of need. This help can be very like insurance: if someone needs money for truck repairs or because they need to go to see the doctor, they can borrow money from their family.

- Do people in your village deal with unexpected demands for money in this way?
- Does it affect people's decision to join the CBHI scheme or not?

- How do you think that the CBHI in your village could be changed to get more people to join?

4. MANAGEMENT OF THE COMMUNITY INSURANCE SCHEMES

LINKAGES OF CBHI SCHEME WITH THE REST OF THE HEALTH CARE SYSTEM

If local community-based financing is to be implemented more extensively across Azerbaijan, it is important to consider whether or not it should be integrated within the national health system or exist in parallel.

- What kind of linkages could be developed between the health post in your village and the policlinic in the district town and hospitals? [Probes: Outreach visits by doctors; shared arrangements for buying and distributing drugs; ongoing education for the nurses; training; etc.]
- What kind of linkages could be developed to improve quality of care?
- What kind of linkages could be developed to improve training?
- Is there scope for shared care in your CBHI scheme? (model for management of many chronic diseases such as diabetes and high blood pressure, where: a patient is managed on a routine basis by their PHC practitioner, but there is input from a specialist on a regular basis e.g. consultations with an eye specialist every two years for a diabetic, and more regular contact with a diabetes specialist)

FINANCIAL FLOWS AND BUDGETING

- Currently, how does government funding for PHC get to the health post?
- How could subsidies from the government (funding) be targeted through existing channels for health financing? (Probes: Direct subsidies to schemes; via payment per capita for particular areas)
- How could the groups in need be identified?
- Small community insurance schemes (say with fewer than 500 members) are particularly vulnerable to financial deficits due to seasonal variations of income and unpredictable demand for treatment. What could be done to prevent schemes collapsing from such deficits?
- Would people in you village accept merging their scheme into a larger scheme to ensure that it was able to cope with unexpected costs. If yes, at what level: national; district; sub-district etc.

COST CONTROL MECHANISMS

People covered by health care insurance tend to use health services more frequently. This can be a good thing if the service is useful high priority) or a bad thing if it is not. Due to the increasing technologies and user demand, there is a tendency for the cost of providing health care to increase, and managing cost containment is important.

- Is there (or would there be) resistance on the part of nurse practitioners to controlling the drugs they are allowed to prescribe?
- How are drugs used in your village health post currently purchased and distributed to the post? Ask about other private and public alternatives; how do people get drugs usually?

USES FOR THE ACCUMULATED FUNDS

- Are you aware of what happens to members' contributions?

- What should the accumulated funds be used for? Paying for drugs, for administration of the scheme, for health care, for additional benefits like secondary care (hospital / specialist care), for infrastructure improvements etc?

5. SCALING UP COMMUNITY BASED HEALTH INSURANCE IN AZERBAIJAN

SCALINGUP COMMUNITY INSURANCE: SYSTEM REQUIREMENTS

- What should the future role for community-based health insurance in your village be? In other parts of Azerbaijan?
- What would be the role of different stakeholders in an expanded community insurance model? Who should be running the schemes? Who should be financing or subsidizing them? Who should be monitoring and regulating them?
- Would you be prepared to join forces with other schemes or villages, and have less direct control over scheme management, if there were benefits such as shortfall funding; increased training and support for the nurses; or outreach by doctor, etc. ?
- How could they be made sustainable? (Subsidies by the government; etc.)
- What health care services should be covered in the benefit package of CBHI schemes? Which population groups should be subsidized realistically?

COMMUNICATION CONSENSUS BUILDING

- In your view would scaling up community insurance nationally be acceptable generally?
- Which actors would oppose or be supportive of it [Probes: The wealthy; the poor; the middle class; rural people; donors; local NGOs; the MoH; the Ministry of Finance; doctors …]
- What needs to be done to ensure support for scaling up community insurance nationally? How should this process be managed?
- Would you expect any challenges to this process?

Questions for Key Informants at the Policy level
(CENTRAL AND DISTRICT LEVEL)

1. PRIMARY HEALTH CARE AND HEALTH POLICY OBJECTIVES IN AZERBAIJAN

CURRENT SITUATION IN RURAL PRIMARY HEALTH CARE IN AZERBAIJAN

Organisation of Rural PHC in Azerbaijan

- What do you see as the major health problems for rural communities in Azerbaijan?
- What health services are most needed by the rural population?
- Central Level: How is primary health care organized and delivered in rural areas? District Level: How is primary health care organized and delivered in your district? Who provides it? What are the referral channels? Do people follow these channels or use other pathways?
- Do you think rural residents face any problems in accessing primary and hospital care? If yes, what are they?

Financing of Rural PHC in Azerbaijan

- How is primary health care for remote rural communities financed? What services are covered in the Basic Benefits Package? In reality, are the services included in the BBP provided for free?
- How are the funds allocated and accounted for? (description of financial flows)
- Are there specific subsidies for poor/ rural people? If so what mechanisms exist for disbursing these funds?
- Are users required to pay out-of-pocket for some services, drugs, etc.?
- Do you think informal payments are also happening here?
- Would you say that out-of-pocket and informal payments are affordable or represent a burden?
- What strategies do people adopt to pay for heath care?
- In your view, is catastrophic health expenditure a problem in Azerbaijan?

Quality of care

- Are their nationally defined quality of care standards at the primary health care level?
- Are there quality related incentives or penalties at the primary health care level?
- Who is responsible for monitoring and evaluation of PHC quality?
- Is re-registration or ongoing registration of medical practitioners (doctors and nurses) dependant on them completing specified ongoing education and training requirements or other competence related criteria?

Health Information Systems

- What are the information requirements for PHC e.g. what sort of information is routinely collected about service delivery, utilisation, reasons for presenting to clinics, diagnoses and treatments. [Probes: national health information strategy; specified data collection formats such as the International Classification of Primary Care; etc.]
- Who sends data to whom?
- Where is it managed and aggregated?

PHC REFORM

Assessment of PHC reform and desirability of alternative options

- What are the main reforms in the PHC in the past several years? Are there any reforms related specifically to PHC in remote rural communities?
- What other issues have to be addressed? [Probes: planning, organization and financing of PHC in rural areas] How could these issues be addressed? [Probes: economic or community development; health sector reform; social support system reform]
- What are the priorities for reform of rural health care? [Probe: more revenue; equity among different groups; feasibility etc.]
- To what extent are the problems of rural PHC delivery related to the way that the health system is financed? [Probes: Discuss pros and cons of financing based on general taxation; on social insurance tax; community prepayment/insurance; out-of-pocket payments; etc.]

Community financing for rural PHC

- Have you heard about Oxfam-initiated community-based health insurance schemes in the rural regions of Barda, Ter ter, Goranboy and Yevlakh districts? [if not, give concise summary]
- How important do you think CBHI schemes are for the delivery of PHC services to rural communities in Azerbaijan?
- To what extent is community-based health insurance (prepayment to a fund in return for guaranteed future access to a defined package of health care) acceptable to people in Azerbaijan? [Probes: Is it too big a change from previous ways of financing health care? Is it compatible with Azerbaijan's culture, and values?]
- Are such schemes helpful in the Azerbaijan's current circumstances?
- Why do CBHI schemes currently exist in Azerbaijan, what is their purpose? [Prompts: raising revenue; improving access to care; improving quality of PHC; as a stepping stone towards universal compulsory health insurance; etc.]
- Do you see community-based health insurance as being compatible with longer-term health policy objectives and national health priorities? [Probes: fundraising; reaching disadvantaged or isolated communities; motivating people to contribute; obtaining donor funding etc.]
- Could you please outline some advantages and disadvantages of CBHI schemes in the Azerbaijan context?

Public preferences/ shared values / social capital

- How strong is the support for public provision of health care?
- In general terms, how willing are people in Azerbaijan society to help each other financially and in other ways? [across communities; social networks]
- Within Azerbaijan society, what are the attitudes to the poor and socially disadvantaged? Do people see them as deserving of assistance? Is there support for exemptions or subsidies for these groups?
- Are there any others groups that Azerbaijanis regard as especially deserving of support or subsidy to enable them to access medical care (e.g. people suffering from chronic diseases; disabled people; war veterans etc.)?

- To what extent is healthcare seen as a personal responsibility, a community responsibility, or a government responsibility? Are perceptions of responsibility changing?
- To what extent is there trust in public and private institutions (incl. the government)? Why? To what extent is corruption an issue within the health system in Azerbaijan?

2. DESIGN OF HEALTH INSURANCE SCHEMES

POPULATION COVERAGE

An important issue when designing CBHI schemes is deciding who the scheme should be aimed at.

- What population is the scheme supposed to serve?
- In Azerbaijan, who should the CBHI schemes aim to cover? [Probes:
  - **a.** Geographical aspect: rural/ urban?
  - **b.** Socioeconomic aspect: everybody; the poorest; those below average…
  - **c.** Vulnerability aspect: groups that do not have good access to care (disadvantaged in other ways, informally employed, children; people suffering from many or chronic diseases …)
- Who should be covering the rest of the population? (the ones not mentioned above)
- Should population coverage under health insurance schemes be extended? If yes, how?

VOLUNTARY OR COMPULSORY MEMBERSHIP

Membership in local insurance schemes is usually voluntary, while in national social insurance schemes it is compulsory, although there are some exceptions.

- In your view, are there any obvious advantages and disadvantages of compulsory versus voluntary membership? [Probes: Advantages: risk pooling; mobilizing resources; improving solidarity… Disadvantages: informal economy; fluctuating incomes…]
- Would compulsory membership of locally managed schemes be acceptable in Azerbaijan? Why yes/ why not? What would people's reaction to that be?
- Would it be feasible in the current circumstances? Would there be any problems? [Probes: administrative costs; difficulty collecting compulsory contributions; corruption etc.]

BENEFIT PACKAGES AND RELATED ISSUES

Benefits package

One of the key questions in every insurance scheme, national or local, is what conditions and services should be covered. This has implication for the willingness of population to participate and for scheme sustainability.

- What type of services do you think should be covered: [Probes:
  - **a.** Primary health care/ first aid
  - **b.** Reproductive health care/ maternal care/ contraception
  - **c.** Chronic diseases (hypertension; diabetes; asthma; cardio-vascular diseases)
  - **d.** Mental health services
  - **e.** (Re)emerging diseases (TB/ HIV)

f. Diseases leading to catastrophic expenditure at the hospital level (cancer, stroke, etc.)]

- Which ones are more important from a policy perspective? Which ones are likely to be preferred by the population?
- How important is that the community based schemes cover hospital care and care leading to catastrophic expenditure and poverty? If not, who should fund it? Do you think that the insurance schemes should aim to cover acute secondary level care e.g. emergency caesarean section, in the long run?
- Should insurance cover non -medical costs such as transportation to hospitals?
- Should benefits be portable (should members be able to access care when away from usual place of residence)?
- Level of contribution and mode of payment
- Do you think that it is a good idea that community based health insurance offers different packages of care at different prices so that people could have choice? Or should all people joining CBHI pay the same?
- Do you think that it would be acceptable in Azerbaijan for different models of payment to coexist in different areas, or for different groups or services? For example if some people had to insure themselves, while others had their insurance subsidized by the state, and others paid out-of-pocket for some services?
- Do you think that it would be acceptable in Azerbaijan for those insured or subsidized by the state to make a co-payment (a small percent of the total cost) when using health services, in order to prevent them overusing the services? (the poorest could be exempted)
- Do you think that it is a good idea that people with chronic illnesses enrol in pre-payment or savings schemes to help them budget for their medical expenses? Is there a better alternative?

Subsidies

Financial analysis of the Oxfam community-base health insurance schemes clearly demonstrate that ongoing Oxfam subsidies of a certain percentage of total costs are required to make the schemes financially sustainable. The scope for increasing population contributions is limited given that many people cannot afford to contribute to insurance even in the current conditions. The following questions relate to who should subsidise the poor and vulnerable groups, who should be eligible for these subsidies and how it might be possible to ensure that the system is not abused.

- Who would provide these subsidies? (Probes: government; donors; population contributions)
- How should subsidies be targeted?
  a. Linked to patients i.e. targeted at specific groups such as the very poor or otherwise disadvantaged?
  b. Linked to particular high priority services (e.g. pre- and post-natal care, chronic diseases that are the major cause of morbidity and mortality)?
  c. Linked to services with significant externalities e.g. immunisation, health education and health promotion (e.g. HIV/AIDS prevention strategies etc.).
- Given that these schemes provide essential services in rural areas that are not otherwise available, should some state institutions seek to subsidize these schemes?

- What groups should be subsidised?
  - **a.** The poorest of the poor (the poorest 25%).
  - **b.** Those who cannot afford to join insurance schemes but are not exempted
  - **c.** Specific groups at risk (pregnant mothers, children, other) who may not be always poor.
  - **d.** Other
- What are the challenges to targeting benefits? (Probes: weak administrative capacity/ seasonal variations in income/ difficulty assessing income due to the informal nature of much economic activity/ difficulty defining and identifying vulnerability/ corruption)
- Do you have any other suggestions as to how access for the poorest could be insured?

MANAGEMENT OF THE COMMUNITY INSURANCE SCHEMES

Linkages of community insurance scheme with the rest of the health care system

If local community-based financing is to be implemented more extensively across Azerbaijan, it is important to consider whether not it should be integrated within the national health system or to exist in parallel.

- What kind of linkages could be developed between a rural PHC health post staffed by a nurse and policlinics in district towns and hospitals. [Probes: Outreach visits by health care professionals; integrated drug procurement and distribution; ongoing education; training; integration of HIS etc.]
- What kind of linkages could be developed to improve continuity of care? (e.g. for patients requiring care at different levels of the system)
- What kind of linkages could be developed to improve quality of care?
- What kind of linkages could be developed to improve training?
- How could nurse practitioners, such as the ones running the health posts in the Oxfam supported schemes, be supported by non-scheme PHC doctors?
- How could vertical programmes like dispensary care for diabetes / HIV/AIDS VCT units be integrated with care provided in village health posts?
- Ideally, what should be the role of the nurse practitioners in the community insurance health posts? [Probes: Referral; follow-up; gate-keeping role]
- Is there scope for shared care in Azerbaijan? (model for management of many chronic diseases such as diabetes and high blood pressure, where: a patient is managed on a routine basis by their PHC practitioner, but there is input from a specialist on a regular basis e.g. consultations with an eye specialist every two years for a diabetic, and more regular contact with a diabetes specialist)
- Could existing financial disbursement, budgeting and payment mechanisms deal with integrating CBHI schemes?

Financial Flows and Budgeting

- Currently, how does government funding for PHC get to the primary health care providers? (From central budget to…)
- What budgeting mechanisms are used? (Probes: Contracting; line-item budgets; global budgets)
- How could subsidies (funding) be targeted through existing channels for health financing? (Probes: Direct subsidies to schemes; via payment per capita for particular areas)

- How could the groups in need be identified?

Small community insurance schemes (say with fewer than 500 members) are particularly vulnerable to financial deficits due to seasonal variations of income and unpredictable demand for treatment.

- What could be done to prevent schemes collapsing from such deficits?
- Merging small insurance schemes into larger entities to increase their ability to cope with unexpected costs? If yes, at what level: national; district; sub-district etc.
- Reinsurance by a different institution (donor; government or others covering deficits)
- Direct subsidy by the Government or donors (underwriting schemes)

Provider payment mechanisms

- How are PHC providers (doctors and nurses) in the public facilities currently paid in Azerbaijan? (Probes: Via salaries, on a per capita basis; income from user-fees ….) Are there any additional benefits or sources of income for providers? (Informal, non-financial)
- Is it possible under current legislative arrangements to pay doctors incentives relating to high priority services such as immunisation or health promotion?

Cost control mechanisms

- Is the essential drug list based on WHO recommendations used across all public facilities in Azerbaijan? Is this monitored?
- Are there treatment protocols based on such a list in Azerbaijan?
- Is there (or would there be) resistance on the part of providers to regulation of their prescribing autonomy?
- Has a standard treatment manual been developed specifying how common medical problems at the PHC level can be treated with drugs from the essential drug list?
- How are drugs currently purchased and distributed in Azerbaijan?
- Would centrally managed drug procurement via international competitive tender for generic drugs on an approved drugs list be possible in Azerbaijan?

3. SCALING UP COMMUNITY BASED HEALTH INSURANCE IN AZERBAIJAN

SCALING UP COMMUNITY INSURANCE: SYSTEM REQUIREMENTS

- What should the future role for community health insurance PHC level in Azerbaijan be? [Probes: Major role in the delivery of PHC; PHC only in rural areas; parallel to government-run PHC, to cover gaps; as an intermediate stage to social insurance]
- To what extent does CBHI fit with the current pattern of PHC provision and financing? How could the expanding number of insurance schemes be integrated into the national health system? [District: If CBHI funds are consolidated in some form within this region, with expanded coverage, do you think some of your PHC budgetary funding could be channelled to them? Under what conditions? (e.g. supervision) Do you think that the existing mechanisms for disbursing funds to the government run village health posts could be used for this?]
- What should be the purpose and the objective(s) of a national roll out of CBHI? [Probes: Supporting equity and improving access; raising revenue; increasing the cost-effectives of PHC provision; ensuring better transparency and accountability etc.)

- What should be the role of different stakeholders in an expanded community insurance model? Who should be running the schemes? Who should be financing or subsidizing them? Who should be monitoring and regulating them?
- How could they be made sustainable? (Subsidies by the government; etc.)
- Is expansion of the community health insurance PHC feasible currently?
- What health care services should be covered in the benefit package of CBHI schemes? Which population groups should be subsidized realistically?
- Expansion of community insurance schemes nationally is likely to require significant technical assistance. In Azerbaijan, who would be able and willing to take this role? [Probes: MoH, donors, NGOs; academic institutions; international consultants…]
- Is such a national rollout feasible currently?

Enabling legislation and regulation

- Does the current legislative framework allow for expansion of the CBHI?
- Is there an appropriate regulatory framework specifying standards and able to monitor costs, quality of care, quality of management etc.? Who could be responsible for regulating the schemes? How?
- Would it be possible to legislate for mandatory insurance cover for the population? Would that be feasible and acceptable?
- Is there a need to mandate risk pooling strategies e.g. requiring reinsurance with a regional or national insurance company; defining a minimum demographic base for insurance scheme coverage etc?

Communication Consensus building

- In your view would scaling up community insurance nationally be acceptable generally?
- Which actors would oppose or be supportive of it [Probes: The wealthy; the poor; the middle class; rural people; donors; local NGOs; the MoH; the Ministry of Finance; doctors …]
- What needs to be done to ensure support for scaling up community insurance nationally? How should this process be managed?
- Would you expect any challenges to this process?

First published online by Oxfam GB in 2010.

This document is part of a collection of programme evaluations available from Oxfam GB in accordance with its evaluation policy.

This document was originally written for internal accountability and learning purposes, rather than for external publication. The information included was correct to the evaluator's best knowledge at the date the evaluation took place. The views expressed in this report are those of the author(s) and do not necessarily reflect Oxfam's views.

For further information on the issues raised in this document email phd@oxfam.org.uk

Oxfam is a registered charity in England and Wales (no 202918) and Scotland (SC 039042). Oxfam GB is a member of Oxfam International.

www.oxfam.org.uk