International Labour Organization

Extending social health protection: Accelerating progress towards universal health coverage in Central and Western Asia

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Abstract

Adequate access to quality health care without hardship and income security is essential to the realization of the human rights to health and social security. In line with a rights-based approach to achieving the Sustainable Development Goals (SDGs), extending social health protection contributes to universal social protection and universal health coverage. Demographic and epidemiological transitions, changes in the world of work, and economic, health and environmental shocks, as well as the climate crisis, all underline the need for robust social health protection systems capable of providing sustainable pathways towards universal coverage.

This compendium provides practitioners and policymakers with an analysis of the strategies, lessons learned and architecture of social health protection systems in countries across Central and Western Asia (Armenia, Azerbaijan, Cyprus, Georgia, Israel, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Türkiye and Uzbekistan). The comparative analysis is guided by relevant international standards, namely the Medical Care Recommendation, 1944 (No. 69); the Social Security (Minimum Standards) Convention, 1952 (No. 102); the Medical Care and Sickness Benefits Convention, 1969 (No. 130); the Medical Care and Sickness Benefits Recommendation, 1969 (No. 134); the Maternity Protection Convention, 2000 (No. 183); and the Social Protection Floors Recommendation, 2012 (No. 202). This publication reaffirms the right to social health protection and its role as a transformative policy tool contributing to effective access to essential health care without financial hardship, in a way that reflects equity, risk-sharing and solidarity in financing.

Key words: social health protection, social protection, universal health coverage, health financing, Central and Western Asia, Armenia, Azerbaijan, Cyprus, Georgia, Israel, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Türkiye, Uzbekistan, universal social protection, social health insurance, national health service, health care.

Foreword

Social health protection, embedded in comprehensive social protection systems and strong health systems, is central to achieving the Sustainable Development Goals (SDGs). The second political declaration of the United Nations General Assembly on Universal Health Coverage adopted in September 2023 recognizes the fundamental importance of "equity, social justice and social protection mechanisms [...] to ensure universal and equitable access to quality health services without financial hardship for all people" (UN 2023). It is necessary to move from implementing ad hoc responses to ensuring universal, comprehensive, adequate and sustainable social health protection systems which uphold human rights to health and social security. Only through legally anchored and coordinated responses will we be able to reach the objectives set out in the 2030 Agenda, most notably universal social protection systems, including floors (target 1.3) and universal health coverage (target 3.8) by 2030.

Strong social health protection systems are supportive of crisis response and a just and smooth transition. The climate crisis engenders changes that directly or indirectly impact human health, including adverse extreme weather events and greater susceptibility to communicable diseases, vector- and water-borne diseases. In recent years, the emergence of new diseases and health security threats such as pandemics have been observed, as well as their interplay with non-communicable diseases. Indirect impacts include disruptions to livelihoods, food systems, human mobility, conflicts and overall intensification of socio-economic inequalities, which act as determinants of health equity. The Global Call to Action adopted in 2021 by the International Labour Conference reaffirmed the centrality of social protection at the core of a human-centred recovery from the COVID-19 pandemic. The pandemic starkly revealed the absolute necessity of social health protection to protect people's health and ensure income security in times of sickness.

Despite laudable progress over the past decades, these rights are not yet a reality for all in Central and Western Asia. Inequalities in access to services and impoverishment due to out-of-pocket (OOP) health spending still exist both across and within countries. Gaps in adequacy disproportionately affect the most vulnerable and jeopardize the social contract. To address these challenges, more attention must be paid to the range of services guaranteed, assuring the spectrum of care from health promotion and prevention to rehabilitation and palliative care, limiting households' OOP spending and securing income support during sickness and maternity. Securing high-level commitments from Member States to assume the primary responsibility for the design, implementation and financing of social health protection is essential to addressing these issues. Such efforts must be informed by other key principles, including collective financing, broad risk-pooling and rights-based entitlements.

Access to social health protection is essential for decent work and needed more than ever to enhance social cohesion and social justice in the face of the climate crisis. It is a moral imperative and essential for a future grounded in solidarity between people, communities and nations, across generations. This report aims to accompany constituents and other stakeholders in their journeys towards universal health coverage. It is based on the acknowledgement that our challenges are interconnected and that addressing them requires exchanges of experiences and knowledge across countries, based on the shared values of global solidarity, for prosperity and for peace.

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Acronyms

ADB	Asian Development Bank
ADP	Additional Drug Package
AEOI	Automatic Exchange of Financial Account Information
AIDS	Acquired Immunodeficiency Syndrome
ALOS	Average Length of Stay
AMI	Acute Myocardial Infarction
ARMED	Armenian National Digital Health System
AZN	Azerbaijan Manat
BBP	Basic Benefits Package
CE	European Conformity (Conformité Européenne)
CHE	Current Health Expenditure
CIS	Commonwealth of Independent States
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Coronavirus Disease 19
CRS	Common Reporting Standard
CT	Computed Tomography
CVA	Cerebral Vascular Accident
CVD	Cardiovascular Disease
CWA	Central and Western Asia
DRGs	Diagnostic-Related Groups
EAEU	Eurasian Economic Union
ECG	Electrocardiogram
EDS	Electronic Digital Signature
eHealth	Electronic Health
ESC & UAC	Emergency Situations Coordination and Urgent Assistance Centre
EU	European Union
EU-SILC	European Union Statistics on Income and Living Conditions
EXT	External Health Expenditure
FAP	Feldsher-Accoucher Posts
FFS	Fee-For-Service

FLSEB	Family Living Standards Enhancement Benefits
FTT	Financial Transaction Taxes
GDP	Gross Domestic Product
GERF	Government Employees Retirement Fund
GGE	Gross Government Expenditure
GGHE-D	Domestic General Government Health Expenditure
GHIS	General Health Insurance Scheme
GHS	General Health Care System
GMSP	Guaranteed Medical Services Programme
GNI	Gross national income
GOA	Government of Armenia
GP	General Practitioner
GVFMC	Guaranteed Volume of Free Medical Care
HDI	Human Development Index
HIC	Health Implementation Communiqué
HIO	Health Insurance Organization
HIV	Human Immunodeficiency Virus
HSPC	Health Care Services Pricing Commission
HTA	Health Technology Assessment
HTP	Health Transformation Programme
HWF	Health Workforce
ICLS	International Conference of Labour Statisticians
IDPs	Internally Displaced Persons
IFFs	Illicit Financial Flows
ILO	International Labour Organization
INN	International Non-proprietary Names
ISSA	International Social Security Association
ISSS	Insurance State Supervision Service
ITC	Information Technology System
KZT	Kazakhstan tenge
LTC	Long-Term Care
MAC	Medical Accreditation Commission
MAP	Medical Assistance for the Poor
MEDULA	E-prescription Process in Medikal Ulak

MHI	Mandatory Health Insurance
MHIF	Mandatory Health Insurance Fund
MICS	Multiple Indicator Cluster Surveys
MMR	Maternal Mortality Rate
MoH	Ministry of Health
MoHSP	Ministry of Health and Social Protection
MoU	Memorandum of Understanding
MRI	Magnetic Resonance Imaging
MSEs	Micro and Small Enterprises
MSHIP	Mandatory Social Health Insurance Package
MSHIS	Mandatory Social Health Insurance System
NANNOUz	National Association of NGOs of Uzbekistan
NCDC	National Centre for Disease Control and Public Health
NCDs	Non-communicable diseases
NDS	National Development Strategy
NHA	National Health Account
OBGYN	Obstetrician Gynecologist
OECD	Organization for Economic Co-operation and Development
OOP	Out of Pocket
P4H	Providing for Health
PD	Personal Doctor
PET-CT	Positron Emission Tomography-Computed Tomography
PHC	Primary Health Care
PPP	Purchasing Power Parity
RMNCH	Reproductive, Maternal, Newborn and Child Health
RMO	Regional Medical Officer
SAMHI	State Agency for Mandatory Health Insurance
SDGs	Sustainable Development Goals
SGBP	State-Guaranteed Benefits Programme
SHA	State Health Agency
SHI	Social Health Insurance
SHIF	Social Health Insurance Fund
SHP	Social Health Protection
SHSO	State Health Service Organizations

SIO	Social Insurance Organization
SIS	Social Insurance Services
SP	Social Protection
SRAMA	State Regulation Agency for Medical Activities
SSA	Social Service Agency
SSI	Social Security Institution (SGK)
SVP	Rural Medical Posts (Selski Vrachebny Punkt)
TABIB	Administration of the Regional Medical Divisions
TB	Tuberculosis
THCE	Total Health Care Expenditure
TPA	Third-Party Administrators
UCP	Unified Cumulative Payment
UHC	Universal Health Coverage
UHC SCI	Universal Health Coverage Service Coverage Index
UHCP	Universal Health Coverage Programme
UHI	Universal Health Insurance
UN WOMEN	United Nations Entity for Gender Equality and the Empowerment of Women
UNDP	United Nations Development Programme
UNGA	United Nations General Assembly
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
US$	United States Dollar
USP	Universal Social Protection
USSR	Union of Soviet Socialist Republics
UZSTAT	Statistics Agency under the President of the Republic of Uzbekistan
VAT	Value-Added Tax
VHI	Voluntary Health Insurance
WHO	World Health Organization

Executive summary

Access to health care without hardship and income security during sickness and maternity are at the core of comprehensive social protection systems. Rooted in international human rights instruments and international social security standards, social health protection (SHP) provides a rights-based framework towards the policy objectives of universal social protection (USP) and universal health coverage (UHC), which are key to achieving the Sustainable Development Goals (SDGs).

This publication analyses and compiles experiences from countries in Central and Western Asia (Armenia, Azerbaijan, Cyprus, Georgia, Israel, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Türkiye, Uzbekistan) in their efforts to build universal SHP systems that are resilient, effective, inclusive, adequate and sustainable over the long term. The report highlights progress made, challenges encountered and remaining gaps, and explores their root causes. The information gathered provides insights for practitioners and policymakers on concrete ways to design, extend, adapt and implement SHP systems and policies. It also constitutes a basis for fostering learning and exchanges of experiences across countries.

This report recalls the following rationale for extending SHP to reach universal coverage [1] in each country: SHP provides a platform for health and social policies to work together and maximize both operational synergies and opportunities to mobilize public resources for a joint agenda; it is a worthy investment as it directly contributes to wellbeing and productive capacities at the individual, household, community, societal and global levels. Such an investment is in line with creating the necessary conditions for a just transition amidst an unprecedented climate crisis and the recent experience of pandemics spreading across the globe.

The research for this publication started in 2022, with a number of countries in Central and Western Asia (CWA) either having recently adopted reforms or currently discussing reforms related to social health protection. In this context, the publication constitutes a timely input to support all concerned stakeholders with strategies for strengthening and extending their systems, with cohesion and synergy between all social protection benefits. This would enable societies in Central and Western Asia to move towards an inclusive transition that addresses the deep structural inequalities that have obstructed progress towards social justice for too long.

The publication is comprised of two parts: The first part provides a comparative analysis of SHP in Central and Western Asia across the dimensions of coverage, adequacy, administrative and financing arrangements. The second part is composed of nine country profiles, demonstrating the diversity of contexts, paths and policy choices made in Central and western Asia.

Coverage

Over the past decades, many countries in Central and Western Asia have adopted reforms related to SHP coverage, following which, most countries that were part of the Soviet Union have had a legal framework guaranteeing access to health care services without financial hardship. However, these countries have encountered difficulties in sustaining these rights in practice and more recently adopted different types of reforms.

Legal entitlements to access health care without hardship are in place and legal coverage is therefore near universal in the subregion. With some exceptions, non-nationals–such as migrant workers, asylum seekers and refugees– enjoy a variable level of inclusion in such legal frameworks and remain legally excluded in some countries. Some countries have put in place legal guarantees that are either limited to population groups below a certain income threshold, or universal guarantees but for a limited range of services, which limits both effective access and financial protection (see adequacy). While legal

[1] Where “universal” means that the entire population is covered.

frameworks tend to secure broad population coverage, a number of countries still have segmented rights where different population groups are entitled to different ranges of services in different networks of service providers.

In practice, the implementation of legal entitlements can be limited by many barriers, such as lack of awareness and registration, physical distance, limitations to the range, quality and acceptability of health services, informal OOP payments at the point of care and long waiting times, linked to shortage and unequal distribution of health and care workers, and opportunity costs such as lost working time. Another limiting factor takes the form of ill-adapted eligibility criteria. In this respect, current reforms to introduce national health insurance schemes, where large segments of the informal economy are meant to be included on a contributory basis, must not conflate financing mechanisms with eligibility to receive benefits. As early as 1944, ILO Recommendation No. 69 called for complete preventive and curative care to be available at any time and place to all members of the community covered by the service, on the same conditions, without any hindrance or barrier of an administrative, financial or political nature, or otherwise unrelated to their health. While the range of health services available in the subregion have been justly expanded to include rehabilitation and palliative care, it has proven difficult for many countries covered in this report to implement these recommendations. It is important to identify the reasons for the delays in implementation.

Guaranteeing access to health care services without hardship should go hand in hand with entitlements to income security during sickness and maternity in order to effectively respond to the risk of hardship faced by households. However, less than half of the workforce in the subregion is mandatorily covered for sickness cash benefits. Five countries in the subregion rely exclusively on employer liability to provide income security in case of sickness, which is less robust in providing effective protection. Legal coverage for maternity cash benefits is high, with most countries providing either contributory or non-contributory entitlements and with limited reliance on employer liability. However, less than 45 per cent of women in the subregion who give birth receive a maternity cash benefit to ensure income security during pregnancy, childbirth and recovery from delivery.

Adequacy

Many countries have made significant progress in terms of increasing SHP population coverage, but the adequacy of benefits provided remains a challenge. Adequacy of benefits implies they are sufficiently comprehensive (wide spectrum of services), of high quality and provide a sufficient level of financial protection, as defined in international social security standards.

OOP expenditures represent less than a fifth of current health expenditure in Cyprus, Israel and Türkiye, while it remains the main source of health expenditure in Armenia, Azerbaijan, Tajikistan, Turkmenistan and Uzbekistan. Catastrophic OOP expenditures on health care are kept relatively low on average in the subregion, but with large discrepancies across countries. Moreover, recent data points are missing for some countries, and measurement of unmet health care needs is lacking.

Four main factors are indicative of significant adequacy gaps in Central and Western Asia:

- Firstly, despite recent reforms, many countries have State-guaranteed benefit packages that include too few services provided without or with low co-payments. This explains why, while legal entitlements cover almost cover entire populations, OOP spending remains the main source of current health expenditure in many countries. This means that countries need to adapt both their legally guaranteed benefit packages and reinforce service delivery on the ground to effectively make services available.
- Secondly, levels of public spending remain relatively low, while countries experience pressures linked to increased costs of care due to new technologies, population ageing and a growing financial and societal burden of chronic diseases.
- Thirdly, high population coverage does not necessarily translate into equitable access to services and health outcomes. This relates to the distribution and quality of facilities and services. Significant efforts have been made to make health services and related infrastructure geographically available and accessible. Nonetheless, the issue of adequate distribution of services and retention of a skilled health workforce remains of concern in many countries.

This goes hand in hand with the need to reinforce primary health care and transition away from systems largely based on hospital care. Many countries in the region have made recent commitments to improve primary health care. Implementing such commitments requires strong stewardship and regulatory capacity on the part of Ministries of Health.

- Lastly, even in countries that have taken specific measures to ensure that the poor and vulnerable have financial protection against health care costs through various measures (non-contributory health cover with broad benefit packages, co-payment and user fee waivers), such as Türkiye for instance, the poorest remain disproportionately at risk of catastrophic health spending, illustrating that efforts to reduce poverty and income inequality, including through adequate social protection cash benefits throughout the life cycle, are urgently needed.

Stronger linkages and better coordination between access to health care and income security are urgently needed to address key social determinants of health. The rise of non-communicable diseases in the subregion calls for a better integrated approach between social protection and health policies in a way that supports healthier life styles and early detection of these chronic diseases to avoid residual disability. Significant coverage gaps in social protection cash benefits, especially when it comes to maternity and sickness, impede such coordinated action.

Institutional arrangements and coordination

Both coverage and adequacy can be increased if strong institutions with effective participation in their governance, and efficient administration are in place. In this respect, despite laudable progress, there is room for improving participatory processes in the governance and administration of social health protection entitlements in Central and Western Asia. The objectives of equity and effective access pursued by SHP schemes need to be at the centre of institutional arrangements and administrative systems.

A number of countries in the region have broad risk pools, either implemented from the design stage of their system or through progressive efforts to consolidate and merge schemes by putting in place single-payer agencies and reducing fragmentation. Other countries maintain differential entitlements for different population groups (segmentation of rights) as well as fragmented risk pools and institutions responsible for purchasing services. A split between purchasing and provision functions is implemented unequally across countries in Central and Western Asia. Most of the countries in the subregion have recently embarked on reforms thereof, with the majority historically lacking such a split. The implementation of newly adopted reforms is uneven across countries.

Institutional arrangements need to foster greater coordination with the broader social protection system, cutting across short-term and long-term social protection benefits, and the burden of such coordination should not fall on the intended beneficiaries. The rationale for such coordination is threefold:

- Firstly, policies aimed at reducing the cost of health care services for the poor alone are insufficient to tackle income inequality and pervasive pockets of poverty. In turn, income insecurity, inequality and poverty are social determinants of health, strongly correlated with poor access to health care services and relatively poorer health outcomes. Access to adequate child benefits, old age pensions or disability benefits provide the necessary income security to live a dignified life, while empowering those who receive them, facilitating their access to healthy life choices and appropriate health care services.
- Secondly, a person's health status affects their capacity to fully engage in the labour market, and poor health can jeopardize income security. Adequate cash benefits are essential to guaranteeing income security when health is affected – in the case of maternity, illness, employment injury or occupational diseases as well as in old-age. Sickness cash benefits in particular, play an essential role in guaranteeing income security and preventing the spread of communicable diseases, as the COVID-19 pandemic has demonstrated.
- Thirdly, where long-term care, child care or social care services are not available, the burden of caring for a sick or dependent relative usually falls on family members (often women), depriving them of the opportunity to fully engage in income-generating activities. This burden may increase as population ages and non-communicable diseases (NCDs) rise, while there is already significant disparity between women and men in terms of labour market engagement in the subregion.

For these reasons, health care benefits need to be closely coordinated with cash benefits and social care within comprehensive social protection systems to respond to population needs, leverage administrative systems and maximize the socio-economic impacts of health and social policies. To ensure continuity of coverage throughout the lifecycle, operational linkages across different types of benefits (health care, family allowances and old age pensions) and between contributory and non-contributory benefits are necessary. This involves the design and implementation of an organizational setup allowing common functions as well as management tools (a coordinated database) to be shared across contingencies, under the umbrella of enabling cross-sectoral policies.

Financing

More public resources are needed to make solidarity in financing a reality in Central and Western Asia. Underfunding remains a major barrier to providing adequate coverage and ensuring social health protection entitlements are effectively availed by populations. The volume of current health expenditure in Central and Western Asia represents less than 6 per cent of GDP, representing about half that of the regional average of Europe and Central Asia. Public resources represent about four fifths of current health expenditure in two countries in Central and Western Asia, while it represents less than half of current health expenditure in five countries. Enhanced public resources, in terms of quality and volume, are necessary to make solidarity in financing a reality, backed by comprehensive legal frameworks with adequate regulatory mechanisms developed through social dialogue to ensure sustainable systems amidst changing political priorities. It is estimated that the subregion would need to mobilize an additional 2.5 percentage points of GDP in order to guarantee a social protection floor (SPF) comprising access to essential health care without hardship, and five cash benefits providing a minimal level of income support along the life cycle contingencies of unemployment, old-age, maternity, disability and child maintenance.

A number of countries in the subregion rely heavily on OOP spending to fund health care expenditure. Reliance on OOP spending and private health insurance reduces social solidarity and maintains inequities in accessing health care and financing the system. Private commercial health insurance plays a small role in health financing in the subregion and is mostly used by those who can afford it, potentially diverting resources that could be otherwise pooled across the entire population.

The share of government expenditure allocated to health in Central and Western Asia has increased in recent decades, indicating that some priority is given to the sector, with countries in the subregion mobilizing different types of sources of public funding to secure entitlements to health care without hardship. With the exception of Georgia, the countries with the highest share of public spending in current health expenditure have used a mix of earmarked resources from social security contributions and non-earmarked resources from the general government budget, encompassing diverse sources of revenues. Aside from social security contributions, few countries have resorted to other earmarked resources, and rather rely largely on non-earmarked sources which tend to require stronger advocacy to be sustained over time, due to changing government priorities. Importantly, with the introduction of new or expanded health taxes in many Central and Western Asian countries, there is potential to increase earmarked resources for health. External resources play a very small role in health financing in the subregion.

As part of ongoing reforms, a number of countries have decided to transition to national social health insurance systems to cover all or some levels of care for the entire population. The expectation is that legislative reforms will lead to new single payers pooling various sources of revenues, including social security contributions made by those in different forms of employment who can contribute. While the process should be straightforward in countries with large formal economies, in others with sizeable informal economies, it will need to be accompanied by broader efforts to facilitate transitions from the informal to the formal economy. Such efforts go beyond the mandate of a single ministry and need to be a national effort. They should allow access to more sources of both earmarked and non-earmarked government revenues of a progressive nature (including income taxation on households and profit taxation on companies) which should eventually be mobilized for social protection and health policies as part of a diversified financing mix.

The way forward

Country trajectories in the region show that there is no one-size-fits-all solution to make SHP a reality for all. Success has more to do with political and societal commitments, historical trajectories and the application of guiding principles in line with international social security standards than with specific financing or institutional models.

While this holds true, to a certain extent, countries face common challenges. At the core of SHP are the principles of solidarity and equity, and the principle that everyone, rich or poor, should have access to the same provision of health care and should have a secure income when sick or during periods of maternity and disability. In practice, too many countries in Central and Western Asia rely on direct payments from households to finance health care, which reinforces inequality. Notably, income security in cases of sickness, disability or maternity is not a reality for the majority of the population. Those who can afford it tend to access health care outside of SHP entitlements when such entitlements are either too limited or not well implemented, leading dual systems to develop and fuelling growing inequalities. A renewed commitment based on broad risk pooling and adequate and stable financing is needed to reinforce the social contract that make societies whole.

A strong focus of SHP systems, often reflecting health systems more broadly, is placed on curative care. Investing in promotion, prevention and primary care is an urgent priority to meet the needs of populations increasingly affected by NCDs and health security issues. This requires greater investments, not only to strengthen health systems and reinforce SHP entitlements, but also to expand social protection cash benefits, and guarantee adequate levels, in the face of significant coverage gaps in Central and Western Asia.

Adopting a primary health care (PHC) approach and addressing the social determinants of health and wellbeing is a cross-sectoral goal. It requires raising the profile of health and care workers to secure their availability and close coordination, and ensure the quality of the services they provide, now and in the future. SHP and social protection systems as a whole should support this much needed shift. Doing so requires overcoming tremendous silos between health and social protection policies in order to mobilize a greater share of public resources and contribute to redistribution in a mutually reinforcing way.

Investing in robust rights-based SHP systems is urgently needed to achieve the 2030 Agenda. Prioritizing public investments to guarantee access to health care without hardship as part of nationally defined social protection floors and systems, is central to delivering on the promise of the 2030 Agenda and leaving no one behind. By making progress on the promise to achieve USP and UHC by 2030, and by protecting and promoting human rights, States can strengthen the social contract.

The dashboard on the following pages provides an overview of the available statistics and selected design features of SHP policies and systems in Central and Western Asia against key guiding principles provided by ILO standards.

Dashboard on social health protection system design and results against key guiding principles from ILO standards

	ARM	AZE	CYP	GEO	ISR	KAZ	KGZ	TJK	TUR	TKM	UZB
Universality of protection											
Percentage of the population legally covered for health care benefits (%)											
Percentage of the population effectively protected by a health care scheme, protected persons (%)								ND		ND	ND
Percentage of labour force aged 15+ years covered legally covered for sickness cash benefits (%)											
Solidarity in financing											
Out-of-pocket expenditure as percentage of current health expenditure (CHE) (%)	78.7	66.0	9.9	31.2	19.8	25.0	40.7	63.5	16.3	78.6	60.3
Financing sources (main scheme) (taxes, social security contributions or a mix of both)	Taxes	Mix	Mix	Taxes	Mix	Mix	Mix	Taxes	Mix	Mix	Taxes
Adequacy and predictability of benefits											
UHC service coverage index: Coverage of essential health services (range 1-100, SDG 3.8.1)	68	66	81	68	86	80	69	67	76	75	75
Skilled health staff density per 10,000[7]	79.4	88.1	81.8	115.9	95.8	109.7	65.7	75.0	55.9	60.6	85.6
Application of user fees & co-payments (main public schemes)	Yes[2,3]	Yes[2,3]	Yes[2,3]	Yes[2,3]	Yes[2,3]	No	Yes[2,3]	Yes[2,3]	Yes[2,3]	Yes[2]	Yes[2]
Proportion of population spending more than 10% of household consumption of income on out-of-pocket health care expenditure (%)	19.9	8.1	14.7	31.4	12.8	3.7	4.9	9.8	4.2	ND	6.7
Non-discrimination, gender equality and responsiveness to special needs											
Financing of maternity cash benefits EL = employer liability NC = non-contributory scheme SI = social insurance	SI / NC	SI	SI / NC	SI	SI	SI / NC	NC / EL	SI	SI	NC / EL	SI / EL
Percentage of women giving birth receiving maternity cash benefits (%) (SDG 1.3.1)											
Pre- and post-natal care and delivery covered without co-payments	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

	ARM	AZE	CYP	GEO	ISR	KAZ	KGZ	TJK	TUR	TKM	UZB
Primary responsibility of the State											
Domestic general government health expenditure (GGHE-D) as percentage of gross domestic product (GDP) (%)	2.2	1.5	8.0	4.5	5.4	2.6	2.9	1.9	3.6	0.9	3.0
Purchasing: Publicly managed & administered schemes act as main purchasers	Single[6]	Single[6]	Single	Single	Single	Single	Single[6]	Single[6]	Single	Single[6]	Single[6]
Entitlements to benefits prescribed by national law											
Benefit package guaranteed by law (main public scheme) Mix = Implicit and explicit depending on scheme	Explicit[1]	Explicit[1]	Explicit[1]	Explicit	Explicit[1]	Explicit	Explicit	Explicit[1]	Explicit	Explicit[1]	Explicit[1]
Equity in access and leaving no one behind											
Births attended by skilled health personnel (%) (SDG indicator 3.1.2)					ND						
Measles immunization coverage among one-year-olds (%)											
Tuberculosis treatment coverage (%)											
Estimated antiretroviral therapy coverage among people living with HIV (%)			ND		ND	ND			ND	ND	
Social inclusion, including of persons in the informal economy											
Workers in all types of employment are legally covered for health care benefits	Yes[5]	Yes	Yes	Yes	Yes	Yes	Yes[5]	Yes	Yes	Yes[4]	Yes
Tripartite participation with representative organizations of employers and workers											
Tripartite representation in governance body (where applicable)	ND	ND	Yes	ND	Yes	ND	ND	ND	Yes	ND	Yes

Notes:

1. A combination of a positive list and a list of exclusion is used
2. Fees are limited and/or regulated
3. Vulnerable groups are exempt
4. Voluntary affiliation
5. For the basic level of entitlements
6. Public purchasing agency / ministry in place but overall purchasing largely private through out-of-pocket expenditure
7. A component of SDG target 3c, indicator Indicator 3.c.1: Health worker density and distribution, reported following thresholds: World Health Report (2006): 22.8; ILO (2010): 41.2; WHO/United States Agency for International Development (2013): 59.4.

Legend:

ARM - Armenia; AZE - Azerbaijan; CYP - Cyprus; GEO - Georgia; ISR - Israel; KAZ - Kazakhstan; KGZ - Kyrgyzstan; TJK - Tajiksitan; TUR - Türkiye; TKM - Turkmenistan; UZB - Uzbekistan.

Out-of-pocket expenditure as percentage of current health expenditure (CHE) (%)		UHC service coverage index: Coverage of essential health services (range 1-100, SDG 3.8.1)		Proportion of population spending more than 10% of household consumption of income on out-of-pocket health care expenditure (%)		Domestic general government health expenditure (GGHE-D) as percentage of gross domestic product (GDP) (%)		Skilled health staff density per 10,0007	
	> 50		> 80		> 10		> 5		> 85
	20-49		70-80		5-10		3-5		65-85
	<20		<70		<5		< 3		< 65

N/A – Not applicable
ND – No data
Sources: Adapted from ILO World Social Protection Database, based on the Social Security Inquiry (SSI) and ISSA/SSA; WHO Global Health Observatory; Global Health Expenditure Database; WHO and World Bank 2022.


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Introduction

Access to universal social protection is crucial for the prevention and reduction of poverty, inequalities and social exclusion. As an automatic stabilizer, social protection also constitutes an effective crisis response measure, enabling access to health care and income security support, thereby stabilizing aggregate demand. As such, social protection increases resilience against future shocks and helps achieve faster recoveries towards inclusive growth and development.

Social health protection (SHP) aims to alleviate financial barriers to accessing comprehensive health care services and to support income during sickness, comprising an integral part of comprehensive social protection systems that effectively protect people against life contingencies and covariate risks throughout their life cycle. Anchored in international human rights instruments and social security standards, SHP provides a rights-based contribution to the policy objective and Sustainable SDG target of Universal Health Coverage (UHC) (Dorjsuren et al. 2022).

This publication compiles experiences from countries in Central and Western Asia in their efforts to build universal SHP systems that are resilient, effective, inclusive, adequate and sustainable over the long term. The information gathered in this compendium provides insights for practitioners and policymakers on concrete ways to design, extend, adapt and implement SHP systems and policies. This publication aims to shed light on the role of SHP as a transformative policy tool contributing to redistribution and effective access to health care without financial hardship.

Social health protection: a concept rooted in the human rights framework

Social health protection provides a rights-based pathway towards the goal of UHC. As an integral component of comprehensive social protection systems, SHP designates a series of public or publicly organized and mandated private measures to achieve (ILO 2008):

i. effective access to quality health care without hardship; and
ii. income security to compensate for lost earnings in case of sickness.

The lack of affordable quality health care risks contributing to both poor health and impoverishment, as well as the inability to participate in education and gainful employment, with a greater impact on the most vulnerable. For this reason, the principle of universality of coverage was underlined in social security standards early on.

In 1944, the ILO Medical Care Recommendation (No. 69) introduced the principle of universality, setting out the principle that health care services should cover all members of the community, "whether or not they are gainfully occupied." The right to health was subsequently formally enunciated in the Constitution of the World Health Organization (WHO) in 1946 and by human rights instruments. The Universal Declaration of Human Rights, 1948, includes health and security [2] as part of the right to an adequate standard of living, stipulating that:

"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control" (Article 25).

[2] The right to social security is also referred to in Article 22 of the Universal Declaration of Human Rights.

The United Nations International Covenant on Economic, Social and Cultural Rights, 1966, in Article 12, further recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.3 In addition, it requires States that are party to the Covenant to take steps towards achieving this right, including action on child health, environmental and occupational health, prevention and control of diseases, and the creation of conditions to ensure universal access to medical services and medical attention in the event of sickness. The right to health is an inclusive right, which is not limited to timely access to appropriate health care, but also extends to the underlying determinants of health (access to safe drinking water and adequate sanitation; an adequate supply of safe food, nutrition and housing; healthy working and environmental conditions; and access to health-related education and information).

The human rights to health and social security are mutually supportive and understood as necessary to guaranteeing universal effective access to adequate protection (UN 2019; 2008). SHP is rooted in this framework and represents the optimal mechanism to substantiate these human rights (ILO 2020a). Therefore, through international social security standards that countries formulate, adopt [4] and ratify,[5] a normative corpus was developed with detailed guidance on the principles that should guide the establishment of SHP schemes, as well as minimum levels of protection countries should attain (box 1).

▶ Box 1. Relevant international human rights instruments and social security standards

- ILO Medical Care Recommendation, 1944 (No. 69)
- Universal Declaration of Human Rights, 1948, Articles 22 and 25
- ILO Social Security (Minimum Standards) Convention, 1952 (No. 102), Part II
- International Convention on the Elimination of All Forms of Racial Discrimination, 1965, Article 5 (e) (iv)
- International Covenant on Economic, Social and Cultural Rights, 1966, Articles 9, 11 and 12
- ILO Medical Care and Sickness Benefits Convention, 1969 (No. 130) and Recommendation, 1969, (No. 134)
- Convention on the Elimination of All Forms of Discrimination against Women, 1979 arts. 11 (1) (e) and (f), (2) (b) and (d),12 and 14 (2) (b) and (c)
- Convention on the Rights of the Child, 1989, Articles 24 and 26
- International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 1990, Articles 28, 43 (e) and 45 (c)
- ILO Maternity Protection Convention, 2000 (No. 183)
- Convention on the Rights of Persons with Disabilities, 2006, Articles 25 and 28
- ILO Social Protection Floors Recommendation, 2012 (No. 202).

Three countries have ratified the Social Security (Minimum Standards) Convention, 1952 (No. 102): Cyprus, Israel and Türkiye; and Azerbaijan, Cyprus, and Kazakhstan have ratified the Maternity Protection Convention, 2000 (No. 183). However, none of the countries in the subregion have ratified the Medical Care and Sickness Benefits Convention, 1969 (No. 130).

[3] The rights to social security and an adequate standard of living are referred to in Articles 9 and 11.

[4] International social security standards are elaborated and adopted by representatives of governments, employers and workers. They are then ratified by Member States and translate into national legislation. International social security standards are subject to a monitoring process whereby a committee periodically reviews the application of the standards.

[5] In particular through the Social Security (Minimum Standards) Convention, 1952 (No. 102), the Medical Care and Sickness Benefits Convention No. 130 (1969) and its associated Recommendation 134 (1969), and the Maternity Protection Convention, No. 183 (2000).

Strategy for the extension of adequate coverage

Following the 2007–2008 economic crisis, it became even more evident that social protection, including in the area of health care, needed to be universalized to cushion the multidimensional impacts of cyclical crises in an interconnected world with a globalized economy. In 2008, ILO constituents adopted the Declaration on Social Justice for a Fair Globalization, which put forth social protection as one of the four objectives of the Decent Work Agenda. With this push, ILO constituents further discussed the need to adopt a new standard that would provide guidance on strategies towards the universal extension of social protection.

The ILO Social Protection Floors Recommendation, 2012 (No. 202) was subsequently adopted by the International Labour Conference and recognized access to essential health care as the first of four basic social security guarantees constituting national social protection floors that should be made a universal reality as a matter of priority (ILO 2017a; 2019; 2021a). Acknowledging this important step forward in forging an international consensus around UHC, the United Nations General Assembly adopted a Resolution on Global Health and Foreign Policy in 2012, which underlines "the importance of universal coverage in national health systems, especially through primary health care and social protection mechanisms, including nationally determined social protection floors."

International social security standards recognize the diversity of national circumstances. Therefore, they offer an approach to the extension of coverage whereby Member States should not only guarantee internationally agreed minimum levels of protection to all in the short run (horizontal extension), but also ensure that they progressively reach higher levels of protection as soon as their national circumstances allow (vertical dimension). This two-dimensional strategy aims at fostering the sustainability of the redistributive role of social protection systems, ensuring that life contingencies are collectively managed risks, and that SHP schemes contribute to social cohesion within societies.

Convention No. 102 establishes minimum levels of protection and promotes a comprehensive approach to social protection, including access to health care, as one of the nine contingencies covered. This comprehensive approach aims to ensure that life risks are collectively shared within society. Therefore, it is an important tool to address not only access to health care services without hardship, but also to provide at least minimum income security, which in turn addresses some of the key social determinants of health. Figure 1 provides an overview of the nine contingencies and the nature of the minimum set of benefits they entail.

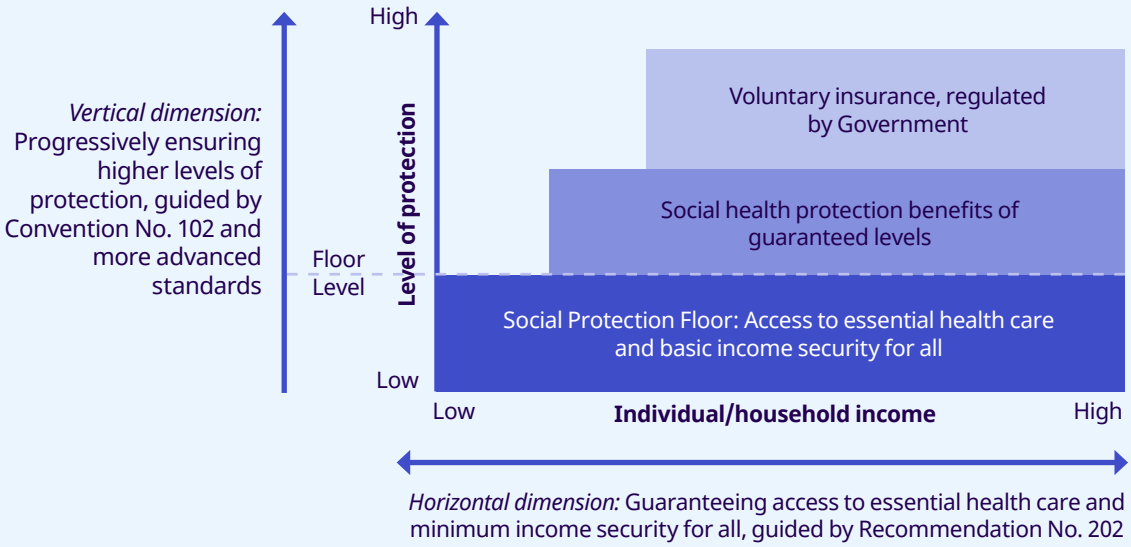
▶ **Figure 1. Comprehensive social protection coverage: A framework to consider health and some of its social determinants along the life cycle**

Contingency	Access to health care without hardship	Income security
Health care	Comprehensive health care, including maternity care and long-term care	
Child and family support		Income support
Sickness		Income support
Maternity	Maternity care services	Income support
Disability		Income support
Unemployment		Income support
Employment injury / occupational disease	Medical care services, including rehabilitation	Income support
Old age		Income support
Death		Income support

Source: ILO 2021b, based on Convention No. 102.

As previously noted, the two-dimensional strategy for the extension of coverage comprises two dimensions (see figure 2). The horizontal extension of coverage aims to cover the entire population across four basic guarantees, including health care as per ILO Social Protection Floors Recommendation, 2012 (No. 202) (ILO 2017a; 2019; 2021a). The vertical extension of coverage aims to progressively improve benefit adequacy, ensuring higher levels of protection. ILO standards establish a minimum level of benefit to be guaranteed by law. The benefit level for health care encompasses two dimensions: (i) The range of services effectively accessible; and (ii) the financial protection against the costs of such services. The minimum requirements for each of these two dimensions are detailed in box 2.

▶ Figure 2. Bi-dimensional strategy for the extension of coverage



Source: Adapted from ILO 2012.

▶ Box 2. ILO standards on access to health care without hardship

Universality and coverage extension: In 1944, the Medical Care Recommendation (No. 69) introduced the principle of universality, setting out that access to health care services without hardship should be secured for all members of the community, "whether or not they are gainfully occupied." Such coverage needs to be granted to the family rather than on an individual basis.

Population coverage: As a priority, coverage should be extended to the entire population across four basic guarantees, one of which is essential health care without hardship as per ILO Social Protection Floors Recommendation, 2012 (No. 202).

Adequacy of coverage: Countries should progressively improve the comprehensiveness and level of health care benefits, ensuring higher protection. ILO standards establish a minimum level of benefit to be guaranteed by law. The benefit level encompasses two dimensions:

i. The range of health care services effectively accessible: While social protection floors should include the provision, at a minimum, of "essential health care" as defined nationally, including free prenatal and postnatal care for the most vulnerable, countries should progressively move towards greater protection for all, as reflected in the Social Security (Minimum Standards) Convention, 1952 (No. 102) and the Medical Care and Sickness Benefits Convention, 1969 (No. 130) which require the provision in national law of a comprehensive range of services. To be considered adequate, in line with human rights compliance monitoring mechanisms, health services need to meet the criteria of availability, accessibility, acceptability and quality (Recommendation No. 202, paragraph 5a).
ii. The financial protection against the costs of such services should be guaranteed: ILO instruments provide legal entitlements to health care "without hardship". Out-of-pocket payments should not be a primary source for financing health care systems. The rules regarding cost sharing must be designed to avoid hardship, with no or limited co-payments and free maternity care.

Financing and institutional arrangements: ILO standards promote collectively financed mechanisms, recognizing recourse to a range of taxes, and contributions made by workers, employers and government. Likewise, the standards recognize a range of institutional arrangements, namely national health services, by which public services deliver affordable health interventions, and national health insurance by which an autonomous public entity collects revenues from different sources to purchase health services, either only from public providers or from both public and private providers, or any combination of such institutional arrangements.

Source: Adapted from ILO 2017; 2019; 2021a; 2021c.

A similar approach guides the extension of coverage for sickness benefits. ILO standards include income security to compensate for loss of earnings due to sickness, quarantine, care-seeking or caring for a sick dependent through publicly led measures (ILO 2020b). Sickness benefits are provided in the form of periodical cash benefits, which guarantee that the opportunity cost of seeking care does not act as an incentive to forgo care, force people back into work before they are fully recovered, or in the case of communicable diseases, act as a disincentive preventing isolation, and thus putting others at risk of infection.

While international social security standards recognize the diversity of financing and institutional arrangements that countries can put in place to achieve the minimum levels of protection they set forth, they also provide a set of guiding principles that such arrangements should reflect. Table 1 lays out the practical implications of some of the key SHP principles (ILO 2020c).

▶ Table 1. ILO guiding principles for social health protection systems

Principle	Explanation
Universality of protection	Health and social security are human rights and as such, should be guaranteed to all persons, leaving no one behind.
Diversity of approaches and progressive realization	Diverse arrangements can exist for the financing, purchasing and provision of health care as long as they respect the guiding principles. Progressive realization recognizes that not all governments can mobilize the needed resources to comply immediately with international standards. It requires governments to take effective measures to gradually establish, as a matter of priority, a USP floor by mobilizing the maximum available resources and continuing to increase available resources to guarantee higher levels of health and social security to as many people as possible as quickly as possible, while refraining from regressive measures.
Risk sharing and solidarity in financing	Collectively financed mechanisms to cover the costs of health care, maternity and sickness are promoted because they generate positive redistributive effects and transfer financial and labour market risks onto society rather than individuals.
Overall and primary responsibility of the State	The State is responsible for respecting, protecting and fulfilling the right to health and social security in line with international human rights. ILO standards confer on the State the overall and primarily responsibility for the proper administration of health care, maternity and sickness schemes and the due provision of these benefits. This includes ensuring the financial sustainability, revenue collection, pooling and purchasing of health services as well as health service provision.

Principle	Explanation
Adequacy of benefits	Both medical care (including maternity care) and cash sickness and maternity benefits need to be adequate and meet the needs of all persons in terms of the range, scope and quality of the benefits provided, as well as financial protection in line with the minimum benchmarks set out in international standards. Specific criteria related to health care include accessibility, availability, acceptability and good quality.
Predictability of benefits	The national legal framework establishes the benefits and ensures necessary financial resources are secured so that benefits and services are delivered in the prescribed situations and conditions according to needs.
Non-discrimination, gender equality and social inclusion	The design of SHP schemes should ensure non-discrimination, gender equality and responsiveness to special needs.
Fiscal and economic sustainability with regards to social justice and equity	The SHP scheme has the capacity to bear the costs of its operation in the country context, while ensuring equity and is regulated through a comprehensive accountability framework.
Participation, social dialogue and accountability	Governance structures include tripartite representation and dialogue with protected persons and employers, consultation mechanisms with other relevant and representative organizations of persons concerned as well as efficient and accessible complaint and appeal procedures within an accountability framework.
Integration within comprehensive social protection systems	SHP should be an integral part of coordinated, coherent and comprehensive social protection systems.

Social health protection and the Sustainable Development Goals

Social health protection includes a series of public or publicly organized and mandated private measures to achieve effective access to affordable health care and adequate sickness benefits for all. Both health care and sickness cash benefits are supportive of the objective of UHC. The second political declaration of the UNGA on UHC adopted in September 2023 recognizes the fundamental importance of "social protection mechanisms [...] to ensure universal and equitable access to quality health services without financial hardship for all people" (UN 2023). The SDG targets on UHC (3.8) and USP (1.3), are synergetic priority measures aimed at achieving a healthy and dignified life for all. The lack of affordable quality health care risks creating both poor health and impoverishment, impacting the vulnerable most acutely. For this reason, the principle of universality of coverage was underlined in social security standards early on.

Extending SHP to all is also key to achieving the targets of SDG 8 on sustained, inclusive and sustainable economic growth, full and productive employment and decent work, which requires a healthy workforce. Social protection is therefore a core component of a human-centred approach to the future of work (Global Commission on the Future of Work 2019). Ill health and the inability to obtain medical care – due to financial, geographical, social or other barriers – negatively impact workforce productivity. A lack of financial protection in cases of sickness undermines the capacity of households to invest in productive assets and pushes them into poverty. Additionally, SHP indirectly supports the achievement of other SDGs, such as SDG 5.4 on gender equality and SDG 10.4 on social protection policies and greater equality.

Diverse realities in Central and Western Asia

This compendium focuses on selected countries of Europe and Central Asia, which are covered by ILO's statistical delimitation of the sub-region "Central and Western Asia". This sub-region includes eleven countries, namely: Armenia, Azerbaijan, Cyprus, Georgia, Israel, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Türkiye, and Uzbekistan. The majority of these countries were previously part of the former Soviet Union (Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan). In total the subregion is home to over 191 million inhabitants over a surface of 5005,963m², with 41.4 per cent of the population living in rural areas (World Bank 2021a; 2022a). The subregion has diverse geographical features which range from high mountain passes, wide deserts, vast steppes, and abundant water and energy resources. While countries within this subregion exhibit a rich array of differences in terms of surface area, population and economic status, some of them share a set of common characteristics (UNDP 2005). The geographical features of certain countries pose significant obstacles to health care accessibility. For example, the mountainous landscapes of Kyrgyzstan and Tajikistan present considerable difficulties in providing services to particularly remote rural areas. Similarly, Uzbekistan, Kazakhstan and Turkmenistan contain vast isolated and scarcely populated regions, coupled with limited transport infrastructure, complicating health care provision in these countries (Rechel et al. 2012).

Among the eleven countries, two of them (Cyprus and Israel) are high income countries; six (Armenia, Azerbaijan Georgia, Kazakhstan, Türkiye and Turkmenistan) are upper-middle income countries; and three are lower-middle income countries (Kyrgyzstan, Tajikistan and Uzbekistan). At least one fifth of the population lives below the national poverty line in Armenia (24.8 per cent), Kyrgyzstan (33.3 per cent) and Tajikistan (22.5 per cent); this is the case among more than 10 per cent of the population in Cyprus (13.9 per cent), Georgia (15.6 per cent), Türkiye (14.4 per cent) and Uzbekistan (14.1 per cent), while this figure is lower in Azerbaijan (5.5 per cent) and Kazakhstan (5.2 per cent), as illustrated by figure 3 (ADB 2024; World Bank, n.d.).

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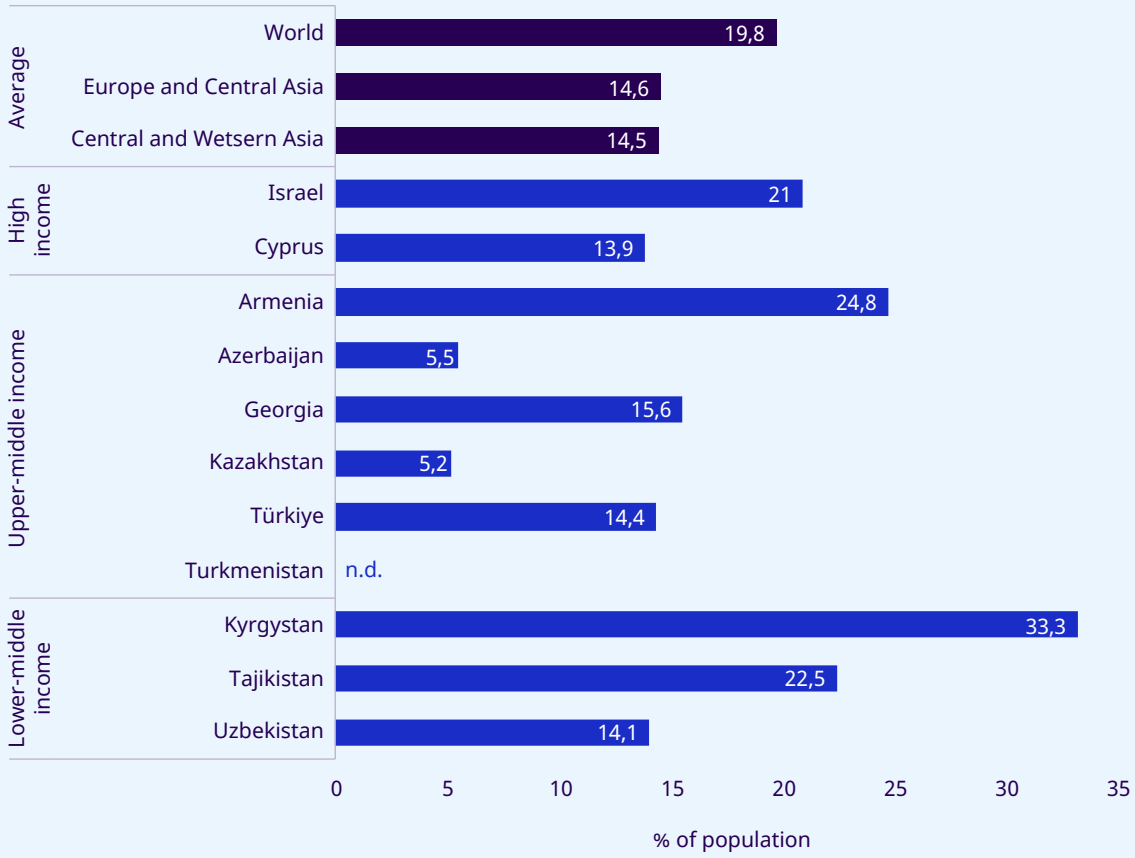
▶ **Figure 3. Share of the population living below the national poverty line, by global, regional and subregional average, and country in Central and Western Asia, by income group, 2022 or latest available year**

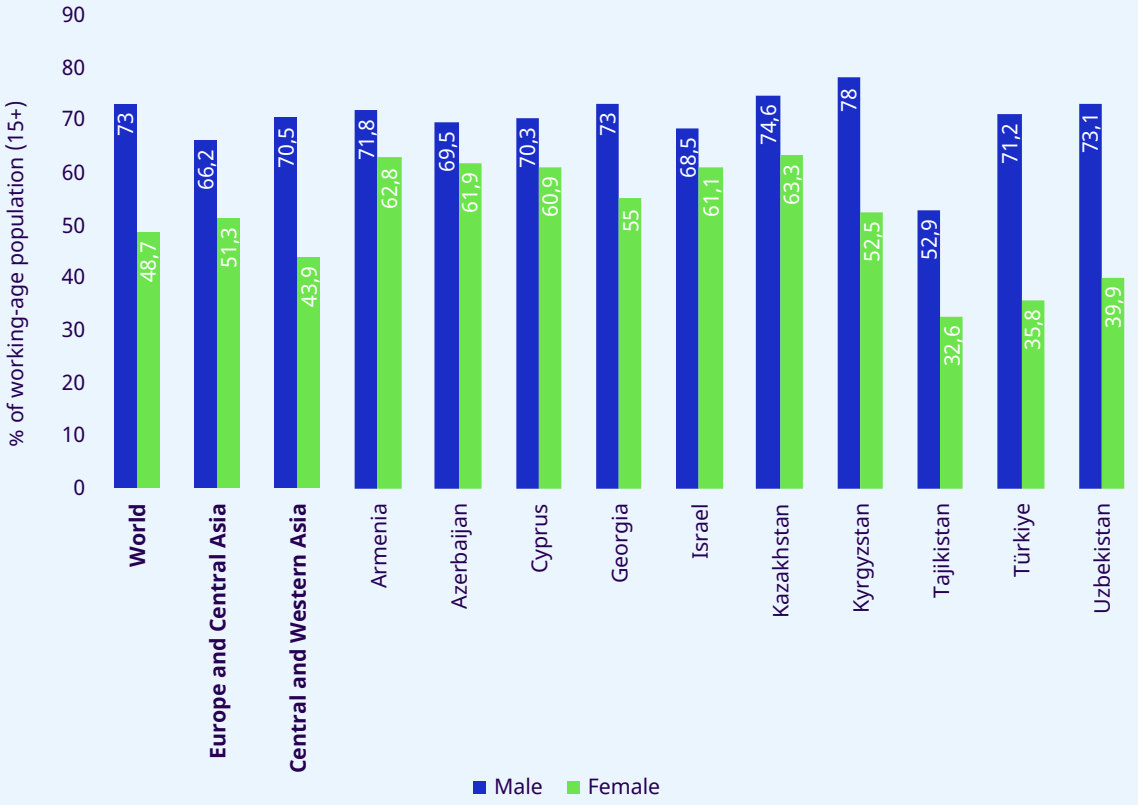


Note: Data on population under national poverty line are from the year 2022, except for Cyprus, Israel and Kyrgyzstan (2021), and Türkiye (2020). Data on Turkmenistan were not available. Global and regional aggregates are weighted by total population.

Source: Based on data from the World Bank World Development Indicators; ADB 2024; Endeweld et al. 2023; and the State of Israel National Insurance Institute.

Across the subregion, female labour market engagement remains significantly lower than male's. It is estimated that 70.5 per cent of men of working age are engaged in the labour market compared with only 43.9 per cent of women (figure 4) (ILOSTAT 2022). Employment in agriculture represents 17.6 per cent of total employment, ranging from 0.8 per cent (Israel) to 51.7 per cent (Armenia). The share of non-agricultural employment outside the formal sector is only available for five countries (Armenia, Cyprus, Georgia, Kyrgyzstan and Türkiye) and varies widely, ranging from 13 per cent (Georgia) to 98.2 per cent (Cyprus) (ILOSTAT 2022b; n.d.).

▶ **Figure 4. Labour force participation rate by gender, by region, subregion and selected country in Central and Western Asia, 2023 or latest year available**



Note: Data on labour force participation rate are not available for Turkmenistan. Global and regional aggregates are weighted by working-age population (15+).

Source: ILO modelled estimates 2023 and LFS (Labour Force Survey).

Countries are undergoing rapid demographic change, with rising life expectancy and falling birth rates (See figure 5). As of 2021, life expectancy averaged 73.3 years at birth, with Cyprus (81.2 years), Israel (82.5 years) and Türkiye (76 years) above average, marking a drop of 1.2 years from 2019, with the decline trend largely influenced by COVID-19 pandemic (WHO 2024; World Bank 2021b). 10 per cent of the total population is 65 and above in the subregion, with Armenia (13.1 per cent), Cyprus (14.8 per cent), Georgia (14.6 per cent) and Israel (12 per cent) above this average (World Bank 2022b). With population ageing and life-style changes, NCDs are the leading cause of death in the subregion, leading to the deaths of an average of 85.2 per cent of the population. Azerbaijan, Georgia and Türkiye account for over 90 per cent of NCD deaths, mainly related to ischemic heart disease (IHME 2019; World Bank 2019).

These demographic changes also impact on the pressure placed on the working-age population to contribute to general taxation and social security, as illustrated by the age dependency ratio,[6] which is an average of 53.1 per cent in the subregion. Specifically, the percentage of elderly people amounted to an average of 13 per cent relative to the working-age population in Central and Western Asia and was higher than 20 per cent in four countries (Armenia, Cyprus, Georgia and Israel) in 2024 (World Bank 2022c; ILOSTAT 2021).

[6] Age dependency ratio is the ratio of dependents (people younger than 15 or older than 64) to the working-age population (those aged 15-64). Data presented is the proportion of dependents per 100 persons of working age.

▶ Figure 5. Trends in life expectancy and birth rate, Central and Western Asia, 2010-2021

Source: Based on data from the World Bank World Development Indicators.

Human mobility is a significant feature of demographic trends in the subregion. Five countries of the subregion (Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan) received an estimated 5.6 million international migrants as of mid-2020, with the majority of the hosted migrant population originating from the Russian Federation (67 per cent), Ukraine (9 per cent) and Uzbekistan (7 per cent). Additionally, 7.8 million international migrants emigrated from these five countries worldwide in the same year, with the highest emigrating rates from Kazakhstan (4.2 million) and Uzbekistan (2 million) (IOM 2024). In 2020, 22 per cent of the Georgian population were living abroad, with the Russian Federation as the leading country of destination (52 per cent of Georgian emigrants), followed by Greece (10 per cent), Ukraine (8 per cent), Azerbaijan (6 per cent) and the United States (5 per cent) (OECD 2022). Türkiye is the largest host country of the refugee population worldwide. In 2022, the country was host to 3.6 million refugees and asylum seekers, the majority of whom are Syrians (3.5 million) (UNHCR 2023). Türkiye also has high levels of emigration—around 71,000 individuals immigrated from Türkiye in 2021, among whom 41 per cent migrated to Germany, 10 per cent to the Netherlands and 7 per cent to France (OECD 2023). Cyprus was host to around 170,000 migrants in 2022, representing 18.8 per cent of the population among which 10.4 per cent originated from the EU (European Commission 2024). Over 20 per cent of the population of Armenia, Georgia and Kazakhstan lived in other countries in 2020 (United Nations population division 2020).

Despite great progress on a number of health and wellbeing indicators in recent decades, in 2020, six countries had more than 27 maternal deaths per 100,000 live births, ranging from 28 in Georgia to 68 in Cyprus. Fewer than 10 maternal deaths per 100,000 live births were observed in Israel and Turkmenistan (WHO 2023a). In 2022, the under- five mortality rate showed that over 15 child deaths per 1,000 live births were recorded in Azerbaijan (18.1), Kyrgyzstan (17.3), Tajikistan (30.3) and Turkmenistan (40.4), compared with less than 5 per 1,000 live births in Cyprus and Israel (UNICEF 2024).

In the subregion, less than two thirds of the population is covered by at least one social protection cash benefit, ranging from 29.8 per cent in Tajikistan to 100 per cent in Israel (see figure 22, section 2.1.2.). Social protection expenditures for cash benefits as a share of GDP (excluding health benefits) range from 4 per cent in Tajikistan to 12.7 per cent in Cyprus (ILO, n.d.).

Regional and subregional commitments to social health protection

Countries of the Commonwealth of Independent States (CIS), including Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan signed the CIS treaty in 1991 and established the CIS free trade area in 2012. The inter-regional Health Council of the CIS has different areas of focus and collaboration, including medicines quality control, health system development, epidemiological surveillance and the control of HIV/AIDS, TB and malaria (ADB 2021).

The Cooperation Council of the Turkic speaking states including Azerbaijan, Kazakhstan, Kyrgyzstan, Uzbekistan, and Türkiye was established in 2009 and promotes cooperation in several domains, including socio-economic development (ADB 2021; Government of Azerbaijan 2023). Several initiatives involving some or all Central and Western Asian countries on the promotion of UHC and the affirmation of the countries' commitment thereof have been developed in recent years, such as the Roadmap for Health and Wellbeing in Central Asia (2022-2025) (Hondo and Kim 2023; WHO 2022a).

The United Nations Issue-based Coalition on Social Protection for Europe and Central Asia serves as a platform for exchange of information, advocacy and policy advice, as well as for building and strengthening partnerships in relation to social protection.

Objective, Methodology and Structure of the Report

National social protection schemes and SHP policies and programmes must adapt to diverse socio-economic realities, while being responsive to demographic and epidemiological changes. In the context of recent reforms, the present publication aims at sharing experiences of Central and Western Asian countries in the expansion of their SHP systems.

There is no unique way to achieve universal SHP. This publication aims to understand how different countries and SHP systems progressively achieve expansion in coverage and adequacy and to answer the following questions: How is coverage extended to different groups of the population? How is a benefit package guaranteed and expanded over time? What measures are in place to limit OOP expenditure? How are resources pooled to ensure solidarity? How are services purchased to ensure they are good value for money and meet the health care needs of the population? What measures are in place to ensure quality medical services are available, accessible and acceptable to all? And underlying all of this, how are resources mobilized to achieve SHP? The report highlights progress, challenges and remaining coverage gaps and explores their root causes.

The report is structured around these key questions, with the aim of presenting practical approaches to institutional arrangements and resource mobilization that have contributed to extending coverage and adequacy of SHP. Because of the diverse socio-economic and political contexts and histories of social protection systems in different countries, the measures and approaches used vary, as does the pace of achievement of different dimensions of SHP.

The first part of the report is comprised of two chapters structured according to these components; chapter one focuses on population coverage and adequacy of benefits; and chapter two focuses on institutional arrangements and sustainable financing, using country experiences to illustrate diverse approaches to achieve a common goal. The report also includes a second part, comprised of nine country profiles providing an overview of the designs and results of national SHP systems in these countries, namely Armenia, Azerbaijan, Cyprus, Georgia, Kazakhstan, Kyrgyzstan, Tajikistan, Türkiye and Uzbekistan. Country profiles for Israel and Turkmenistan could not be developed as part of the report but related information was nonetheless included in chapter one. Unless otherwise specified, the country examples provided throughout the first part of the document are sourced from the country profiles, where full references can be found.

1

Comparative analysis

Chapter 1. Extending population coverage and improving adequacy

Key messages

- Central and Western Asian countries have adopted legal entitlements to health care without financial hardship that are universal or near universal, yet some legislative gaps exist for certain categories of migrants. In addition, legal frameworks do not always grant unified benefits to all, and a segmentation of entitlements exist in several countries, which affects equity.
- In practice, many barriers can impact the implementation of legal entitlements. Such barriers to accessing health care can take the form of lack of awareness and low levels of registration, physical distance to health care facilities, opportunity costs such as lost working time, limitations in the range, quality and acceptability of health services, informal OOP payments at the point of care, and long waiting times linked to shortage and unequal distribution of health and care workers.
- Guaranteeing access to health care services without hardship should go hand in hand with entitlements to income security during sickness and maternity in order to effectively respond to the risk of hardship faced by households. However, less than half of the workforce in the subregion is mandatorily covered for sickness cash benefits. These legislative gaps translate in practice implmentation. Five countries in the subregion rely exclusively on employer liabaility to provide income security in case of sickness, which is less robust in providing effective protection. Less than 45 per cent of women who give birth effectively receive a maternity cash benefit.
- OOP expenditure from households remains the main source of health expenditure in Armenia, Azerbadjan, Tajikistan, Turkmenistan and Uzbekistan. It represents less than 20 per cent of current health expenditure only in Cyprus, Israel and Türkiye. This situation has a disproportionate effect on low-income households, who tend to delay care seeking, with significant impacts on their own health and public health more broadly. Catastrophic OOP expenditures on health care remain relatively low but with large discrepancies across countries. Recent data points are missing for some countries, and there is a lack of systematic measurement of unmet health care needs. Collective financing, broad risk-pooling and rights-based entitlements are key conditions to supporting effective health care access for all. The principles outlined by ILO standards are more relevant than ever, and the ratification of Conventions No 102 and 130 is a key marker of a long-term commitment to meeting these standards.
- Investing in the availability of quality health care services is crucial. Central and Western Asia fairs relatively well on the UHC service coverage index in comparison to the rest of the world, but remains below the regional average. Investments in the health workforce are required to facilitate improved working conditions, and health systems need to maintain a stronger focus on NCDs, which are on the rise.
- Stronger linkages and better coordination between access to medical care and income security are urgently needed to address key determinants of health. Pockets of pervasive poverty remain and therefore even small payments on health care can have impoverishing effects on vulnerable populations. The rise of non-communicable diseases in the subregion calls for a better integrated approach between social protection and health policies in a way that supports healthier life styles.

Introduction

Leaving no one behind requires that comprehensive rights-based SHP is in place and that it is thoroughly monitored. Monitoring is key to assessing the implementation of laws, following progress in coverage expansion, identifying uncovered groups and supporting the development and implementation of strategies to cover them. Monitoring SHP progress requires the consideration of population coverage (making sure that all members of society are covered) and adequacy of benefits (such as the range of health services covered and the extent of financial protection provided), both in law and in practice (table 2). The complexity and interdependency of these dimensions, as well as the lack of systematic data collection, make SHP coverage challenging to monitor. Performing well in one dimension does not automatically translate into good performance in the other.

▶ Table 2. Dimensions of coverage and adequacy of health care benefits

	Legal	Effective
Population coverage	Share of the population identified in the law as entitled to health protection (comprehensive benefit package without hardship).	Share of the population effectively protected by a scheme which translates their legal entitlements into practice (affiliation to scheme, rights holders' awareness of their entitlements, and so on).
Service coverage	Benefit package provided for in legislation.	The extent to which people effectively access and utilize health services, meeting the criteria of availability, accessibility, acceptability and quality.
Financial protection	Share of the costs of health services covered and hence not borne by individuals, as defined in legislation.	The extent to which the costs of care are effectively borne collectively by pooled mechanisms and the resulting level of financial burden for households.

Source: ILO 2021b.

For sickness and maternity cash benefits, legal coverage encompasses both the share of the working age population *entitled to such benefits by law* as well as the prescribed level of benefit, as prescribed in the relevant ILO standards. Effective coverage encompasses the share of the population in need effectively protected and/or benefiting in cases of sickness, accident or ill health.

This chapter introduces historical trends in the development of social health protection policies and health sector policies more broadly, before analysing the dimensions of population coverage and adequacy. The analysis draws on the SDG framework which fostered additional data collection efforts and provides new proxies for the measurements of such dimensions relating to legal and effective coverage (ILO 2021c; WHO and World Bank Group 2023). Lastly, the chapter positions the efforts undertaken to date and outlines what remains to be done in order to leave no one behind.

▶ 1.1. Diversity of historical trajectories and recent reforms within the countries that were formerly part of the Soviet Union

1.1.1. A common heritage at the onset of the 1990s

The Soviet Union was a pioneer in efforts aimed at implementing socialized medicine with access to health care to all its citizens, as a basic human right (Schecter 1992). Accordingly, the right to health protection to all citizens of the USSR was enshrined in article 42 of its Constitution. Article 43 notes that "Citizens of the USSR have the right to maintenance in old age, in sickness, and in the event of complete or partial disability or loss of the breadwinner".[7]

Former Soviet Union countries of Central and Western Asia (Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Tajikistan Turkmenistan and Uzbekistan) followed the Semashko model for establishing their health care system, whereby care was provided for free to all through a network of publicly owned providers, with a strong reliance on inpatient and hospital-based care (Glonti 2015). The health system was organised hierarchically following three administrative levels: the republican (national), oblast (regional), and district (rayon) or city level, each of which had a separate budget to administer health services (Rechel et al. 2012). This system was characterized by a high level of duplication in functions, with multiple overlapping roles and responsibilities. Hospitals played a major role in forming the health system, while primary health care facilities tended to be underdeveloped. Local authorities were given responsibility for providing public health services, including mandatory immunization against infectious diseases. The health workforce was also poorly prepared to deliver primary care, as many physicians specialized early in their undergraduate training (as a result of a heavy reliance on specialist care), leaving a void in skills for general practice. Moreover, despite universal access to at least a basic level of care, the soviet health system had many flaws that reduced efficiency, such as under-investment and poor maintenance of health facilities and unnecessary hospital admissions for cases manageable in PHC settings. Additionally, with a system highly reliant on hospitals, health expenditures were mostly skewed towards utility costs and staff budget lines rather than patient outcomes (McKee et al. 2002).

While early successes of the Soviet Union materialized in an exponential number of facilities and medical staff, leading to improved health outcomes during the first phase, it did not succeed in adapting to the evolving needs of populations over time. Life expectancy progressed up to the 1960s as a result of improving childbirth conditions, progress in tackling infectious diseases and overall improvements in living conditions, but in general, progress stagnated after this period. This stemmed from the system's emphasis on quantitative targets to increase inputs such as increasing hospital beds and physicians (see figure 6), rather than adapting to disease burden changes, particularly the need to address the rise of non-communicable diseases (Hohmann and Lefèvre 2014; European Observatory on Health Systems and Policies 2014).

[7] Constitution (Fundamental Law) of the Union of Soviet Socialist Republics, adopted at the Seventh (Special) Session of the Supreme Soviet of the USSR, Ninth Convocation, on October 7 1977, available at: constitution-ussr-1977.pdf (marxists.org)

Figure 6. Number of hospital beds (per 10,000 persons), selected countries in the former Soviet Union, 1990 and 2021

Note: Due to missing data points, data for Armenia, Georgia and Kazakhstan are based on 2020 data instead of 2021 data, and Azerbaijan is based on 2019 data.

Source: Based on data from the WHO Global Health Observatory and World Bank World Development Indicators.

Consequently, after independence in 1991, post-Soviet countries were left with a significant number of facilities which had suffered decades of underinvestment. As a consequence, countries moved towards a reduction in the number of facilities and beds, alongside investments in their modernization. As an example, between 1994 and 1997, about 70 per cent of village hospitals in Kazakhstan were closed (McKee et al. 2002). Most of the closures were concentrated in rural areas, and in urban areas, the number of hospital beds were reduced. Some rural hospitals were also transitioned to primary health care facilities. In general, facilities remained publicly owned (Glonti 2015), except for in Georgia where almost all public facilities were acquired by the private sector (European Observatory on Health Systems and Policies 2014) (see box 3).

After Independence, countries embarked on primary care reforms and restructuring the health system (Rechel et al. 2023; 2012). The network of PHC providers remaining from the Soviet era was dense, but had severely suffered from underinvestment (Kühlbrandt and Boerma 2015). In response, some countries resorted to merging previously separate polyclinics for adults, children, reproductive and dental services in urban areas, into one simple unit for family medicine. For example, in Kyrgyzstan facilities were merged and renamed Family Group Practices, which provided specialized outpatient care (Rechel et al. 2023). In Armenia, a commitment to primary health care reforms was evident through the introduction of the family doctor and general practitioner role, with the country becoming the first post-soviet nation to offer training in family medicine. Additional reforms included formalizing a fee-for service payment system, defining a basic benefit package, providing free care for certain segments of the population, and a strong emphasis on improving child and maternal care (Hohmann and Lefèvre 2014). Moreover, the focus shifted to improving primary care in rural areas; for example, in Uzbekistan health posts in rural areas were staffed by physicians, replacing the traditional feldsher-midwifery posts. Moreover, in Tajikistan the previously complex structure of primary care delivery in rural regions transitioned into a two-tiered system, with health houses serving as an entry point to the system, referring patients that need a higher level of care to rural health centres (Rechel et al. 2023)

On the financing side, many central governments faced fiscal collapse and decided to decentralize the task of financing health services to regional and municipal levels immediately after independence. When it comes to pooling arrangements, countries of the former Soviet Union have adopted varied approaches. The decentralized arrangements in Azerbaijan, Tajikistan and Uzbekistan shifted pooling responsibility to the regional level with some level of national level contribution. Armenia maintained a centralization of pooling to avoid fragmentation at the national level within the Ministry of Health. Kazakhstan and Kyrgyzstan both adopted decentralized pooling at the regional level, before later recentralizing pooling at the national level (European Observatory on Health Systems and Policies 2014) (see section 2.2.1.)

Different trajectories in the 2000s

Countries followed different pathways, leading to a diversity of situations. While most countries of the Former Soviet Union have maintained a public delivery model, Georgia underwent neoliberal reforms in the 2000s, which focused on system-wide privatization, the abolishment of taxes and a massive downsizing of the public system. Today, these reforms continue to have an impact on the achievement of health protection for all (Gugushvili 2017) (see box 3).

▶ Box 3. Evolution of the health system in Georgia

Following the collapse of the Soviet Union, the newly independent Georgian state was faced with economic stagnation and increased rates of poverty and unemployment. These waves of economic and political uncertainties led to what is known as the Rose Revolution (2003), which resulted in a regime change and nationwide reforms. The newly elected government undertook a series of neoliberal reforms that focused on privatization, reducing regulations and taxation and downsizing of the public sector (Gugushvili 2017). Reforms in the health sector were premised on the assumption that privatization, competition and market principles could improve cost containment, quality of care and infrastructure development.

The newly structured health system underwent several reforms immediately after the collapse of the Soviet Union, which can be divided into the following three stages (Natsvlishvili et al. 2022):

First wave reform (1994-2003)

This phase focused on the decentralization of health system management, privatization and reduction of hospital beds, a move from general budget funding to programme-targeted funding, the establishment of state health insurance, and efforts to enhance the primary health care system.

Additionally, the new Georgian constitution (1995) recognized the rights of citizens to access affordable and high quality health care services within the scope of state capacities.

The overarching goal was to extend state-funded coverage of basic primary and hospital care, while reducing administrative and financial responsibilities through decentralization and privatization. However, the reform encountered setbacks due to corruption and fiscal constraints. Despite efforts, only dental facilities and pharmacies underwent privatization, and the state struggled to mobilize sufficient funds for public health care. Additionally, the system was plagued by high informal payments.

Second wave reform (2004-2012)

After the revolution, the Government adopted neoliberal transformation plans that focused on large scale privatization, deregulation of the economy and the minimization of the role of the state in public service provision. Many regulatory bodies were dismantled, a flat rate tax was introduced and health care tended to be viewed as a market commodity.

The state health insurance company was eliminated and replaced by private commercial insurance companies. State funding for health care was limited to vulnerable populations, and from 2008-2012 the Medical Assistance for the Poor (MAP) programme was introduced. The scheme was means tested, targeting households living below the poverty line, and provided comprehensive health care for this limited population group. Additionally, the Government provided certain segments of the population with subsidized private health insurance coverage, while leaving the rest of the population uncovered. There were also a number of vertical state-funded health programmes for specific services such as HIV/AIDS and TB treatments. The introduction of MAP marked the shrinking role of the state in SHP and the rapid expansion of the private insurance industry. The private health insurance industry became extremely profitable during this period, with profit margins as high as 30-40 per cent (Richardson and Berdzuli 2017).

Third wave (2012- current)

In 2012, a reform for a universal health coverage programme was introduced. Initially, financing of the health system shifted from private insurers to the Ministry of Health, which become a single payer. This led to improving access to health care and increasing financial protection, especially for previously uncovered segments of the population. This transformation advanced alongside a significant increase in state health care funding, rising from 400 million in 2012 to 1.3 billion in 2019. Despite progress, many challenges remain, most of which are inherited from the previous waves of reforms which fostered the commercialization of the health sector.

1.1.2. Recent reforms

Between 1996 and 2006, countries implemented major reforms with the stated objective of extending the right to social health protection coverage to all, alongside improving health care provision and quality more broadly. Some of these reforms had to be delayed or discontinued, but most continue to define the SHP landscape to an extent. These reforms include:

- The adoption of laws enshrining SHP entitlements for all (all citizens or all residents), such as in Armenia (the Law on Medical Care and Services to the Population of 1996), Azerbaijan (the Law on Medical Insurance of 1999) and Uzbekistan (Law No. 265-I on Health Protection of 1996) (table 3).
- The introduction of single-payer systems, sometimes merging pre-existing schemes under one umbrella, for example in Armenia (establishment of the State Health Agency in 1997) and Kyrgyzstan (establishment of the Mandatory Health Insurance Fund in 2001).
- The introduction of state-guaranteed benefit packages to reduce informal payments and improve accessibility to health services, for example in Kyrgyzstan (the implementation of a State-Guaranteed Benefits Programme in 2001), Tajikistan (the implementation of a Guaranteed Medical Services Programme and the Basic Benefits Package in 2005), Uzbekistan (the institutionalization of a state-guaranteed package of basic health benefits 1996).

More recently, reforms to create autonomous SHP agencies and schemes in post-Soviet Union countries have revived discussions.[8] These developments include the adoption of the Universal Health Coverage Programme (UHCP) in Georgia in 2013, the Mandatory Health Insurance (MHI) scheme and its management state agency (SAMHI) in Azerbaijan in 2016, the introduction of the Guaranteed Volume of Free Medical Care (GVFMC) and Mandatory Social Health Insurance (MSHI) system in Kazakhstan in 2020, and the introduction of the Social Health Insurance Fund in Uzbekistan in 2021, among others. Kyrgyzstan was at the forefront of this wave with the introduction of the Mandatory Health Insurance Fund (MHIF) in 2001, while in Tajikistan, the introduction of the Mandatory Health Insurance scheme

[8] See P4H webinars, available at:
WEBINAR 1 on social health care reforms and health care financing in the CIS - P4H Network
WEBINAR 2: Social Health Protection and Health Financing Reforms in the CIS - P4H Network

envisioned in 2008 was postponed several times. Discussions on the introduction of similar reforms are under discussion in Armenia.

▶ 1.2. Progress in expanding population coverage

This section explores the dimension of population coverage, both in the law and in practice. It provides an overview of newly available data on legal and effective population coverage from the World Social Protection Database. The trajectories of countries in their journeys towards extension of coverage are outlined, as well as the remaining challenges to expand coverage. Dimensions related to adequacy of coverage (service coverage and financial protection) are explored in the next sections of this chapter.

1.2.1. Access to health care without hardship

Legal coverage

Effective access to health care without financial hardship and to income security during sickness and maternity is of paramount importance to the realization of the human rights to health and social security. From a rights-based perspective, an essential prerequisite is to enshrine the provision of these benefits in legislation so that protected persons have a clear entitlement that they can claim.

In Central and Western Asia, it is estimated that over 99 per cent of the population is legally covered for health care benefits (in that a benefit package is guaranteed for free or affordable to a designated population in the law) (ILO, forthcoming). Most countries have adopted legal entitlements for health care without hardship that are universal or near universal in their scope, with the notable exception of Georgia where an income threshold is applied, but which currently concerns around 4 per cent of the population (see table 3).

▶ Table 3. Overview of the law and scope of population coverage for SHP schemes in Central and Western Asia

Country	Name of program	Legal basis	Scope of population coverage
Armenia	Basic Benefits Package (BBP) for the general population	• Law of the Republic of Armenia on Medical Care and Services of the Population No ZP-41, dated 4 March 1996 • Government Resolution No 318-H, dated 4 March 2004 • Government Decree N 318-N, dated 4 March 2004 on Free and Preferential Medical Care and Services Guaranteed by the State • Government Resolution of the Republic of Armenia N 1717-N dated 23 November, 2006 on the approval of the List of Diseases and Social Groups of the Population Entitled to Free or Preferential Purchase of Medicines • Government Decree N 375-N of 27 March 2014 on the Procedure of Social Package Services Provision and financing	'Everyone has the right to free or licensed medical care and services within the framework of health care and improvement programmes'
	BBP for socially vulnerable and special categories		Vulnerable groups, disabled, children, pregnant women, military service personnel, victims of human trafficking, asylum seekers, among others (full list available in Armenia Country Profile)
	Social package		Civil servants, teachers at public schools, health workers at public PHC facilities and employees of other particular public institutions

Country	Name of program	Legal basis	Scope of population coverage
Azerbaijan	Mandatory Health Insurance (MHI)	• Law of the Azerbaijan Republic on public health care, dated 26 June 1997 No. 360-IQ • Law of the Republic of Azerbaijan on health insurance dated 28 October 1999 No. 725-IQ • Law No. 1441-VQD, dated 28 December 2018 on amendments to the Law of the Republic of Azerbaijan on health Insurance (the Medical Insurance Law); Further amendments include No. 520 Decree of the President of the Republic of Azerbaijan on the Statute of the State Agency for Mandatory Health Insurance dated 7 February 2019 • Decree of the President of the Republic of Azerbaijan on Measures to Ensure Implementation of Mandatory Health Insurance in the Republic of Azerbaijan, dated 20 December 2020	All citizens including foreigners legally residing in the country (permanently or temporarily), refugees and stateless person under the protection of UNHCR Excluding: detainees, prisoners and stateless persons without official status
Cyprus	General Health care System (GHS)	• The General Health care System Law of 2001 (N.89 (I)/2001) • Law (1(1)/2005) on the Entitlement and Protection of Patients' Rights • The General Health care System (Amending) Law of 2017 (N.74 (I)/2017)	Citizens of the Republic, citizens of the EU and of third countries who have legally acquired the right to permanent residence, recognized refugees or persons with protection status and their families Excluding: Asylum seekers and undocumented migrants
Georgia	Universal Health Coverage Programme (UHCP) – 3 types of entitlements: 1) Universal Health care package for specific age groups and vulnerable groups 2) Standard State Universal Health care package 3) Minimal State Universal Health care package	• Resolution of the Government of Georgia concerning measures to be taken in order to transition to universal health care, No. 36, dated 21 February 2013 • Resolution of the Government of Georgia on approval of the 2014-2020 State Concept of the Health Care System of Georgia for Universal Health Care and Quality Control for the Protection of Patients' Rights Ordinance No. 724, dated 26 December 2014	Residents below the annual income threshold of 40,000 LIR, Stateless persons legally residing permanently in the country Different packages: 1) Children aged 0–6, pensioners and other specified categories of the population (such as IDPs) 2) Children above 6 years of age and people of working age subject to income tests 3) Those who were previously privately insured and whose policy was discontinued"
Israel	National Health Insurance	• National Health Insurance Law, 5754-1994	Every resident is entitled to health services under this Law, unless s/he is entitled to them by virtue of another law Excluded: Those who are not determined to be residents by the NHI institution and asylum seekers

Country	Name of program	Legal basis	Scope of population coverage
Kazakhstan	Guaranteed Volume of Free Medical Care (GVFMC)	• Decree of the Government of Kazakhstan No. 672 on Approval of the List of Guaranteed Volume of Free Medical Care and Invalidation of some Prior Decisions of the Government of the Republic of Kazakhstan dated 16 October 2020 • Code No 360-VI of the Republic of Kazakhstan on the health of the people and the health care system, dated July 2020	All citizens, 'Kandas' – ethnic Kazakh - who might not have Kazakh citizenship; refugees; foreigners who permanently reside in Kazakhstan; stateless persons who permanently reside in Kazakhstan and have appropriate residence permits Excluding: Temporarily visiting foreigners, stateless persons and asylum seekers
	Mandatory Social Health Insurance (MSHI)	• Code of the Republic of Kazakhstan No. 193-IV on People's Health and Health Care system, dated 18 September 2009 • Law No. 405-V ZRK of the Republic of Kazakhstan on Mandatory Social Health Insurance, dated 16 November 2015 • Decree of the Government of Kazakhstan No. 421 on Approval of the List of Medical Care in the System of Mandatory Health Insurance, dated 20 June 2019 (amended in 2020)	Citizens of Kazakhstan or those who have a permanent residence permit
Kyrgyzstan	State-guaranteed Benefits Programme (SGBP)	• Law on Health Insurance in the Kyrgyz Republic of 1999 • Law on Single Payer system in the Kyrgyz Republic of 2003 • Law on Health Care Organizations in the Kyrgyz Republic of 2004 • Law on Health Protection of 2005 • Decree No. 790 on the Programme of State Guarantees for Providing Citizens with Health Care, dated 29 November 2015 • Regulations on Co-Payment for Medical Services Provided by Health Care Organizations under the State Guarantee Programme for Providing Citizens of the Kyrgyz Republic with Health Care of 2012 (Approved by Resolution No. 645 of 2012 on the Programme of State Guarantees on Provision of Citizens with Medical and Sanitary Care) • The Resolution of Cabinet of Ministers on the Mandatory Health Insurance Fund under the Ministry of Health of the Kyrgyz Republic of 2021 • Amendments to the Law on Medical Insurance of Citizens in the Kyrgyz Republic, dated 29 March 2023, and related regulations based on Resolution of Cabinet of Ministers, N 493, dated 21 September 2023 on Providing Citizens with Medical and Sanitary Assistance in SGBP	Citizens of Kyrgyzstan, Foreign citizens, kairylmans, returnees and stateless persons permanently or temporarily residing in the country
	Enhanced SGBP under MHIF		Contributors to the SGBP under MHIF and vulnerable groups
	Additional Drug Package (ADP) of Mandatory Health Insurance	• Decree No. 28 on Approval of the Regulations on Preferential Drug Provision of the Population at the Outpatient Level under the State Guarantee Programme; and the Additional Mandatory Health Insurance Drug Package, dated 12 January 2012	Contributors to the SGBP under MHIF and vulnerable groups

Country	Name of program	Legal basis	Scope of population coverage
Tajikistan	Procedure of health service provision in public health facilities (depending on place of residence)	• Decree No. 600 of 2008 on the Procedure for Providing Medical and Sanitary Services to Citizens of the Republic of Tajikistan and Decree No. 485 of 2018 (amendment)	All citizens without exception. "Vulnerable" population groups eligible for exemption of co-payments for certain services (the poor, infants, and adults over 80, pregnant women, patients with acute myocardial infarction and terminal cancer)
	Guaranteed Medical Services Programme (GMSP), also called Basic Benefits Package (BBP) (depending on place of residence)	• Code of Health Care of the Republic of Tajikistan, dated 30 May 2017 • Decree No. 90 of 2017 on the Programme of State Guarantees for Provision of Health Care in the Pilot Areas of the Republic of Tajikistan for 2017-19	All citizens without exception. "Vulnerable" population groups eligible for exemption of co-payments for certain services (the poor, infants, and adults over 80, pregnant women)
	Mandatory Health Insurance (not implemented yet)	• Law of the Republic of Tajikistan No. 408 'About Health Insurance´, dated June 18, 2008	Citizens of Tajikistan "carrying out activities on the basis of labour contracts" and their dependents; persons engaged in labor activities on other conditions (self-employed, informal workers, etc.) and their dependents; other beneficiaries (unemployed persons, children under 16, students, participants in Great Patriotic War and their dependents); other persons insured in the MHI system
Turkmenistan	State Voluntary Medical Insurance (SVMI)	• Presidential Decree No. 1617, issued on 14 August 1995 on the introduction of state voluntary medical insurance • Presidential Decree No. 2398 Exempting Selected Population Groups from Medical Charges, issued on 21 November 1995 • Presidential Decree No. 3640 on Establishing the State Fund for Health Development, issued on 13 March 1998 • Decree of the president of Turkmenistan on the Establishment of Basic Size of Payment of State Voluntary Medical Insurance, dated 1 April 2014 • Order No. 428 on State Voluntary Health Insurance, dated 28 December 2017	Voluntary coverage Citizens including working citizens, students, citizens who receive non-working pension, individuals who do business without creating a legal entity, creative workers, farmers and citizens who do not have regular incomes

Country	Name of program	Legal basis	Scope of population coverage
Türkiye	General Health Insurance Scheme (GHIS)	• The Social Insurance and General Health Insurance Act No. 5510, dated 31 May 2006	All citizens, refugees, recipients of different social protection benefits (pension, disability and so on), nationals of foreign countries who have a residence permit and are not insurance holders under legislation of a foreign country Excluding: Convicts, arrested individuals, detainees and temporary residents who are residing in Türkiye for a period of less than one year
Uzbekistan	State-guaranteed Basic Benefits Package (SGBP)	• Chapter III of the Law No. 265-I of 1996 on Health Protection • Resolution of the Cabinet of Ministers of the Republic of Uzbekistan No. 832, dated 30 September 2019, approved the Regulations on the procedure for the formation of the List of guaranteed volumes of (free of charge) medical care covered by the State budget of the Republic of Uzbekistan	Citizens of Uzbekistan, foreign citizens in accordance international treaties; stateless persons permanently residing have equal rights to citizens of Uzbekistan
	Complementary services under the State-guaranteed Basic Benefits Package		Vulnerable categories of the population (defined and approved by the Cabinet of Ministers of the Republic)
	Social Health Insurance	• Concept of Health System Reform of the Republic of Uzbekistan, Presidential Decree of the Republic of Uzbekistan, December 2018 No. UP-5590	All citizens and permanent residents in piloted region

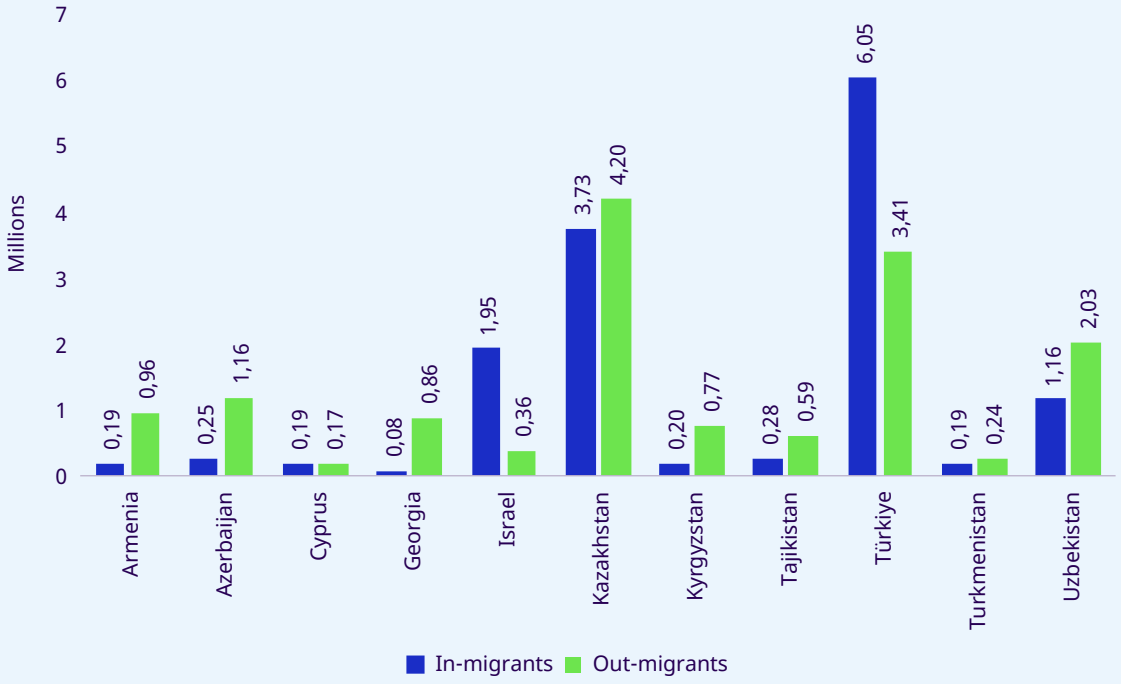
Remaining gaps concern:

- The exclusion of non-nationals, based on a diverse range of status requirements depending on the country. Such gaps are particularly prevalent among temporary migrant workers and irregular or undocumented migrants.
- A segmentation in entitlements whereby while all are covered to receive a basic package of health care services without financial hardship, some population groups are entitled to a wider range of services and often higher levels of financial protection.
- A reliance on voluntary mechanisms.

Non-nationals

Migration is motivated by different factors in the subregion, ranging from internal labour migration involving movements from rural to urban areas, political and environmental migration, to international migration and displacement across borders, which is often attributed to conflicts and violence such as in Nagorno-Karabakh in Azerbaijan (Council of Europe 2023), or extreme weather events and natural disasters such as in Uzbekistan (KUN.UZ 2022) (see figure 7).

Figure 7. International in- and out-migrant stocks, Central and Western Asia, 2020



Note: For out-migrants, the figure indicates their country of origin. For in-migrants, the figure indicates the country of destination.

Source: Based on data from the United Nations Population Division 2020.

Regulations related to migration status are the main cause of remaining legal coverage gaps in CWA. All countries but one have laws that include citizens as well as a list of additional groups in their scope of personal coverage. Non-nationals residing permanently in the country are most often included, but sometimes with some specific exclusions (such as asylum seekers, for example). According to the principle of equality of treatment, migrants should have access to social protection that is on par with nationals, which is also in line with good practice in public health (Ron and Nitzan 2023). As per the General comment No. 14, States party to the UN Committee on Economic, Social and Cultural Rights have immediate obligations in relation to the right to health, such as the guarantee that the right will be exercised without discrimination of any kind (article 2.2) and the obligation to take steps (article 2.1) towards the full realization of article 12. Such steps must be deliberate, concrete and targeted towards the full realization of the right to health.

Even when legally included in SHP policies, migrants and refugees may face unique obstacles to effective access due to the type and duration of their stay or employment, and issues related to documentation, among other challenges. For instance, in Azerbaijan, migrant workers are legally entitled to SP benefits if they hold an official residence permit and basic identification documents (see table 3). In practice, many migrants arrive to their respective country of destination on a seasonal and irregular basis and thus are not in a position to produce such documentation. Persons in these categories may face compounded challenges in accessing health care and other social protection benefits.

Similarly, refugees must be in possession of identification documents and/or documentation on their legal status granted by the country of destination. In Türkiye, refugees are granted free access to SHP on an equal footing with nationals, in line with the Law on Foreigners and International Protection (LFIP) of 2013. However, conditions for access are tied to the registration with the PDMM (Provincial Directorate of Migration Management), through which individuals are provided international protection IDs. Upon registration and receipt of temporary protection status, they are granted free access to

primary, secondary and tertiary public health facilities (see box 4). However, navigating the complex process of obtaining legal status, which might be exacerbated by lack of documentation, and completing registration procedures, remains a critical challenge for many. Furthermore, refugees are restricted to access services solely in the city of their registration, unless they obtain referral documentation from their designated city (Asylum information Database 2023).

▶ Box 4. Türkiye's Response to the Syrian refugee crisis

Türkiye is a signatory to the 1951 Refugee Convention,[9] however it retains a geographic limitation to its ratification. This means that the status of refugee is only granted to those who are fleeing as a consequence of events taking place in Europe. This geographical limitation has shaped the legal framework for the Turkish asylum system and posed major barriers for processing asylum applications for those fleeing from outside of Europe. In 2013, in response to the large influx of Syrian refugees in the context of the civil war, Law No. 6458 on Foreigners and International Protection (LFIP) was adopted to extend "conditional refugee" status, extending the scope of protection to non-European refugees, without lifting the limitation to the 1951 Convention (Ergin and Kader 2021; Human Rights Watch, n.d.).

For non-European refugees, there are two legal tracks: Temporary protection status is granted for individuals such as Syrian refugees in the context of mass influx situations; and international protection status is granted to asylum seekers from countries other than Syria. These two categories involve different procedures in terms of registration mechanisms and conditions access to health care (Spahl and Österle 2019). Currently, Türkiye hosts the largest population of refugees, the majority of which are Syrian refugees. According to the Law on Foreigners and International Protection, refugees and asylum seekers may benefit from health care insurance services for one year. When in possession of Turkish identification documents, refugees are on an equal footing with Turkish citizens under General Health Insurance. Unregistered refugees only have access to free emergency services in hospitals. The Turkish Government also allowed Syrian doctors to provide health care services in MoH-established health facilities for migrants in 29 provinces. This strategy aimed at enhancing access to health services for this population by addressing language and cultural barriers. However, millions of unregistered refugees and migrants still face challenges in accessing health care (Barış et al. 2023).

Social security agreements allow migrant workers to maintain and transfer their social security rights and benefits already acquired or in the process of being acquired, otherwise known as portability. This is particularly relevant for continuity of care and addressing social determinants of health equity. To ensure the portability of social protection benefits from one country to another, cooperation through bilateral and/or multilateral social security agreements cooperation is necessary (ILO 2021d).

In the context of Central and Western Asia, such agreements are actively concluded between a country in the region and a third country outside the region – for instance, between Uzbekistan and the Republic of Korea. Of the three notable countries hosting a large number of migrants (Kazakhstan ,Türkiye and Uzbekistan), there is a constant migratory flow between Uzbekistan and Türkiye, for which the two countries signed a bilateral agreement to protect the rights of migrant workers and their families in 2018 (Erdoğan 2021). The portability of social security coverage and benefits, which offers long- and/or short-term benefits,[10] also applies to Azerbaijan, Georgia and Kyrgyzstan under a bilateral agreement with Türkiye (Republic of Türkiye Ministry of Labour and Social Security, n.d.).

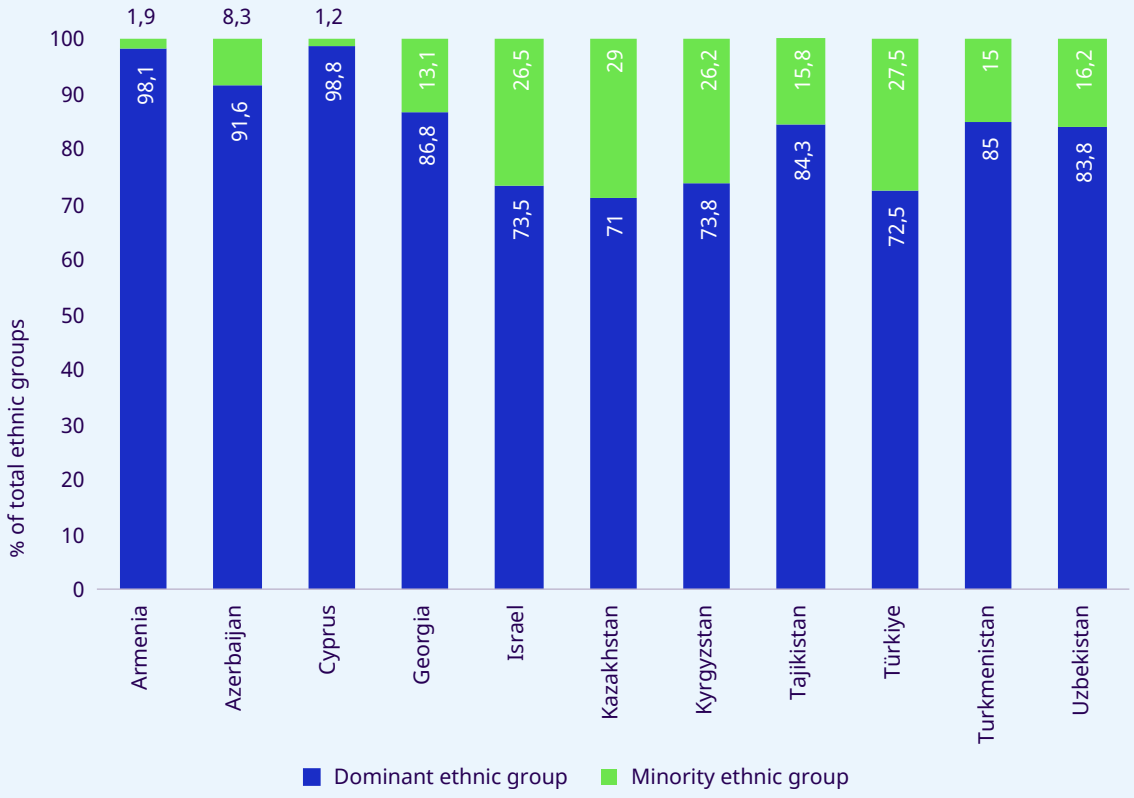
[9] The 1951 Refugee Convention is the key legal instrument illustrating the fundamental rights and treatment of refugees on an equal footing with foreign nationals and nationals. Article 23 of the Convention stipulates that refugees should enjoy access to health services equivalent to that of the host population (UNHCR 2011).

[10] Long-term benefits include old-age and disability pensions; short-term benefits include access to health care (medical tests, examinations and so on).

Ethnic minorities

Despite the fact that international human rights prohibit discrimination on the basis of race, skin colour, language, national or social origin, or any other status, minority groups still have limited access to health care and social security worldwide. There are a number of ethnic minority groups in the subregion, accounting for around 16.6 per cent of all populations in Central and Western Asia (see figure 8). In most countries, laws guarantee SHP to citizens and/ or residents, including ethnic minorities. For example, in Kazakhstan "Kandas" are entitled to access free medical services in GVFMC. Similarly, in Kyrgyzstan, "Kairylmans" who are resettling in the country have rights to SHP benefits equal to that of all residents. However, in general minority groups might face discrimination and additional challenges when accessing health services as they tend to remain disadvantaged in terms of basic human rights due to the post-Soviet authoritarian legacy (Terzyan 2021).

Figure 8. Proportion of ethnic minority groups as a percentage of total ethnic groups, Central and Western Asia, latest available year



Source: Based on data from the Central Intelligence Agency, n.d.

Segmentation in entitlements

While all countries offer near-universal entitlements to health care without hardship, some countries do not offer the same entitlements to all population groups in the law in terms of the range of benefits included in the cover.

In Georgia, the UHCP provides three different benefit packages. The comprehensiveness of the services covered, and the financial protection level depend primarily on a person's age and income level. A full comprehensive package covering primary care, hospitalization and other services plus additional insurance is provided to young children aged 0–6, pensioners and certain other specified categories (such as IDPs). Older children and people of working age subject to income tests can receive a basic

package, and the self-employed, among a few other groups previously privately insured, can receive a limited package of services (ILO and UN Women 2020).

In some countries there are several layers of protection. While the first layer is near-universal, additional ones may be restricted to some population groups, in law or in practice. For instance, in Armenia there are enhanced benefit packages for socially vulnerable groups and special categories and in Kyrgyzstan enhanced benefit packages are in place for people who contribute to the scheme and the poor and vulnerable.

- In Kyrgyzstan the SGBP provides free access to emergency care, basic primary care, limited outpatient specialist and inpatient services, and selected medicines for chronic and socially significant diseases for all. The enhanced scheme on the other hand offers a comprehensive list of inpatient and outpatient services, only covering contributors and the poor and vulnerable. Contributing members and the poor and vulnerable can also access the additional drugs package (ADP), which offers discounted medicines from contracted pharmacies. This leaves the population who does not meet the vulnerability criteria but cannot meet the contribution requirements outside of the scope of coverage for the complementary package under the enhanced scheme and ADP.
- In some countries, the legislation provides the same level of benefits to all, but the way in which these are implemented may create protection gaps, even when laws are intended to avoid such gaps. For instance, in Kazakhstan, the GVFMC offers a benefit package inclusive of most essential services at primary, secondary and tertiary levels for all residents, and MSHI beneficiaries are entitled to a range of additional and complementary services. These additional services include a higher level of coverage for preventative, diagnostic, specialist, hospital and rehabilitation care, and were further extended to include elective dental care and elective inpatient treatment. While by law the two schemes are meant to be near-universal, in practice, contribution payment is used as eligibility criteria for the MSHI, which excludes those who do not meet the vulnerability criteria but cannot meet the contribution requirements, namely the "missing middle" (see next section on effective protection). Lastly, this segmentation creates a lack of clarity as to the scope and level of protection offered to different population groups. This confusion as to what services beneficiaries are entitled to and under which conditions can ultimately create barriers of access and impact effective protection.

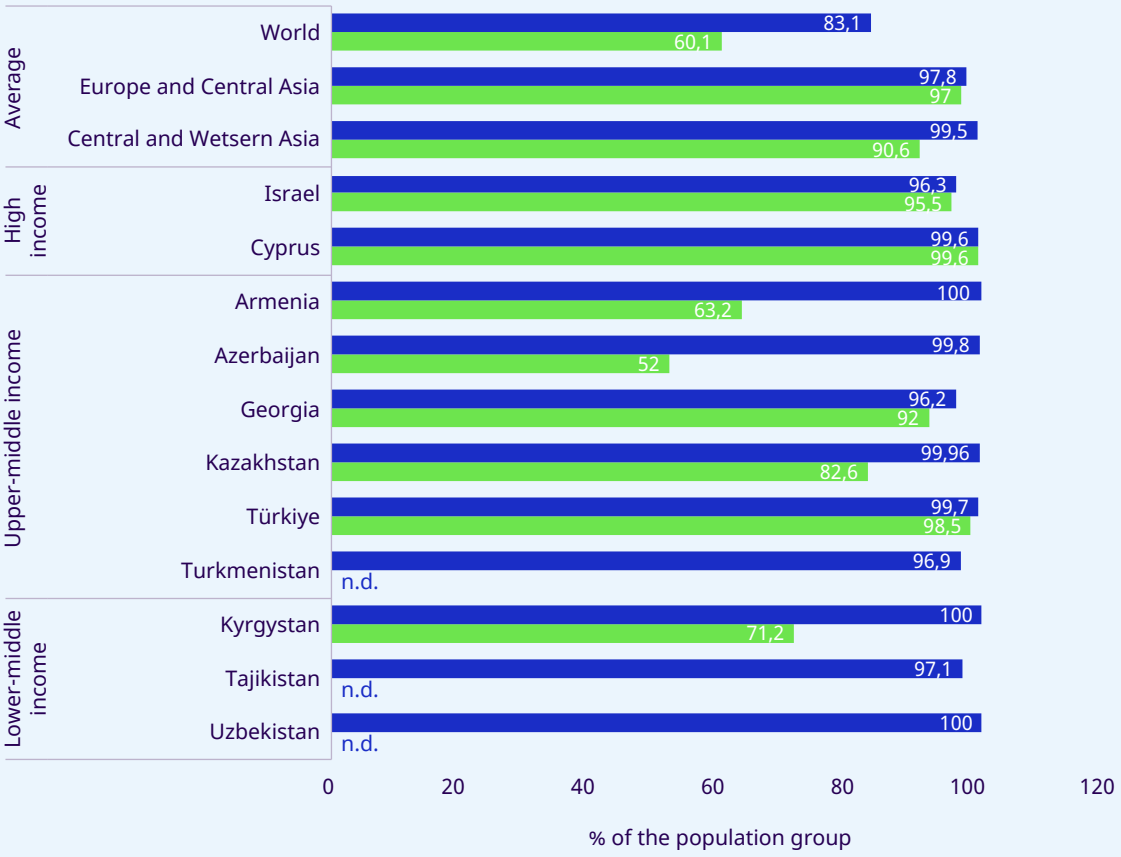
Voluntary schemes

In Turkmenistan, while legal entitlements to health care without hardship are near-universal, State Voluntary Medical Insurance (SVMI) is a voluntary scheme (European Observatory on Health Care Systems 2000; Government of Turkmenistan 2023). Voluntary schemes have proven very difficult to implement in a number of settings, due a range of factors such as adverse selection, low awareness of schemes, especially among populations groups who tend to need them the most, and the absence of enforcement mechanisms. While most of the countries in Central and Western Asia have opted for mandatory or automatic registration, in practice, some countries implement part of their system on a voluntary basis, as explored in the next section.

Effective protection and awareness of rights

For individuals to access health services without hardship at the time of need, it is important that this is considered a right and for it to be embedded in the legal framework. It is equally important that populations are aware of their legal entitlements and modalities to avail themselves of services, and that they understand the scope and level of protection they are entitled to. A proxy indicator in this regard is the percentage of the population protected by SHP. In striving for universal protection, in recent decades, a large number of countries globally, across all income levels, have made laudable progress in extending the effective reach of SHP mechanisms, resulting in two thirds of the world's population being protected by a scheme. In Central and Western Asia, comparable data is not available for all countries, but figure 9 illustrates some gaps between legal entitlements and their implementation.

Figure 9. Gaps between the share of the population legally entitled to health care without hardship and the share of the population protected by a scheme (protected persons), Central and Western Asia, 2023 or latest available year



Note: Data on protected persons not available for Tajikistan, Turkmenistan and Uzbekistan; data on Armenia are from 2015; data on Kazakhstan concern the MSHI scheme; data on Kyrgyzstan concern the MHIF. Global and regional aggregates are weighted by the population.

Source: Adapted from ILO estimates, World Social Protection Database, based on the SSI, ISSA Social Security Programs Throughout the World, ILOSTAT and national sources; data from ILO Social Security Inquiry and OECD Health Statistics 2023 national administrative data published in official reports; and information from regular national surveys of target populations on awareness on rights.

Monitoring awareness of entitlements and registration (when applicable) is important and should be a core component of a UHC and USP dashboard at the national level. Without this information, it is difficult to assess the level of implementation of SHP legal guarantees in practice and some of the pathways that lead to financial hardship related to the use of health care services. A better measure of effective coverage must take into account in-country inequalities across different population groups. Indeed, coverage gaps tend to mirror social, economic and geographical inequalities. For example, while in Tajikistan the GMSP is a near-universal guarantee, in practice it is estimated that about a third of people benefited from free services under a government scheme in 2021 (WHO 2021a). Similarly, in Armenia while the BBP is meant to provide PHC for the entire population, in practice the existence of co-payments and other non-medical costs (such as transport and lost working time) may explain why actual coverage is estimated to be much lower (ILO and UN Women 2021).

Covering people living in poverty and vulnerable groups

Within the framework of their SHP policies, most countries in the subregion expanded coverage to the poor and several vulnerable population categories. Most countries have developed SHP guarantees that extend to all citizens or residents and in practice have implemented a family-based registration process (rather than on an individual basis). Most countries also took additional measures to secure the appropriate protection of the poor and vulnerable, such as ensuring their affiliation on a non-contributory basis when applicable and/or waiving user fees and co-payments for these groups. This is achieved through several types of measures:

- Coverage of the entire population on a non-contributory basis, such as in Armenia, Georgia, Kazakhstan, Tajikistan and Uzbekistan. For example, in Uzbekistan the list of services in the state-guaranteed benefit package is free at the point of care and financed entirely via general government revenues.
- Coverage of the poor and vulnerable on a non-contributory basis within schemes that are partially contributory (receiving social security contributions from other groups of the population), such as in Cyprus, Israel, Kazakhstan, Kyrgyzstan and Türkiye (and under consideration in Armenia). In Kazakhstan, the GVFMC is a programme under which a comprehensive benefit package of primary and higher levels of care is provided to the entire population on a fully non-contributory basis. In addition, the MSHI is a national health insurance scheme that provides a complementary range of services which vulnerable groups benefit from through MSHI on a non-contributory basis. In Türkiye, under the GHIS vulnerable households are also included on a non-contributory basis. The assessment of vulnerability is comprehensive and based on a range of criteria that are not limited to monetary wealth or assets but encompass a wider understanding of social vulnerability, such as age, existing chronic conditions or disability for example. This assessment is conducted under the centralized mechanism applied for all social assistance benefits (World Bank 2016).
- Exemption or reduction of co-payments and user fees for all or for the poor and vulnerable, such as in Armenia, Cyprus, Georgia, Kyrgyzstan, Tajikistan and Uzbekistan. In Kyrgyzstan, there is an extensive system of exemptions from co-payments for the poor and vulnerable under the SGBP, which aims to protect people from high expected health care costs (Jakab et al. 2018).

Usually, a combination of these measures is used by countries. When measures are put in place specifically for the poor and vulnerable, a mechanism is needed to identify beneficiaries. Existing mechanisms may be used, offering opportunities to coordinate with the wider social protection system, that allow for the adequate identification of vulnerable populations in order to effectively capture vulnerability in its multidimensional nature (see box 5). Such assessments should not be limited to means tests or proxy means tests. In this respect, the Committee of Experts on the Application of Conventions invites policymakers to give full consideration to the possible impacts of the use of means-tested or proxy means-tested schemes, and particularly their suitability to address social protection deficits in light of the specific national circumstances. The Committee considers that, before opting for one targeting mechanism rather than another, policymakers should carefully consider all policy options from a rights-based perspective and evaluate their respective advantages and drawbacks, including the high costs incurred by certain targeting mechanisms, especially in terms of data collection, processing and regular reassessments (ILO 2019). In Kyrgyzstan, children under 16, pensioners, students, persons with disabilities and persons receiving social assistance are exempt from contributions and automatically enrolled in mandatory health insurance alongside access to the ADP scheme which guarantees the right to purchase medicines at reduced prices. Conversely, in Armenia, some co-payment exemptions or reductions are limited to specific vulnerable groups, which may be more narrowly defined, with coverage estimated to reach a little over 10 per cent of the population (ILO and UN Women 2021).

▶ Box 5. Means testing and its challenges

Within the framework of social assistance schemes, a means test is used to assess the financial situation of individuals or households, and determine whether their income and/or assets fall below a certain threshold set for eligibility. However, traditional means testing requires time and resources to obtain the relevant financial information of beneficiaries. Many countries have therefore adopted proxy-means testing, which involves using readily observable indicators or proxies to estimate a household's income or expenditure. These factors can include household assets, housing conditions, level of education and so on. While proxy-means tests can be a cost-effective and less resource-intensive option, challenges arise in terms of inclusion and exclusion errors as well as access to up-to-date information on household actual situation. This is relevant in the case of rural populations, for instance, when the growth of saleable crops is reduced by climate factors resulting in a severe drop in income.

Source: Adapted from ILO 2017a.

As previously noted, many countries do not use (or do not exclusively use) means tests, but define vulnerability more broadly. In particular, a number of countries consider pregnant women, persons living with disabilities and older persons as falling within this category.

- **Pregnant women and newborns**

In Central and Western Asia, in line with international social security standards, most countries provide maternal and child health care services free of charge for pregnant women and new mothers and, where applicable, with co-payment exemption and subsidized contributions when applicable. Children and pregnant women are included in groups for whom national health insurance is non-contributory, such as in Kazakstan and Türkiye. However, financial protection is not always a guarantee. In Georgia, childbirth services are free up to a certain amount, while beneficiaries are still required to pay a co-payment if they exceed this threshold (see box 9, section 1.4.1.).

- **Older persons**

Similarly, the contribution of pensioners and/or retirees to national health insurance schemes is subsidized by the Government in Azerbaijan, Kazakhstan and Kyrgyzstan. In countries with non-contributory systems, such as in Tajikistan, older persons are sometimes exempt from co-payments. Having SHP mechanisms in place inclusive of older persons with adequate financial protection is of the utmost importance, as they are especially at risk of incurring hardship due to chronic diseases requiring recurrent medical costs, and their income is usually comparatively lower than the working age population. Therefore, the lack of adequate social health protection is compounded by low levels of old age pensions. In Central and Western Asia, over 90 per cent of the population above retirement age receives an old age pension, yet there are gaps in terms of gender (the women's coverage rate is on average over 10 percentage points lower) and adequacy of pension levels (in particular non-contributory pensions tend to remain low). Indeed, in some countries and for some population groups, the level of old age pensions can be very low and may not ensure a life of dignity. For instance, in Georgia, the non-contributory minimum pension level is set lower than the poverty line (ILO, forthcoming). In this context, older persons may face financial barriers to accessing health care if it is not provided free-of-charge, and may forgo care altogether.

As people age or face disabilities that limit their ability to perform daily activities, access to long-term care becomes essential for people to live a life in dignity. In the context of a rapidly ageing society, such care can come in different shapes and forms, should encompass health and social care, and should ideally allow ageing for as long as possible (ILO 2021b). Although populations are ageing, thus far, most countries in Central and Western Asia are not prioritizing long-term care and social services for ageing populations when designing their SHP schemes, which can impact on poverty rates among older persons, and impede their ability to seek care. Some countries have included a limited set of long-term care

services in their benefit packages, such as Azerbaijan and Cyprus. In Türkiye, access to publicly financed long-term care is restricted to low-income individuals assessed using means tests and dependency level criteria. Subsequently, there is a significant reliance on private long-term care, which is often covered through OOP spending (Guduk and Ankara 2022).

• People living with disabilities and long-term illnesses

People with disabilities typically have unique health needs that require a more comprehensive range of health care services, which encompass both disability-related care as well as general health services needs, such as immunization and screening services. In general, people with disabilities are more likely to experience poor health and are at a greater risk of poverty (Banks et al., 2021). This is attributed to higher health care costs on average, often exacerbated by lower incomes due to barriers to employment and opportunity costs incurred by family members providing support. These family members may then be limited in their own earnings (Addati et al. 2022). Additionally, direct (non) medical costs and indirect costs incurred when accessing health care impose a double burden, ultimately resulting in increased OOP health spending.[11] The combined burden of extra expenses and lost income due to disability lead to disability-related costs and risk perpetuating a vicious cycle. This can be addressed by effective, well designed and inclusive social protection mechanisms. Disability-inclusive social protection systems guarantee effective access to health care and income security, including coverage of disability-related costs, through disability cash benefits. In 2020, only 40.9 per cent of persons with disabilities had legal entitlements to disability cash benefits in WCA countries (ILO 2021c; Kupper and Banks 2023). In some countries, people with disabilities are identified as vulnerable and thus access SHP programmes on a non-contributory basis (such as through Kazakhstan's MSHIS) and, where applicable, are exempt from co-payments, as in Azerbaijan, Georgia and Tajikistan. Such benefits are often accompanied by the provision of fully subsidized outpatient medicines, including for those suffering from chronic or long-term illnesses (for example, through BBP in Armenia).

The vicious cycle of poverty and poor health also applies to individuals suffering from chronic and long- term illness, as illustrated by the evidence on Tuberculosis (TB) (ILO and WHO 2024). TB imposes significant financial burdens on patients, encompassing expenses related to disease management, health care seeking and loss of income due to disability. These financial pressures not only hinder and delay access to health care and treatment adherence but also increase the risk of disease transmission. A systematic review of available studies on TB patients and household costs indicates that, on average, the financial burden can be equivalent to more than one year of income (WHO 2017). Evidence has shown that social health and social protection programmes have a significant positive impact on TB incidence, treatment outcomes as well as the number households experiencing catastrophic total costs (ILO and WHO 2024; WHO 2017). Data analysis has shown that social protection spending levels are inversely associated with TB prevalence (Siroka et al. 2016). Further, adequacy of benefit levels is strongly associated with health outcomes (Lönnroth and Weil 2014).

Similar evidence on the need for and the impact of social protection are emerging in the context of a range of long-term or chronic diseases (such as HIV, diabetes, hypertension and so on) and co-morbidities, illustrating the need for a systemic response (Jan et al. 2018; Kazibwe et al. 2021). In CWA, over 85 per cent of deaths are caused by non-communicable diseases which are often chronic in nature. Some countries in CWA have adopted mechanisms to improve access to SHP for people living with chronic conditions. For instance, in Tajikistan, individuals suffering from TB, HIV/AIDS, haemophilia and insulin-dependent diabetes are eligible for access to free public health services for these conditions. Other countries lack such mechanisms. For example in Uzbekistan, outpatient services for the screening, prevention and management of common chronic diseases such as asthma and COPD are not readily covered by existing SHP schemes.

[11] Health care costs in the context of social health protection include:
- Direct medical costs, such as general health care services, rehabilitation and specialist health services, assistive devices and community/home-based long-term care.
- Direct non-medical costs, such as transportation, housing and personal assistance required to access health care.
- Indirect costs, such as loss of income or time are faced by people with disabilities face while seeking care, or for other family members who provide personal assistance or caregiving support.

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• The informal economy: A “missing middle”?

In line with the ILO Transition from the Informal to the Formal Economy Recommendation 2015 (No. 204), paragraph 2 (a), the term “informal economy” refers to all economic activities undertaken by workers and economic units that are – in law or in practice – not covered or insufficiently covered by formal arrangements. It is a broad term which encompasses a diversity of realities and work arrangements in practice. It is inclusive of the informal sector and informal employment, as the respective definitions do not completely overlap (see box 6).

▶ Box 6. Defining the informal economy, informal sector and informal employment

People working in the informal economy – which does not cover illicit activities – carry out economic activities that are not covered or insufficiently covered by formal arrangements, either in law or in practice.[12]

The informal economy accounts for over half of the world's workforce and over 90 per cent of Micro and Small Enterprises (MSEs) worldwide. In fact, the informal economy is a lifeline for those that fail to find employment in the formal economy and are thus forced to rely on informal wage employment, unregistered self-employment or alternative activities to survive. According to the ILO, the informal economy comprises informal employment in both the formal and the informal sector.

Informal sector[13]
According to the resolution adopted by the 15th ICLS, the informal sector comprises units engaged in the production of goods or services with the primary objective of generating employment and income for the persons concerned. These units typically operate at a low level of organization, with little or no division between labour and capital as factors of production, and on a small scale. Labour relations – where they exist – are based mostly on casual employment, kinship or personal and social relations rather than contractual arrangements with formal guarantees.

The new informality standards adopted by the 21st ICLS align with the forms-of-work framework by defining informality not only within employment, but also within other forms of work.

Informal work covers all productive activities carried out by persons that are – in law or in practice – not covered by formal arrangements, including productive activities defined as employment not covered by formal arrangements and productive activities carried out with a different intention than to generate pay or profit (own-use production work, volunteer work, unpaid trainee work, and other work activities) that are not covered by formal arrangements. The concept of informal work is meant to serve as an overarching reference concept, not intended to be measured in its totality (since this would be too laborious and of little practical use).

Informal employment is defined as any activity undertaken by persons to produce goods or provide services for pay or profit that is not effectively covered by formal arrangements such as commercial laws, procedures to report economic activities, income taxation, labour legislation and social security laws and regulations providing protection against economic and personal risks associated with carrying out the activities (ILOSTAT 2023).

Informal employment is often associated with low pay and limited access to legal and social protection and resources. It translates into limited bargaining power and representation, as well as an inability to project oneself into the future. For individual businesses and/or MSEs, informality hinders growth, productivity and access to general resources.

Although it has reduced over time in many countries, informal employment represents half or more of total employment in some Central and Western Asian countries, such as Armenia, Georgia and Kyrgyzstan. As noted previously, CWA countries have adopted universal or near universal legal entitlements for SHP, and therefore the informal economy is not legally excluded from these systems, yet in some countries coverage barriers remain. In some cases, coverage is voluntary for informal workers under SHP programmes that grant higher levels of protection, and they are expected to make contributions in order to be eligible to access such schemes. Until recently, in Kyrgyzstan, informal workers had the option

[12] Transition from the Informal to the Formal Economy Recommendation, 2015 (No. 204), available at: https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_CODE:R204

[13] Resolution Concerning Statistics of Employment in the Informal sector, adopted by the Fifteenth International Conference of Labour Statisticians (January 1993), available at: https://www.ilo.org/wcmsp5/groups/public/---dgreports/---stat/documents/normativeinstrument/wcms_087484.pdf

to voluntarily join the MHI scheme and were required to contribute around 1.6 per cent of their average monthly income to be able to effectively benefit from the scheme. This translated into a coverage rate of 72.4 per cent of the population for the MHI, as such workers were largely unregistered in practice. However, following a law amendment in 2023, their inclusion in the scheme is now mandatory. Similarly, in Kazakhstan, while the MSHI is mandatory by law, in practice enforcement is lacking when it comes to persons in vulnerable employment who are not included on a non-contributory basis. This is illustrated by a difference in almost ten percentage points in coverage rates between the GVFMC and the MSHI schemes. While there is minimal documentation, a similar situation may be at play in Azerbaijan, where registration as a taxpayer is a prerequisite for informal workers to be automatically affiliated to SAMHI. However, data indicates that only about one in five economically active people were registered as a taxpayer in Azerbaijan in 2019 (Valiyev 2020). As a result, the Government reports a coverage rate of just over half of the population, while the legal framework provides for near universal coverage.

While it is advisable to combine various sources of funding to ensure the maximum allocation of public resources for the population to access health services without hardship, it is crucial that financing arrangements do not create barriers to eligibility (ILO, forthcoming). Most countries in the subregion have or are in the process of moving from a fully non-contributory national health service system to a national social health insurance scheme using a mix of resources, including social security contributions. This shift is motivated, among other factors, by a willingness to collect contributions, usually including from some categories of workers in the informal economy, the self-employed and very small business units. For such shift to occur smoothly and successfully, measures need to be in place outside of the scope of SHP policies to foster formalization. Moreover, contribution levels (as well as income tax levels, since registration with a social health insurance scheme often means data shared with tax authorities) need to be appropriately set. Most importantly, as previously noted, it is crucial that financing arrangements should not create barriers to eligibility in practice, and contributory capacity should not condition access to health care. Social health protection should be for all members of society, regardless of their capacity to contribute (ILO Recommendation No. 69).

Legal entitlements, as well as registration and regular monitoring of entitlement awareness presented in this section do not automatically translate into effective access to available, accessible, acceptable and quality health care services at times of need. Many barriers can remain, representing adequacy gaps (see section 1.3):

- The availability, accessibility, acceptability and quality of health care services may be poor, not allowing effective access in practice or access to a level that would allow improvements in health status (section 1.3).
- Benefit packages may be limited, covering few services and leaving patients to cover high OOP expenses (section 1.3).
- High official co-payments or informal payments may be requested, leaving an important share of the total costs of care to be borne by patients (section 1.4).

Adequate SHP schemes play an important role in ensuring access to health care with reduced financial barriers for vulnerable persons, such as pregnant women, new mothers, children, older persons and people with disabilities and long-term illnesses. It is imperative that direct medical costs are properly covered through sufficient funding and improved community outpatient services, including prescribed medicines. It is of equal importance to ensure income benefits such as sickness and disability benefits that guarantee compensation for loss of income, thus contributing to the human rights to health and social security.

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1.2.2. Income security in case of sickness and maternity

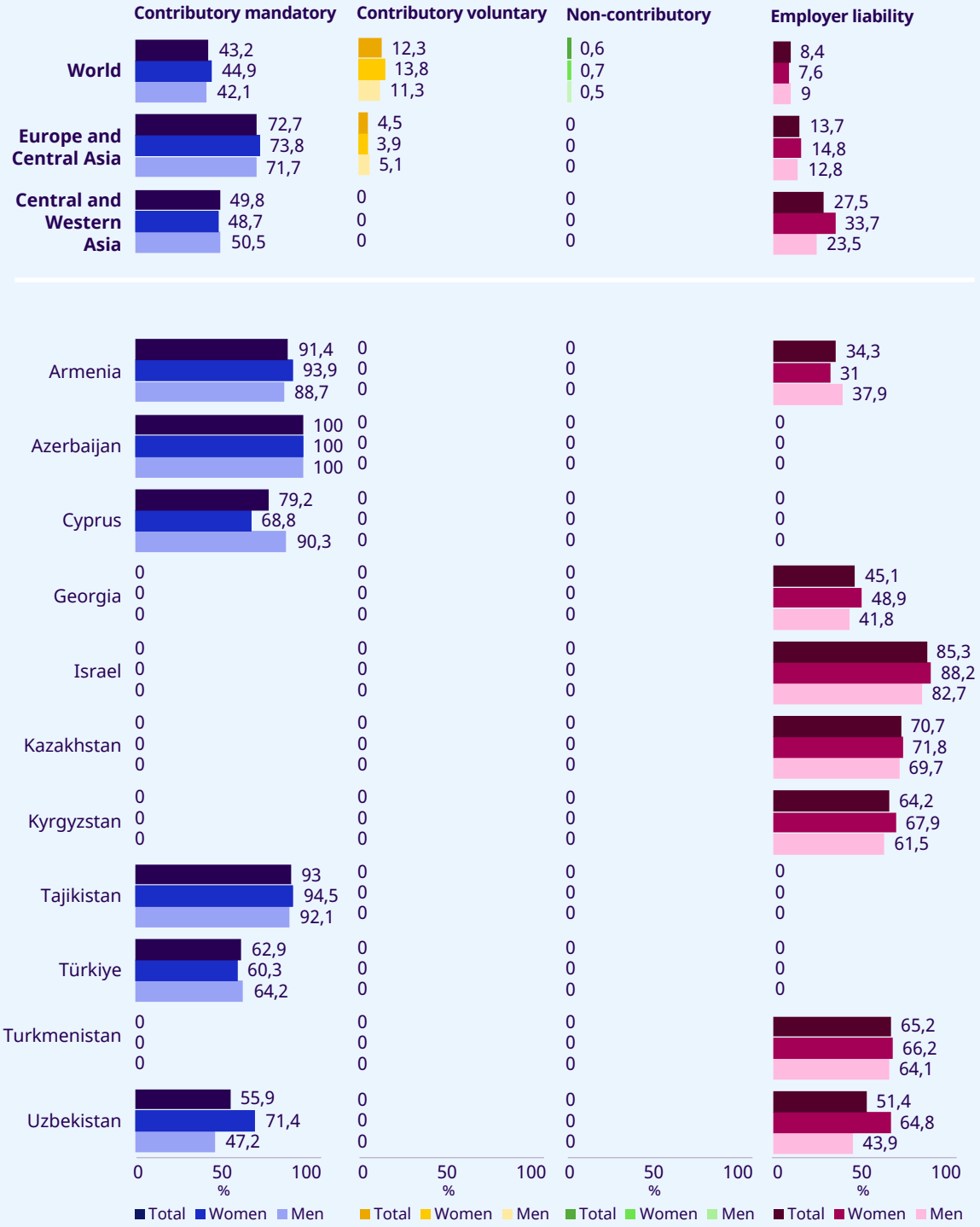
Legal coverage

In Central and Western Asia, while legal entitlements to health care benefits are near-universal, less than half of the labour force has a right to sickness cash benefits and only 54.4 per cent of women in the labour force are legally entitled to maternity cash benefits (ILO, forthcoming).

Sickness

In instances of illness, cash sickness benefits guarantee income support, thus contributing to the human rights to health and social security (ILO 2020b). Guaranteed sickness benefits provide an environment conducive to recovery and promote timely access to health care. Delays or failure to seek care during illness among workers usually results in higher costs, as severity increases when diagnosis and treatment are delayed. With such mechanisms eliminating fears of income loss, people can avoid worsening their health by giving themselves appropriate space and time to treat their illness. It also limits the risk of spreading of diseases, in case of communicable diseases (ILO 2020d). It is estimated that an average of 49.8 per cent of the workforce in Central and Western Asian countries is legally entitled to income security through social insurance (see figure 10), and no social assistance programmes are recorded.

Figure 10. Legal coverage for sickness protection: Percentage of labour force aged 15+ covered by sickness cash benefits, by type of scheme, Central and Western Asia, 2023 or latest available year



Note: Global and regional aggregates are weighted by the labour force 15+.

Source: ILO estimates, World Social Protection Database, based on the SSI; ISSA Social Security Programs Throughout the World; ILOSTAT; national sources.

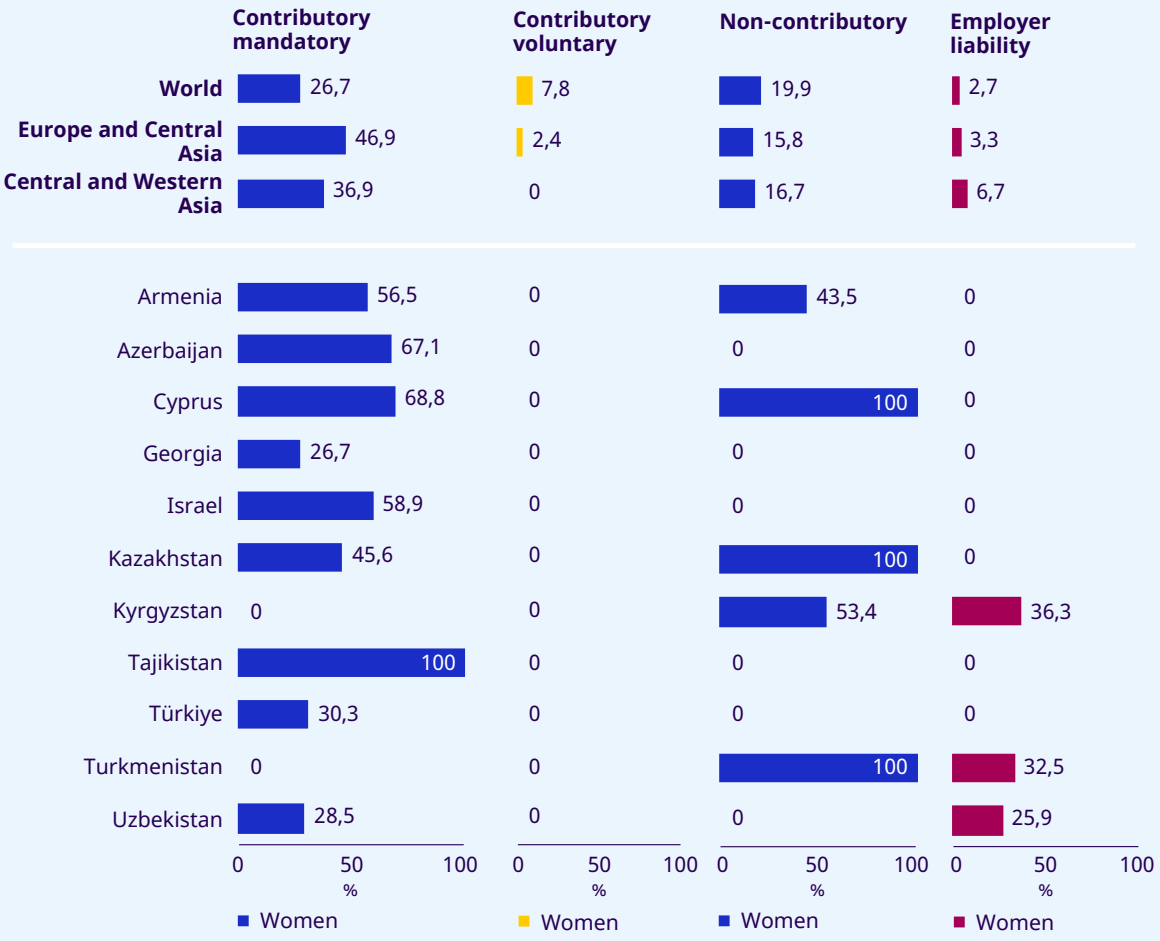
An additional 18.1 per cent of the labour force is legally entitled to income security during sickness, provided through employer liability. In Georgia, Israel, Kazakhstan, Kyrgyzstan and Turkmenistan, as per labour legislation, employers are obliged to continue paying workers' wages during sickness through employer liability, which is solely relied on to provide income security in the event of sickness and maternity. However, reliance on employers' liability may have adverse effects. Employer liability is limited, by definition, to salaried work only (the self-employed being their own employer). This may exclude certain categories of workers, such as casual, seasonal and hourly workers. Solidarity in financing is also absent and individual enterprises, especially small ones, may not have sufficient financial resources to comply with the legislation and provide sickness benefits for employees. Workers may therefore involuntarily refrain from taking sick leave, and those with pre-existing diseases may be discriminated against in hiring processes. Therefore, sickness benefits that are financed by way of taxation, contributions or both, offer a more robust way to provide income security in cases of ill health (ILO 2020b).

Maternity

Similarly, social protection benefits to support income security during maternity are imperative to protect women's rights to health and social security. This should be part of a broader set of policies to guarantee maternity protection, including an array of labour protections as well as free access to maternity care and income security during the maternity period (Addati 2015). The female population, especially women of working age, bear not only productive but also reproductive responsibilities (ILO 2009). However, in the world of work, women of childbearing age are subject to unequal and discriminatory treatment, which limits their participation in paid work and receipt of decent and equal wages. Due to this so-called "motherhood penalty", women may be discouraged from fully pursing their professional aspirations as valued members of society, and may have fewer opportunities to generate income to ensure their subsistence, which often leads to impoverishment (ILO 2023). In addition, pregnant women and new mothers who lack income security are highly likely to receive inadequate and inappropriate maternal health services during pregnancy, childbirth and the postnatal period. This increases the incidence of poor maternal health, and can impact on early childhood development.

In Central and Western Asia, only 54.4 per cent of women in the labour force is legally entitled to maternity cash benefits (see figure 11). Six countries rely on contributory social insurance exclusively, two adopted solely non-contributory entitlements for all women giving birth, while three countries use a mix of the two types of programmes. In addition, some countries continue to rely on employers' liability mechanisms. It is therefore crucial to ensure that all women giving birth enjoy income security. Armenia, Cyprus, Kazakhstan and Turkmenistan have taken efforts to enshrine this in their legal framework. For those countries adopting a fully non-contributory type of benefit, embedding it in the law can play a role in securing adequate budget allocation from the general government budget to secure rights that translate into effective coverage (ILO, forthcoming).

Figure 11. Legal coverage for maternity protection: Percentage of women of working age (15+) covered by maternity cash benefits, by type of scheme, Central and Western Asia, 2023 or latest available year



Note: Global and regional aggregates are weighted by women of working age (15+).

Source: ILO estimates, World Social Protection Database, based on the SSI; ISSA Social Security Programs Throughout the World; ILOSTAT; national sources.

Effective protection

Countries are making strides towards extending population coverage in order to ensure rights to health and income security during periods of sickness and maternity. However, legislated provisions do not necessarily translate into coverage of the target groups defined by law.

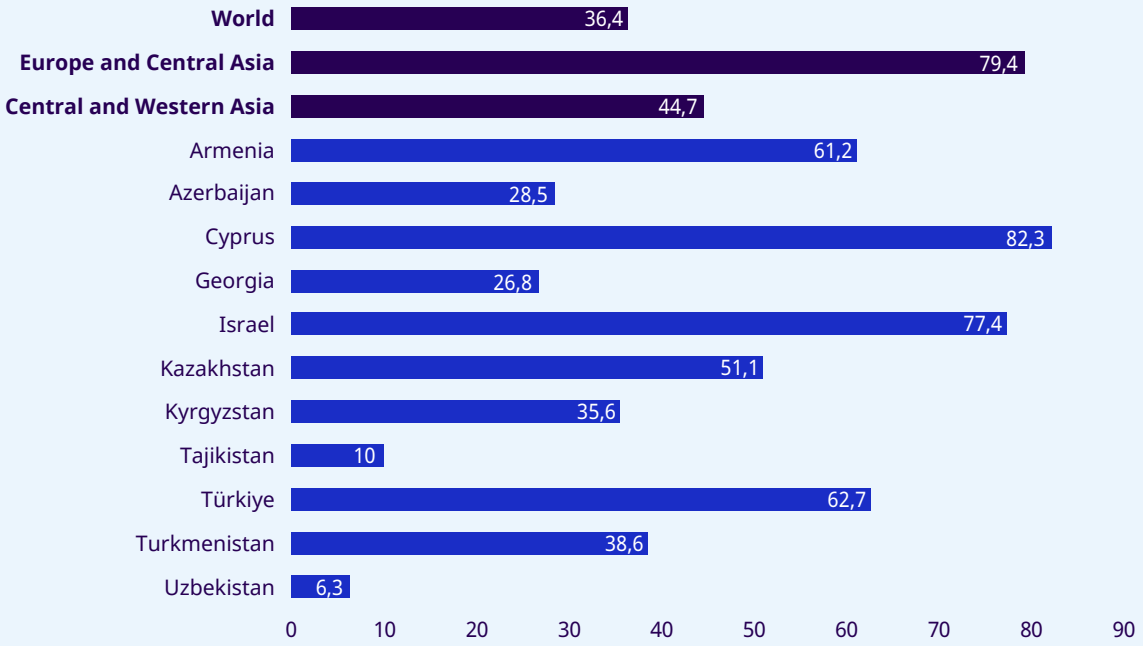
Effective coverage for sickness cash benefits is not currently monitored at the global or regional levels. The lack of a systematic compilation of comparable data thereof needs to be urgently addressed (ILO 2021c). As noted in the previous section, the mechanisms put in place to guarantee income security in case of sickness are not neutral, which influences implementation in practice. A lack of adequate financing is also an explanatory factor for high rates of legal coverage translating into low rates of effective coverage.

A gap between law and practice exists when it comes to maternity cash benefits. In 2023, less than half of the women who gave birth in Central and Western Asia received a maternity cash benefit, with significant differences across countries. For instance, Azerbaijan (28.5 per cent), Georgia (26.8 per cent), Tajikistan

(10 per cent) and Uzbekistan (6.3 per cent) all have coverage rates below regional and world averages (see figure 12). Overall, all countries show a discrepancy between legal entitlements and effective receipt of benefits.

The absence of maternity cash benefits before and after childbirth may lead many women to expose themselves to health risks by continuing working under unfavourable conditions until late stages of pregnancy or returning to work prematurely. This often translates into increased economic vulnerability at a time of increased household expenditures related to pregnancy and birth.

Figure 12. SDG indicator 1.3.1 on effective coverage for maternity protection: Percentage of women giving birth receiving maternity cash benefits, Central and Western Asia, 2023



Note: Global and regional aggregates are weighted by the number of women.

Source: ILO modelled estimates, 2024, World Social Protection Database, based on the SSI; ISSA Social Security Programmes throughout the World; ILOSTAT; national sources.

Population coverage is an important dimension to consider in efforts to expand effective access to health care without hardship, as well as access to sickness and maternity cash benefits. While this holds true, the adequacy of such coverage is equally important. The population groups that tend to be the most vulnerable and at risk of being left behind are often most likely to be faced with gaps in the adequacy of the coverage they receive, with more limited access to a comprehensive range of services (1.3) and/or more limited access to adequate financial protection (1.4).

▶ 1.3. Providing an adequate range of health care services

Adequacy of coverage encompasses two complementary dimensions both in the law and in practice. Firstly, the range of services covered needs to be comprehensive and meet the criteria of availability, adaptability, acceptability and quality (explored in this section). Secondly, the share of the cost of accessing such services borne by collectively financed mechanisms needs to be high enough to avoid shifting the financial burden of care onto the individual, effectively protect income and prevent impoverishment (explored in the next section). The status of these dimensions in Central and Western Asia is explored, firstly looking at design features related to the scope of benefits and their provision, and then analysing effective coverage based on existing data on access and utilization.

A comprehensive analysis of the range of services covered by SHP policies requires an examination of: (1) the services that are covered under the benefit packages defined by law and the network of service providers designated to deliver them (1.3.1 and 1.3.2), as well as (2) which services are effectively available and used in practice (1.3.3).

1.3.1 Designing comprehensive benefit packages

Defining a benefit package including the range of services provided in an SHP scheme is a priority setting exercise determined by different stakeholders. The process of defining such entitlements should be participatory and inclusive, and is typically the result of numerous trade-offs between different stakeholders' interests. This process differs from one country to the next, with wide variations in the use of evidence on the effectiveness and cost effectiveness of interventions, the level of participation and consultation with relevant stakeholders and the degree to which such entitlements are actually available on the ground and of sufficient quality (WHO 2021b). In Armenia, the composition of the benefit package was initially based on evidence on service efficacy, burden of disease and cost effectiveness, yet subsequent revisions did not follow such a systematic process. Gathering evidence through technology assessments is considered a good practice, though this is not systematically applied in Central and Western Asia.

UHC includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care (WHO 2021c). Social health protection policies contribute to this goal when they are in line with international social security standards and principles. According to Convention No. 102,[14] such benefit packages should at least include general practitioner care; specialist care outside of and at hospitals for inpatients and outpatients; essential pharmaceutical supplies as prescribed by medical or other qualified practitioners; hospitalization where necessary; and reproductive, maternal, new born and child health (RMNCH) services, including pre-natal, confinement, post-natal care and hospitalization if needed. The Medical Convention No. 130 [15] further notes the inclusion of dental care and rehabilitation. While terms may change, such as primary health care and family physicians replacing general practitioners in some countries, these standards make it clear that the basic benefit package should be adequate and comprehensive, covering both curative and preventive care, as outlined in ILO Recommendation No. 202 on national social protection floors, which emphasizes the need to ensure access to a set of goods and services that constitute essential health care, including maternity care. The determination of the scope of essential health care should be defined through a national dialogue process, with due consideration of the principles of availability, accessibility, acceptability and quality. Moreover, the scope should be regularly revised to ensure services covered remain sufficient to ensure a life with dignity, and to align with changes in medical technology and epidemiology.

ILO standards stipulate that institutions responsible for SHP shall make a proactive effort to encourage protected populations to utilize population health interventions and more generally implement promotion and prevention services. This is in line with the vision promoted by the WHO on service

[14] Convention C102 - Social Security (Minimum Standards) Convention, 1952 (No. 102) (ilo.org)
[15] Convention C130 - Medical Care and Sickness Benefits Convention, 1969 (No. 130) (ilo.org)

delivery. PHC has long been recognized as a pivotal function and core approach to health care delivery (see box 7). However, implementing this approach often necessitates health system transformation and strong stewardship and regulatory power from Ministries of Health. Many countries still face challenges in fully realizing the PHC function (WHO 2019a).

▶ Box 7. The Primary Health Care approach

The Primary Health Care (PHC) approach that emerged through the Alma-Ata Declaration, adopted at the International Conference on Primary Health Care in 1978, reinforced the goal of Health for All. The Declaration states that: "Primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family, and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first elements of a continuing health care process."

Traditionally, service delivery has been analysed and compartmentalized between different levels of care (primary, secondary and tertiary care) depending on the level of specialization, the type of clinician and technology used, as well as types of interventions, depending on whether they were population-based or individual-based (Starfield 1994). The PHC approach is intended to break these silos and ensure that people can access people-centred, comprehensive, integrated, first contact care within their community (WHO 2008). The World Health Report of 2008 and the Astana Declaration of 2018 further reiterated that this approach is not only the most effective, but also the most cost effective. Moreover, they emphasized the importance of collaboration with actors outside the health sector, including workplaces, through mainstreaming a Health in All Policies approach. This comprehensive approach focuses on addressing the social determinants of health and aligning this with the promotion of human rights to health and social security. ILO Recommendation No. 202. serves as a guiding framework to ensuring effective access to essential health care.

There are different benefit packages used under different SHP policies which tend to concern different levels of care and/or population groups in most of the CWA countries, creating a segmentation in rights (see section 1.2). For example, in Kazakhstan the benefit package of the GVFMC covers primary care and a range of additional services while a complementary benefit package with other services exists under the MSHI.

The first layer of protection provided in CWA countries is generally comprehensive and included in various types of policies. Often referred to in the subregion as "state-guaranteed benefit packages", universal entitlements provided fully on a non-contributory basis for the whole population act as a first layer of protection and include different sets of services across the countries that have adopted this approach (Armenia, Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan). Many of these packages include a set of emergency care, preventive, health promotion and outpatient primary health care (with the exception of Armenia, which excludes preventative care). Conversely, Azerbaijan, Georgia, Cyprus, and Türkiye have unified benefit packages inclusive of most levels of care for the whole population under mandatory national health insurance. In the case of Tajikistan and Uzbekistan, while the legal entitlement to SHP has been almost universally extended, benefit packages are narrowly defined and remain limited. In Tajikistan, a limited list of services is provided in the state-guaranteed benefit package, inclusive of emergency care, preventive health services and immunization, basic diagnostic tests and consultations at primary and secondary levels. In Uzbekistan, the legally prescribed benefit package includes services that are limited to emergency care, preventative services, health promotion and education, alongside

specialized care provided for a limited number of conditions such as respiratory diseases, infections and chronic disorders, excluding mental health illness and cancers.

It is common in the subregion for certain services such as dental care to be excluded (in Azerbaijan, Cyprus, Georgia, Kyrgyzstan, Tajikistan and Uzbekistan), even from the benefit packages considered most comprehensive. However, dental care is included in Türkiye's GHIS, Kazakhstan's MSHI, and under the enhanced BBP in Armenia. Many countries also largely exclude pharmaceuticals (Tajikistan and Uzbekistan) or limit access to a specific list of medicines, which may not always be fully in line with the WHO essential drug list and/or periodically adjusted to reflect changes in needs and technologies. For example in Kyrgyzstan, medications for diabetes, haemophilia and TB are included, in Georgia, only essential medicines are included, and in Armenia only medicines covered by specific national disease programmes are available. The extent to which benefit packages are accessible in practice largely depends on the designated network of providers (1.3.2) and the adequate resourcing of the health care system.

The PHC approach is not fully implemented in many countries in the subregion, and therefore a traditional distinction between levels of care is used in the following analysis of guaranteed benefit packages in CWA. The analysis outlines the ways in which most benefit packages are formulated in practice, identifying where benefits are explicitly or implicity, positively or negatively defined. In most of the CWA countries, they are explicitly defined and subject to revisions on a regular or irregular basis. The analysis is not only organized by level of care but also by type of intervention, namely population health, individual-based primary care, Reproductive, Maternal, Newborn and Child health (RMNCH) services, specialized inpatient and outpatient care, pharmaceuticals and long-term care.

Population health and primary care

Population health is an approach that focuses on the collective improvement, promotion and restoration of the health and wellbeing of an entire population, through policies and interventions to deliver appropriate care focused on outcomes pertinent to the wider determinants of health and health inequities (Buck et al. 2018; Kindig and Stoddart 2003). Population or public health are interventions targeting the entire population and include services such as health situation analysis, health surveillance, health promotion, prevention, infectious disease control, environmental protection and sanitation, disaster and health emergency preparedness and response, and occupational health, among others (WHO 2018).

Because of the collective nature of these interventions, they can be considered public goods (Cichon et al. 1999). The specific services included in population health vary across countries, but some of them are guaranteed under SHP legislation, usually included in a guaranteed benefit package nationwide or integrated in high-cost and high-priority disease control programmes, which are commonly managed vertically (Atun et al. 2008).

Prevention, early diagnosis and treatment of diseases such as TB and HIV have traditionally been covered by vertical disease-specific control programmes, sometimes supported by donor funding. In Georgia for example, access to antiretroviral therapy is made available for free to the entire population and co-funded by the Global Fund to fight AIDS, Tuberculosis and Malaria, as a key public health measure to avoid disease transmission within and across borders (WHO 2022b). Georgia has 23 vertical national health programmes identified as a public health priority, provided for the whole population, even for those excluded from the Universal Health Coverage Programme (UHCP) scheme. The programmes include disease prevention, immunization, early detection and screening, disease management and counselling for various conditions. In Kazakhstan, as stipulated by the legal framework, a set of state budgeted population health interventions is accessible for the entire population, including health education, antiretroviral therapy, HIV prevention, immunization, maternal care, and sanitation-epidemiological and sanitation-preventive interventions for infectious diseases. In Azerbaijan, management of TB, AIDS and diabetes are examples of such programmes. Armenia provides a limited range of health promotion, prevention and sanitation services in its BBP, yet it utilizes general government resources to finance a range of vertical health care programmes, including for HIV/AIDS, TB, oncology, and maternal and child health.

In some countries, such as Cyprus, Kyrgysztan and Tajikistan, these services are not included in packages defined in the legal framework. In Uzbekistan, the state-guaranteed basic benefits package only includes primary and emergency care, largely excluding prevention, secondary and tertiary care services. This creates a significant gap in addressing NCDs compared to infectious disease such as HIV, and TB, which are covered to avoid the spread of these highly infectious diseases. Notably, common NCDs (such as asthma, chronic obstructive pulmonary disease and others) remain uncovered. In the context of the changing disease burden landscape, with NCDs on the rise, population health interventions, alongside other measures, are increasingly essential to cope with these changes (Afshari et al. 2020). Such services should be available and the population should be financially protected to ensure they can access them.

Primary health care is closely associated with population health. It serves as the cornerstone of a comprehensive health system, integrating population-based interventions delivered at the community level with individual-based services. Effective primary health care is based on a generalist approach that adapts to the needs of the individual and is provided closer to their community (Stange et al. 2023). Primary care providers often assume the function of gatekeeping and referral mechanisms, preventing unnecessary use of specialist care (see section 1.3.2).

Entitlements to individual-based primary health care are provided in countries through different mechanisms. In Central and Western Asia, all countries typically include primary and emergency care services in their benefit packages. In many countries, including Azerbaijan, Georgia and Kyrgyzstan, the components of benefit packages that are related to primary care services provided to individuals, whether funded by the state budget or covered by national health insurance, are explicitly defined through positive lists.

Health promotion and prevention services are often provided as population health interventions through vertical disease-specific programmes. Alternatively, entitlements to prevention services can be included in the benefit package covered by SHP programmes. In Kyrgyzstan, child immunizations, antenatal care and management for hypertension, obesity and TB are included in the SGBP. In Uzebkistan, care for blood-borne infectious diseases, including HIV/AIDS and TB, is part of the Cabinet of Ministers Resolution regulating the list of services provided as part of guaranteed medical care.

Primary care for NCDs is receiving increased attention in benefit package design due to population aging and life style changes. However, adding specific diseases or services to the benefit package is only part of the needed response. In addition to this, countries will need to apply multi-sectoral NCD prevention strategies to control risk factors, such as tobacco use, harmful alcohol use, unhealthy diets, lack of physical exercise, environmental pollution and exposure to hazards in the workplace, as well as addressing broader social determinants of health which will require coordination with the wider social protection system (ILO 2021b). For instance, in Armenia, the emphasis of PHC is on curative care rather than health prevention and promotion services, although the MoH recently stepped up efforts to fight smoking and promote health life styles through adopting anti tobacco laws and measures Progress is also being made in areas of intervention that have historically received less visibility. For example, in 2015 a suicide prevention programme was launched in Kazakhstan as part of a mental health initiative (WHO Regional Office for Europe 2022).

In many countries (Georgia, Kyrgyzstan, Tajikistan and Uzbekistan), PHC services remain largely underutilized, leading to increased reliance on costly specialized care. Challenges in adopting a PHC centred approach vary, including a lack of alignment across different health system levels and inconsistent investment in infrastructure, digital solutions and the workforce, among others (Rechel et al. 2023; WHO Europe 2023a; 2023b).

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RMNCH services

RMNCH services have often been prioritized in benefit package design, in line with international social security standards, particularly Convention No. 102 which mandates free maternity and newborn care as well as Convention No. 183 on maternity protection. Different countries provide different kinds of RMNCH services in their benefit packages.[16] In Kyrgysztan, for example, pregnancy-related preventive and medical services are included under SGBP (see box 9, section 1.4.1).

While RMNCH services are included in benefit packages in most countries, some have placed higher priority on ensuring more comprehensive policies and programmes that guarantee coverage of mothers and children. For instance, in 2017 Georgia adopted a long-term Maternal and Newborn Health Strategy (2017–2030). In Uzbekistan, the development of evidence-based national standards for the management of pregnancy care led to improvements in indicators in the field of maternal and child health in practice.

Specialized outpatient and inpatient care

Most countries in Central and Western Asia have some form of legal entitlements to these services, often defined as a positive list (for example, Armenia's BBP, Cyprus' GHS, Georgia's UHCP, Kyrgyzstan's SGB and Türkiye's GHIS). The range of services vary in scope from country to country. In Türkiye, a comprehensive range of specialist care is provided, including surgery, blood and bone marrow treatments, cancer treatment, burn treatment, renal dialysis, rehabilitation services and organ transplants. In Kazakhstan,

[16] In Armenia, the benefit package includes antenatal and delivery services and child immunization; in Azerbajan, obsetetric care is included; in Cyprus, midwives services and routine childhood immunization are provided; in Kazakhstan, pregnancy monitoring, follow-up and immunization are included; in Kyrgystan, antenetal and child immuniation services are included; in Tajikistan, health monitoring, delivery services and preventive check-ups (including periodic dental check-ups) are included.

a range of both outpatient and inpatient specialized services are provided under GVFMC, in addition to expanded service coverage of specialist care under the MSHIS. Georgia has a list of specialist inpatient and outpatient services, including surgery, oncology services, obstetric care, some essential medicines, and emergency outpatient and inpatient services for more than 450 conditions. In Azerbaijan, the categories of specialist inpatient and outpatient services are explicitly defined, including physiotherapy, surgeries and specialized long-term care, and accessing services on the positive list does not require co-payment in public health care facilities. In contrast, some countries, such as Uzbekistan, include a limited range of specialized outpatient and inpatient care. As noted for primary care, some countries also provide specialist care for specific conditions through national disease-specific programmes.

Inclusion of specialized outpatient and inpatient care in benefit packages, provided with financial protection, is crucial to mitigating impoverishment resulting from accessing these services, which are typically high-cost services. However, solely including these services and leaving PHC to be financed out of pocket is problematic because it incentivizes people to delay seeking care.

Pharmaceuticals

Many CWA countries have fallen short in the inclusion of essential pharmaceuticals in their benefit packages. Uzbekistan, for instance, while facilitating free access to some categories of the vulnerable population, has largely excluded outpatient drugs from its basic benefit package. Tajikistan also has a limited list of drugs provided under the GMSP. In Georgia, until 2020, the list of covered outpatient medicines under the UHCP was limited to around 50 essential medicines. In Kazakhstan, under GVFMC, drugs are included as part of emergency care as well as for a list of 54 groups of conditions defined by the MoH.

Some countries such as Armenia, Azerbaijan, Cyprus and Türkiye and have succeeded in including essential pharmaceuticals within their benefit packages. In Türkiye, universal access to perscribed drugs and vaccinations is guaranteed through the GSHI scheme, and in Cyprus, the list of prescribed pharmaceuticals (mostly generics) is defined by the Health Insurance Organization (HIO).[17] In Azerbaijan, a list of essential drugs is reviewed by the Ministry of Health annually, and in Armenia, drugs for patients of 15 conditions including TB, diabetes, cancer and mental illnesses, among others, are included.

Some countries have complementary programmes in place to increase access to medicines. In Kyrgysztan for example, medicines for the treatment of certain diseases (diabetes, haemophilia and tuberculosis) are available under the SGBP, while a complemantary scheme (ADP) allows contributors and poor and vulnerable populations to purchase selected drugs at reduced prices from contracted pharmacies. In Kazakhstan, aside from the limited list of pharmaceuticals provided under GVFMC, an additional list of outpatient and inpatient drugs for 128 groups of conditions defined by the MoH is included under the MSHI.

It is important to note that drugs account for a sizeable share of health care spending (Kaplan et al. 2012; Ozawa et al. 2019), comprising the majority of OOP payments for households with catastrophic health expenditures in Georgia and Armenia (WHO 2023b). Providing legal entitlements to free or affordable drugs necessarily entails having a national drugs list which meets the criteria set at global level (WHO 2019b). Further strategies to pass regulations to secure drugs that are effective, safe and available at a fair price are needed to contain costs and ensure public funds are used effectively.

[17] It is also possible to obtain the original brand of the medicine in cases whereby the generic option is unavailable.

1.3.2. Network of service providers and pathways to access services

The networks of service providers and mechanisms associated with access to health care are key design features of SHP schemes, and the way that these networks and mechanisms are designed, often defined in legislation, is key to ensuring effective access to health care services. This section provides an overview of: i) the types of providers in health systems in CWA; ii) the main characteristics of the designated networks of providers used specifically in SHP policies; and iii) their organization in terms of the pathway to care.

Public and private provision in health systems in Central and Western Asia

Health systems in CWA vary substantially in terms of the mix of public and private health care providers (for profit and not for profit), which has important implications for SHP policy design. Indeed, the question of whether or not to include private providers within a designated network of providers whereby financial protection is granted is an important design consideration with financial consequences (ILO 2021b; 2021c).

In some countries, public provision is dominant and private providers account for a relatively small share of all services provided. For example, in Azerbaijan, public health facilities are widespread across all regions except in the capital of Baku, where the private health care sector is growing (USAID 2022). In Kyrgyzstan, public providers are also dominant [18] and PHC services are exclusively provided by public Family Medicine Centres or General Practitioners Centres. Private providers are mainly pharmacies and a few private practices and facilities that are focused on obstetric, cardiac and dental services. Tajikistan operates a publicly-run centralized health care system, with the exception of the pharmaceutical sector. In Uzbekistan, health services are mainly provided by the public sector. Neverthless, the private health sector is gradually growing through small-scale private practices.

In other countries, such as Amernia, Kazakhstan and Türkiye, health care systems are pluralistic, with health services provided through a mix of public and private providers. In Türkiye, the Ministry of Health provides primary, secondary and tertiary care. Hospitals and hospital beds are predominantly publicly owned, but the private health sector has grown in recent years resulting in a sizable network of private hospitals. In Armenia, regional hospitals are predominantly public and provide secondary specialized services, while in the capital there is a blend of public and private facilities providing secondary and tertiary specialized inpatient care.

In some countries, health care service provision is skewed more towards the private sector. In Georgia, for example, the health care system is largely privatized (80 per cent of hospitals and most of primary and specialist care are private). Public sector providers are limited to a few single profile hospitals (TB and psychiatry) and those in remote rural areas. In Cyprus, until very recently, health services were overwhelmingly provided by private providers due to a shortage in public sector personnel. This was caused by the financial crisis and subsquent public sector reruitment freeze policies, in place until 2016.

Designated networks of health care providers

Designated networks of providers providing health care services that are available, accessible, acceptable and of sufficient quality are crucial to the achievement of SHP goals. If these are not available, people may seek care outside of the designated network and pay OOP for health services, hindering the objective of financial protection. There is also a risk that this may incentivise people to forgo health care to the detriment of their health.

The designated network of service providers can encompass a diverse range of providers or may be limited to certain types of providers, and usually follows specific eligibility criteria and contracting processes (see chapter 2). For instance, in some countries, such as Kyrgysztan and Uzbekistan, the

[18] With 54 hospitals, 60 general practitioner centres, 18 family medicine centres and 13 dental clinics, compared to 32 private health facilities.

networks predominantly include public providers. In Kyrgyzstan, there are a few private medical centres providing haemodialysis services, while laboratories and pharmacies are contracted by MHIF for the SGBP enhanced scheme and ADP beneficiaries. For the SGBP, the law allows the contracting of private entities, yet this is rarely undertaken in practice. In Uzbekistan, the purchasing of services from private providers has recently been implemented, limited to some laboratory, diagnostic and haemodialysis services.

In some countries, such as Armenia, Azerbaijan, Cyprus, Georgia, Kazakhstan and Türkiye, private providers are part of the designated network of service providers under SHP policies. Both public and private providers are usually contracted under the same contracting and reporting arrangements regardless of their ownership status.

It can be challenging to effectively implement SHP policies when the health care sector is largely made up of for-profit commercial entities. In Georgia, the Social Security Agency (SSA) contracts both public and private health care providers based on standardized reimbursement procedures. However, the pricing structures have a tendency to align with those used by private insurance companies which own a large share of health care providers in the country.

It is important to emphasize the need to strengthen regulations and to pay particular attention to the contractual arrangements of for-profit provision within SHP policies. These contractual arrangements should be designed in a comprehensive way, including conditions of empanelment, quality requirements, accreditation by the Ministry of Health or accreditation agencies, frequency of contract revisions and adoption of provider payment methods conducive to quality and which limit risks of cost escalations and moral hazards (see Chapter 2, section 2.3).

Geographic distribution, registration and gatekeeping function

The design of networks of health care providers must take into account the distribution of populations across territories, which might cause significant gaps in coverage. For example, Tajikistan faces a critical shortage of health care providers, exacerbated by migration trends, particularly in rural areas where three quarters of the population reside (WHO 2022c). Some countries have attempted to address regional disparities in health workforce distribution in their health care system. For example, Türkiye introduced the Family Medicine Programme to incentivize health care providers to serve in rural areas, with an aim to achieve equitable distribution of providers across all regions. Family doctors are contracted by the GSK to provide primary health care for those living in rural areas, including the provision of mobile health services for those unable to travel to clinics. Additionally, since 2009, Türkiye introduced a mobile pharmacy service to improve access to drugs in rural areas (Atun et al. 2013).

Accessing health services through designated networks of providers is usually subject to certain rules and conditions that determine how the system can be navigated by patients. Such rules should be supportive of the PHC approach and ensure that first-contact care refers patients towards higher levels of care when necessary. In contexts with referral systems, the primary level of care plays a gatekeeping role, fostering a rational use of health care interventions. Registration mechanisms assign individual patients to primary care providers creating a first point of contact for most health needs. This approach aims to facilitate access to preventive and curative care closer to communities. The gatekeeping function can help guide patients to an appropriate provider when their needs extend beyond primary care. Ensuring convenient access to effective essential health care at low cost, with the appropriate specialist and hospital services, is an important strategy for SHP policies to pursue.

A registration and referral system exists in many countries in Central and Western Asia, including in Armenia, Azerbaijan, Cyprus, Kazakhstan, Kyrgyzstan and Uzbekistan, with different degrees of compliance. For example, in Armenia people need to register with a PHC provider to access outpatient and inpatient specialist care. However, due to low perceived quality of services, sometimes people bypass the referral system when accessing secondary and tertiary providers. Similarly, in Azerbaijan, registration and gatekeeping mechanisms are in place by design, but in practice referral system regulations lack strict enforcement as there are no payments or sanctions imposed upon those bypassing them. In Uzbekistan, to access SGBP services the patient must first visit their family doctor or their local or central polyclinic in their registered area. Referrals are required for accessing specialized care in higher level facilities. In practice, this is loosely followed by both patients and health care providers.

A number of countries, such as Georgia, Tajikistan and Türkiye, either lack systems to register patients with specific providers and do not use referral systems as conditions to access higher levels of care or have low compliance. This can be caused by low confidence in the system, lack of PHC culture and lack of effective coordination mechanisms. The lack of a gatekeeping mechanism results in undermining prevention measures and PHC as a cost-effective pathway to care (Lordkipanidze et al. 2020; WHO Europe 2021a).

Patient registration, referral mechanisms and a strong gatekeeping function are conducive to the rational use of resources and cost containment. However, it is important to avoid designs that are too rigid. For instance, the choice of a primary care provider with whom patients feel comfortable is often reported as an important determinant of the perception of quality care (Campbell et al. 2000). This is the case in Cyprus, where the SHP scheme allows for registration with the PHC provider of the beneficiary's choice.

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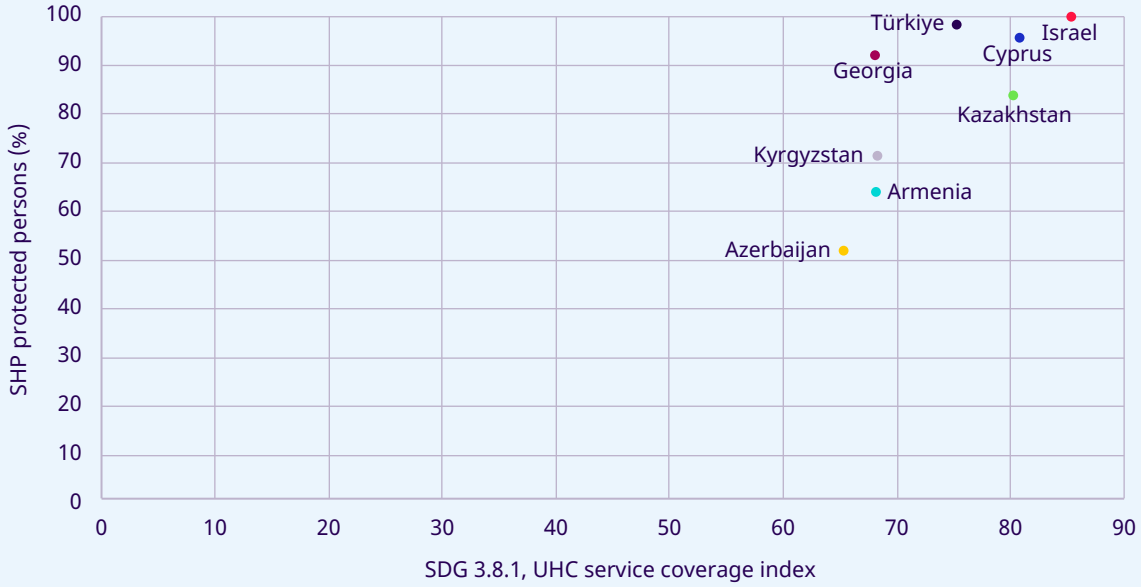
1.3.3. Effective access and utilization

Despite legal entitlements and effective affiliation mechanisms for different schemes, discrepancies between what people are entitled to and what they can access in practice often persist. The absence of standardized monitoring systems with globally comparable data makes it challenging to paint an accurate picture of: i) how the range of services people actually access and utilize compares with their needs and legal entitlements; and ii) the extent to which these services fully meet the criteria of availability, adaptability, acceptability and quality. Factors such as monitoring costs and the lack of consensus on outcome measurement are dimensions that contribute to this challenge. While this holds true, considerable progress has been made and a wealth of data has been collected through the SDG 3 targets, allowing for some analysis of the state of effective access and utilization.

UHC Service Coverage Index

The target indicator for SDG 3.8.1 is the UHC Service Coverage Index (SCI)—a composite measure of health services that combines 14 tracer indicators of service coverage in a single summary measure (WHO and World Bank Group 2023). The SCI indicates small variations across countries in Central and Western Asia (see figure 13). Higher-income countries (Cyprus and Israel) and one upper middle-income country (Kazakhstan) have achieved an SCI level of more than 80. Türkiye, an upper middle-income country, also achieved relatively high effective service coverage levels (more than 70). Here we can see a correlation between country income levels and service access performance. Countries with a high share of protected persons under SHP policies, such as Cyprus, Israel, Kazakhstan and Türkiye also tend to have more effective access and utilization of health care services in practice (see figure 13).

Figure 13. Correlation between the share of the population protected by a social health protection scheme and the essential Service Coverage Index (SDG indicator 3.8.1), selected countries in Central and Western Asia, latest available year



Note: Data on protected persons are from 2023; data points for Turkmenistan, Tajikistan and Uzbekistan are not available. Data on SDG 3.8.1 are from 2021.

Source: Based on data from the WHO Global Health Observatory; ILO Social Security Inquiry and OECD Health Statistics 2023; national administrative data published in official reports; information from regular national surveys of target populations on awareness on rights.

An important component of the SDG 3.8.1 index is RMNCH services. Coverage of RMNCH services is often given priority in SHP policies and it is considered a high-return investment in terms of health gains. Maternity protection was one of the earliest concerns of the ILO normative framework, and over time has been promoted through revisions of the maternity protection standards (most recently the adoption of Convention No. 183) and its integration in Recommendation No 202 on social protection floors. However, effective availability and access varies substantially across and within countries and specific services (See figure 14).[19] Improved harmonized monitoring thereof is needed, as only a few comparable indicators under SDG 3.8.1 are available across the CWA subregion. The importance of a comprehensive approach encompassing the full range of RMNCH services, including sexual and reproductive rights and services, should be emphasized. While immunization rates and births attended by a skilled health

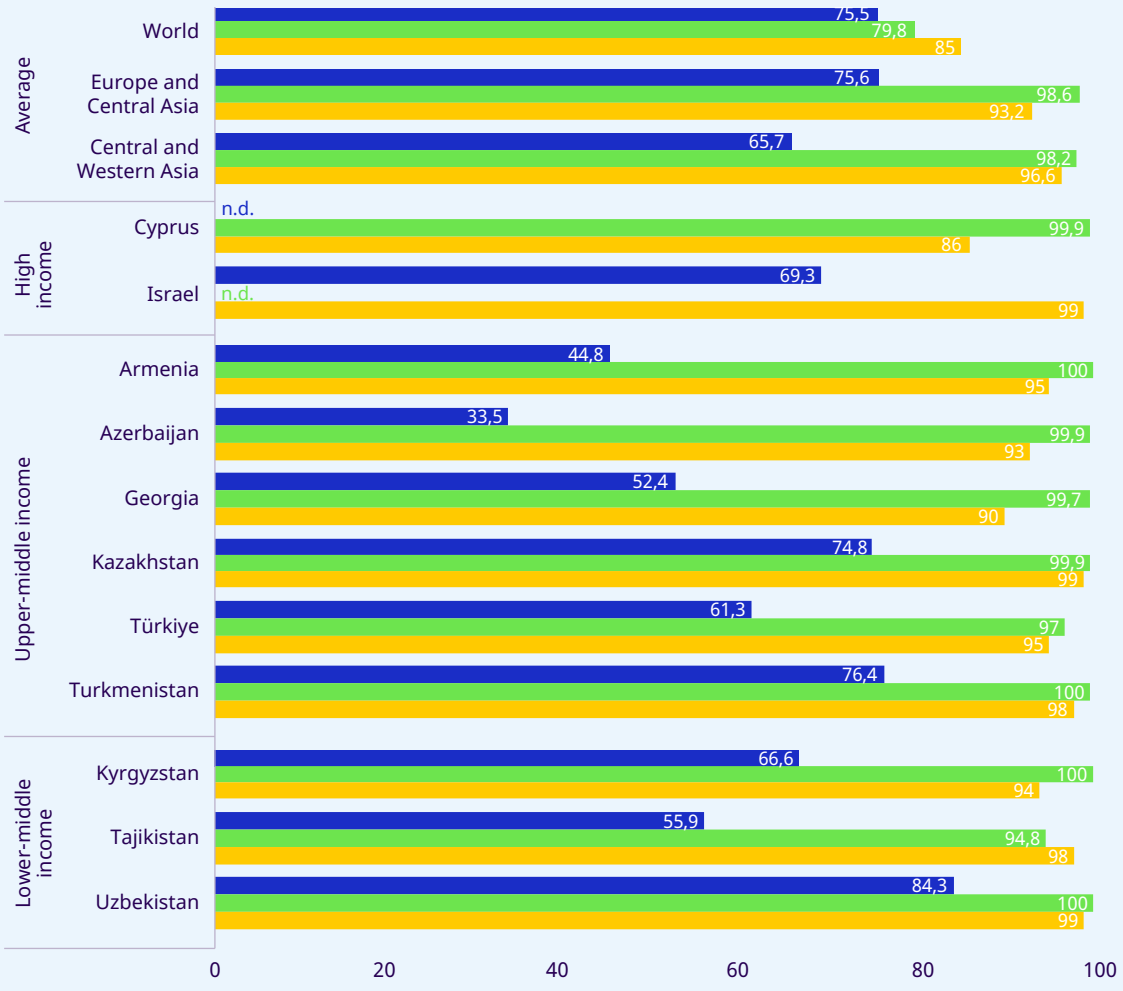
[19] For this comparison only three RMNH indicators were used due to limited data on antenatal care (percentage of women attended at least once by skilled health personnel).

professional have progressed and have almost fully met targets, the share of women with a demand for family planning who satisfied with modern methods remains variable, indicating that many CWA countries remain far from universality of access to such services. Prioritizing effective access to RMNCH services is imperative to ensuring a healthy pregnancy, mitigating maternal and infant mortality rates and upholding women's rights, including their right to work and rights at work.

Access to a skilled birth attendant is often used as a proxy indicator to gauge equity in access to health care and the impact of financial and other barriers on effective access. The available indicator suggests relatively equitable access to delivery care across population wealth quintiles, indicating some success in lifting financial and other barriers in Central and Western Asia (see figure 15).

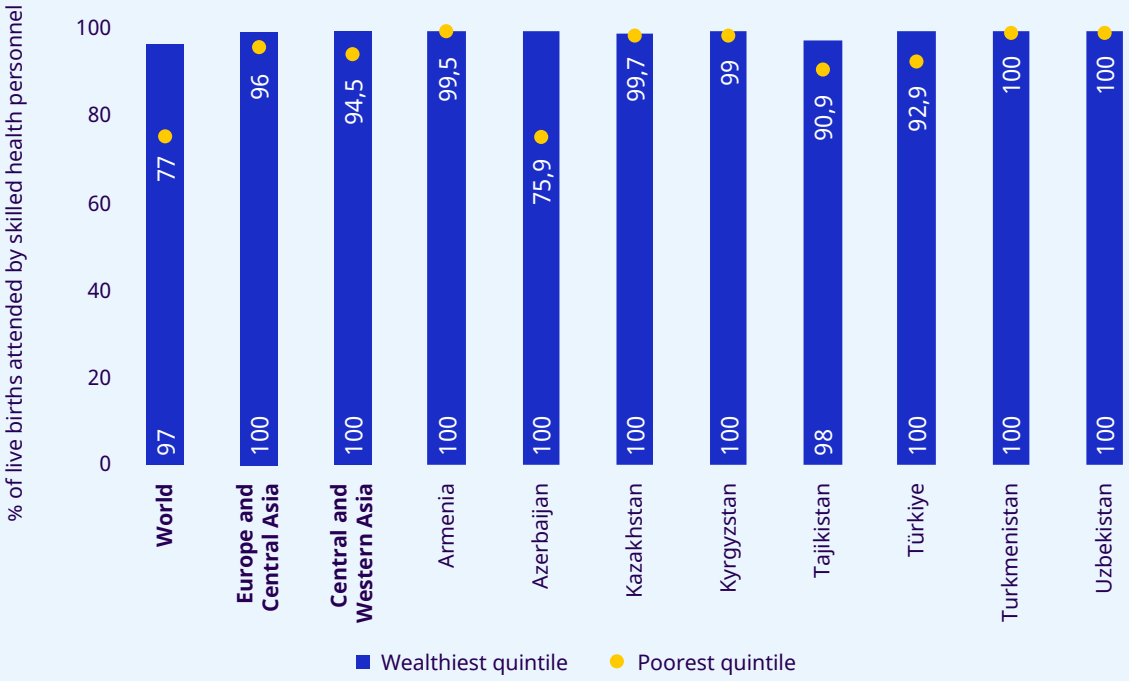
In light of the growing burden of NCDs, which are the primary cause of mortality in CWA, progress in improving the availability of related services is needed, and there is a pressing need to prioritize investing in related services (see section 1.3.1 and figure 16).

Figure 14. Unequal advances in RMNCH service coverage, Central and Western Asia, by global, regional and subregional average, and by country income group, latest available year



Source: Based on data from the WHO Global Health Observatory.

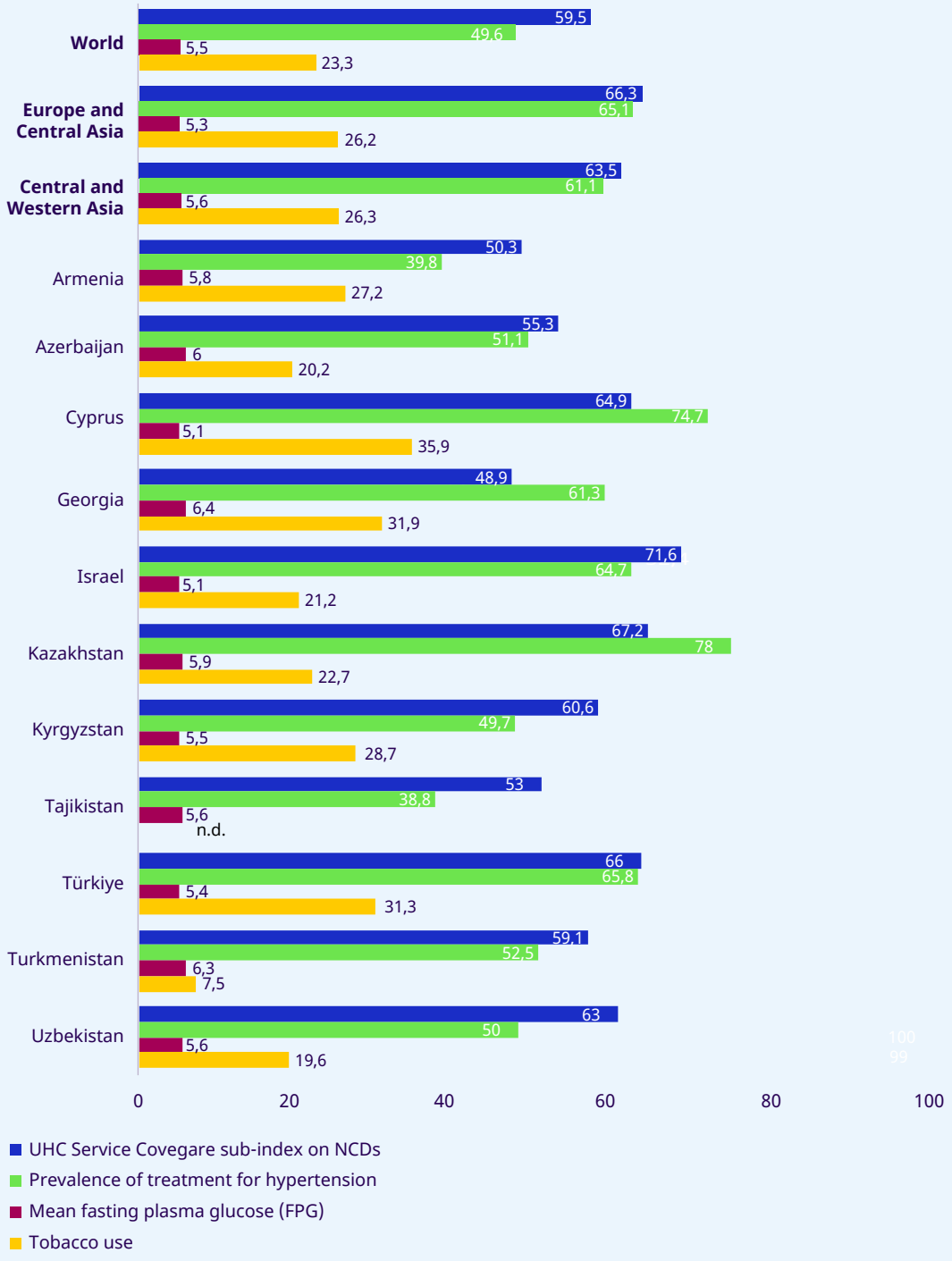
Figure 15. Percentage of live births attended by skilled health personnel by wealth quintile, selected countries in Central and Western Asia, latest available year



Note: Data for Cyprus, Georgia and Israel were not available at the time of collecting the data set in December 2023.

Source: Based on data from the WHO Global Health Observatory.

Figure 16. UHC Service Coverage sub-index on non-communicable diseases and its indicators, Central and Western Asia, 2022 or latest year available



Note: Global and regional aggregates are weighted by the following population data for each indicator as follows: Adults aged 30-79 (prevalence of treatment for hypertension); Adults aged 18+ (means fasting plasma glucose (FPG); Adults aged 15+ (tobacco use).

Source: Based on data from the WHO Global Health Observatory and UN 2022 Revision of World Population Prospects.

Health workforce and infrastructure

Effective access to services is partially determined by the availability of a skilled workforce of sufficient quantity with the necessary physical infrastructure, equipment and supplies. As highlighted in section 1.1, in CWA countries formerly part of the Soviet Union, the health workforce and physical infrastructure of the health sector largely builds on historical trajectories.

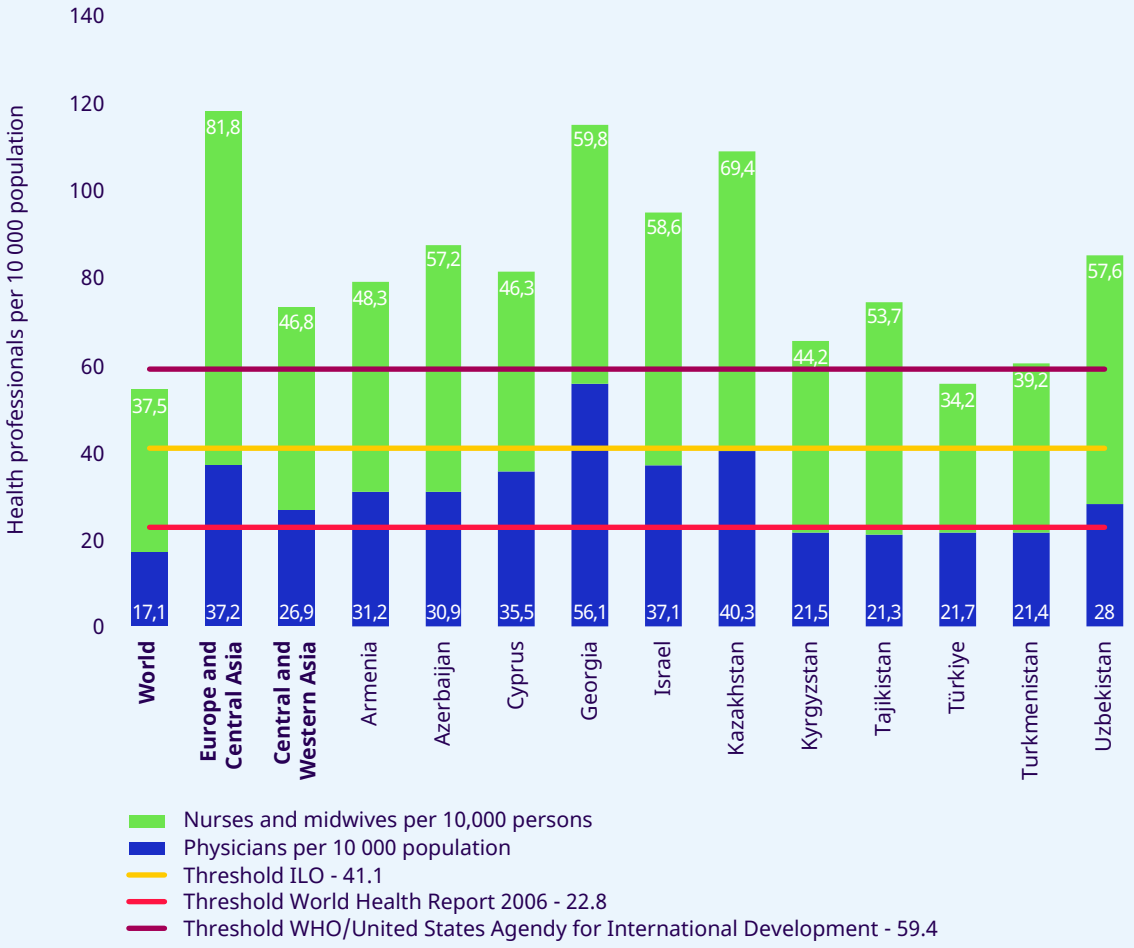
Health workforce

Access to quality health services critically depends on features of the health workforce, including the number of workers, skills mix, competency, distribution and productivity. The number of doctors per 1,000 persons varies significantly across countries. It is relatively high in Georgia and Cyprus (above 5 medical doctors per 1,000 persons) compared to the CWA average, while it is very low in lower-middle income countries (Kyrgyzstan, Tajikistan and Uzbekistan), as well as in Türkiye and Turkmenistan (see figure 17). However, this needs to be viewed in the context of the broader framework of the model of care and skills mix in each country. Former Soviet Union countries relied heavily on feldshers and a number of countries had to transition through the adoption of new health system architecture.

Investments in education and health services are crucial to ensuring that health workers are adequately protected and supported to perform their duties and that all categories of workers in the health sector operate in adequate working conditions in line with ILO Nursing Personnel Convention 1977 (No. 149) and other international labour standards, such as ILO Recommendation No. 69, which clearly links access to health care without hardship to the availability and adequate working conditions of the health workforce. It is also crucial that the health sector is adequately staffed. Prior to COVID-19 global estimates indicated a deficit of 10 million workers in the health sector, which is projected to further increase by 2030 (High-Level Commission on Health Employment and Economic Growth 2017; WHO 2022d). In Tajikistan and Uzbekistan, shortages in the health workforce are caused by unfavourable working conditions leading to high rates of migration to neighbouring countries. Addressing the imbalance in the distribution of health workers within countries, particularly between urban and rural areas, is also imperative. In Armenia, there is a notable discrepancy in health staffing, with 74 per cent of physicians situated in the capital, where only 37 per cent of the population reside. This is directly related to a higher concentration of specialized facilities and better working conditions in the capital compared to other regions of the country. Capital cities with high-income households are also attractive to health professionals because of the potential to engage in private practice.

Nursing and midwifery roles are of particular importance, as they play a central role in improving service coverage and are central to progress in RMNCH service coverage. Nurses and midwives account for nearly half the global health workforce, and are predominantly women (WHO 2019c). Prioritizing hiring, training and retention efforts, especially in rural areas, is key in ensuring availability, accessibility, acceptability and quality of care in line with ILO standards (ILO 2018a). Furthermore, investing in improving working conditions in this context, in line with the labour standards, is urgent and requires the adoption of a gender lens to ensure the delivery of non-stigmatizing and woman-centred health services (ILO 2022).

Figure 17. Skilled health staff density against three thresholds, Central and Western Asia, 2022 or latest available year



Note: Global and regional aggregates are weighted by the total population of skilled health staff.

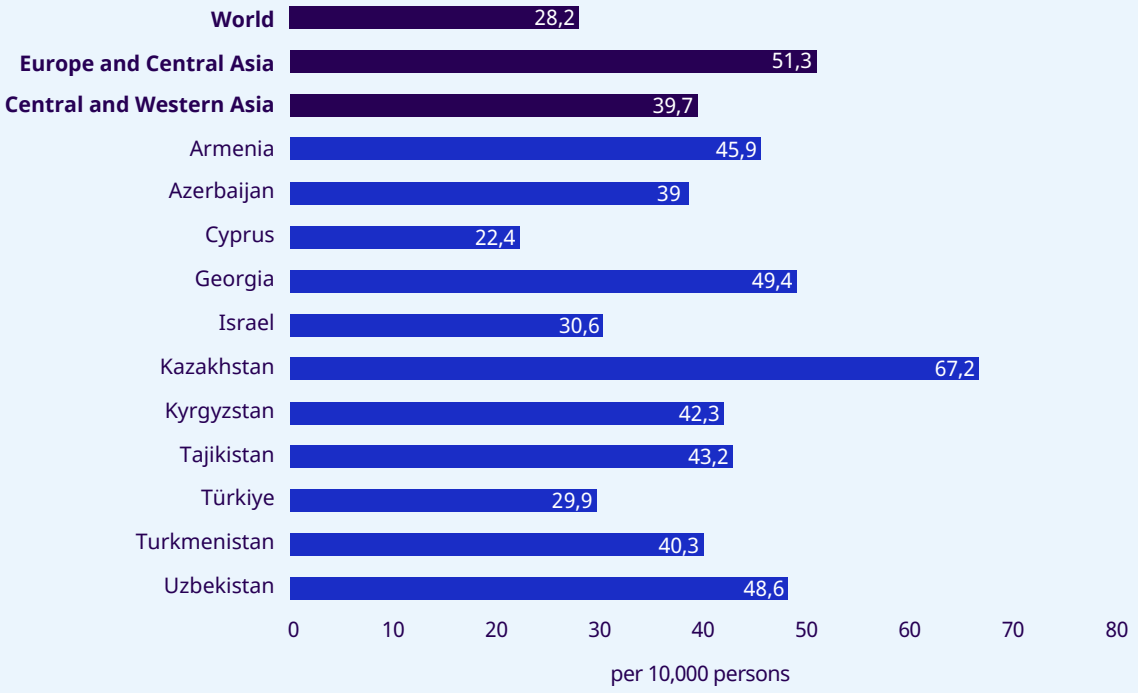
Source: Based on data from the WHO Global Health Observatory.

Infrastructure

Geographical disparities persist within countries, particularly in terms of health care infrastructure between urban and rural areas. For example, in rural Georgia, medical facilities often lack high quality infrastructure and essential equipment. However, the Government of Georgia is currently implementing a primary health transformation strategy to enhance the availability and quality of services nationwide, with particular emphasis on rural areas, especially after the COVID-19 pandemic (WHO Europe 2021b). Primary health care facilities in former Soviet Union countries such as Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan received special attention due to PHC reforms (see section 1.1), with varying degrees of investments. In Uzbekistan, for example, according to a national self-assessment for water and sanitation services in facilities in 2020, only 57 per cent of primary health care facilities reported having basic water services, and only 26 per cent had basic sanitation services (Rechel et al. 2023). Together with health centres, hospitals, which generally account for a large share of health care expenditure, play an important role in service provision. Capacity of the hospital sector is assessed by the number of hospital beds per 10,000 persons. While the appropriate number of hospital beds depends on criteria such as demographics, average length of stay, admission rates and bed occupancy rates, most CWA countries (Armenia, Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan) have higher

hospital bed density compared to the subregional average, with Kazakhstan surpassing the regional average (see figure 18), largely inherited from the Soviet Union care model (see section 1.1).

Figure 18. Hospital beds density (per 10,000 persons), Central and Western Asia, 2021 or latest available year



Note: Global and regional aggregates are weighted by total population.

Source: Based on data from the WHO Global Health Observatory.

Service quality and acceptability

Quality is one criterion that must be met by health care services as part of SHP guarantees in line with ILO standards, following the definition provided in the framework of the human right to health: "Health facilities, goods and services must be scientifically- and medically-appropriate, and in good working condition." Therefore, health care services should be effective, safe and responsive to meet people's needs, delivering evidence-based care while avoiding harm and respecting individual's needs, values and preferences (WHO 2018). Patients' trust in clinical effectiveness of services and satisfaction of care provided by health care providers directly influences the adherence to SHP policies among the population. Moreover, quality of care is essential to ensuring that health services are able to protect and restore health. Investments in service quality, including adequate infrastructure and equipment within dedicated network of providers, especially in public facilities, are needed. Indeed, deficiencies in provision can push people to use other providers and forgo the financial protection afforded by SHP entitlements. Ultimately, ensuring quality of services provided through SHP is crucial to preventing patients from seeking care outside the designated network of providers and facing adverse financial effects on their household (ILO 2021b).

1.4. Financial protection against health care expenditure

Securing access to essential health care services to maintain and restore health as well as progressively expand the range of services is a key objective of SHP policies. An equally important goal is to ensure such access does not cause financial hardship and that populations are protected against the impoverishing impact of health care costs. This section explores the ways in which CWA countries have made progress in securing such protection in law and in practice.

1.4.1. Policies affecting financial protection

International social security standards provide guidance on both:

- The level of cost coverage, stipulating that co-payments should be limited and that, if they are in place, the rules concerning such cost sharing should be designed so as to avoid hardship and avoid prejudicing the effectiveness of medical and social protection. Such co-payments should not apply to maternity care, which should be free-of-charge.
- The level of income support for people who cannot work as a result of sickness, quarantine, care seeking or caring for a dependent.

Co-payments

If set too high, policies relating to co-payments to access services can be associated with OOP spending which can undermine financial protection. Co-payments or user fees are usually introduced with a rational of reducing the risk of moral hazards,[20] but in practice they are often imposed through structural adjustment policies to contain health spending. ILO standards stipulate that they should not be used as a mechanism to fund the health sector. Co-payments and user fees can take several forms (see box 8).

▶ Box 8. Direct payment, formal cost sharing and informal payments

OOP expenditure can take the form of direct payments, formal cost sharing or informal payments.

- **Direct payment** refers to the full price of services, not covered by any form of protection
- **Formal cost sharing** includes user fees and co-payments:
  - **User fees or charges** can comprise a combination of fees, ranging from registration, consultation, drugs and medical supplies, treatment, hospitalization, delivery fees, laboratory tests or other health services provided in public or publicly subsidized sectors– not necessarily reflecting the full cost of services.
  - **Co-payments** are a defined proportion of the total cost of a service that protected persons need to pay out of pocket upon use. They can take the form of a percentage of the cost, a fixed amount, deductibles, ceilings, or maximum number of days, sessions or cases.
- **Informal payment** refers to all payments in cash or in-kind made voluntarily or not by the user, to health care providers, outside of official user fees or co-payments.

Source: ILO 2021b.

[20] To avoid increased health consumption when users are not the ones covering the costs of the service.

Co-payments take various forms in CWA. They may be a nominal fixed amount, such as in Armenia for diagnostic tests, or for inpatient care and certain laboratory and diagnostics, such as in Kyrgyzstan. Alternatively, some countries impose co-payments as a percentage of the charges for services. In Armenia, co-payments are imposed on inpatient services, dental care and perscribed outpatient medicines, varying from 15-50 per cent of the service cost. In Kyrgyzstan, under the ADP package, co-payments amount to up to 50 per cent of the price of medication. Outside of the state-funded services in Tajikistan, patients must pay a 50-70 per cent co-payment to access a set of 1,200 different services not covered by the public sector. Some countries introduce co-payments for specific interventions. The GHS in Cyprus applies small fixed co-payments with annual ceilings, as well as personal contributions when bypassing referrals. In the case of Türkiye's GHIS scheme, co-payments are required for physical examinations, medicines and fertility treatments, but not for PHC or hospitalization.

To strengthen financial protection of the beneficiary, some countries apply a cap to the amount of co-payment an individual or a household can incur during a given time period. The recent GHS reform in Cyprus has extended coverage to hospital care and speciality pharmaceuticals, accessible for all the population since June 2020. Low co-payments (with annual caps) are required when accessing specialist services upon referral from a primary care facility. Similarly, in Israel, ceilings for co-payments apply quarterly, including on drugs.

Deductibles and ceilings are features that are designed to shift the risk from the insurer to the patient, and are not in line with ILO principles. In some countries, a deductible is imposed, whereby the patient pays up to a certain amount out of pocket before availing of health benefits. Once the patient reaches the cap or ceiling, they are obliged to pay any additional amounts out of pocket. The ceiling or cap is either set per episode of care or on an annual basis. For example, in Georgia, the State will not cover services over the 15,000 Georgian lari cap for each episode of emergency inpatient care, 15,000 lari a year for elective surgery, or 12,000 lari a year for cancer treatment.

Policies vary widely across the region, with countries' rules and practices classified as follows:

- No or very low official cost-sharing mechanisms by design for most interventions under the defined benefit package (Azerbaijan, Kazakhstan and Uzbekistan). For example, in Kazakhstan co-payments are prohibited by law for services provided in GVFMC and MSHIS packages.
- Cost sharing for a limited number of items. For example, Cyprus imposes co-payments only on drugs, diagnostics, hospital visits, outpatient specialists and allied health professionals, while Türkiye imposes fixed co-payments for examination and 20 per cent co-payments for perscription drugs. Conversely, in Armenia, co-payments for cancer surgeries were recently abolished.
- Cost sharing as a standard practice for most levels of care. In Armenia, there are co-payments for all services included in the BBP. Co-payments are applied to outpatient prescribed medicines (percentage co-payments), diagnostic tests (fixed co-payments), dental care treatment and inpatient care (percentage co-payments). Variations in hospital services co-payments exists between the capital and other regions. In Kyrgysztan, the co-payment level differs based on population group, level of facility, type of intervention and benefit package (standard or enhanced).

Cost-sharing arrangements vary across benefit packages for different population groups. In Georgia, the level of co-payments differs based on priority grouping, income, age and other criteria. While some groups are fully or partially exempt, other groups have to cover about 30 per cent of the costs of secondary outpatient and inpatient services. In Kyrgysztan, pensioners under 70 and persons receiving social assitance pay a minimum level of co-payment, the contributors to the MHIF and the poor and vulnerable pay a middle level, while the rest pays the highest co-payment level under SGBP.

Importantly, a number of countries are applying co-payment exemptions for the poor and vulnerable to remove financial barriers to access (see section 1.2). For example, Armenia has a list of 22 socially vulnerable categories of the population that are exempt from co-payments. In Georgia, the poor, children, pensioners and war veterans are either exempt from co-payments or pay minimal co-payments. People with severe mental disabilities, children covered by social assistance services and prisoners are exempt from co-payments in Cyprus. In Kyrgysztan, the list of exemptions is specified in the SGBP programme for 30 socially vulnerable categories and 17 medical conditions. In Tajikistan, adults and children with

disabilities, Chernobyl victims and many other vulnerable segments of the population are exempt from co-payments for services that are not provided for free in GMSP services in public health facilities under Decree 90 and 600. In Türkiye, children, pregnant women, stateless persons, the poor and those who receive social assistance payments, are all exempt from co-payments.

Cost sharing for maternity care

ILO standards stipulate that maternity care should not be subject to co-payments. This is rooted in three important findings from international practice (Frota et al. 2020):

- Ensuring the highest level of financial protection is crucial to improving effective access to maternity care for all. In this respect, the ILO minimum standards recommend that maternal care is provided at no charge for women. It is important to keep in mind that women may face greater challenges than men when having to make payments upfront to health facilities. Moreover, they may not have the same weight in decision making regarding resource allocation in the household, which compounds lower financial capacities.
- Timely maternity care accessed at early stages and without delay is an efficient and highly impactful investment in terms of health outcomes. Adressing women's health needs promptly contributes to preventing the need for more intensive and costly care at a later stage. Prenatal visits and surveillance have yielded significant results in reducing complications and associated costs. Postnatal care also ensures prompt recovery and early identification and management of problems, and contributes to health promotion, including infant immunization and advice on breastfeeding. This comprehensive approach is designed to facilitate the full recovery of women's capacity to work, alongside maternity cash benefits during maternity leave.
- Investing in maternal health protection offers high returns for the health system and beyond. The cost of maternal health package per individual is relatively low, due to the limited number of events during a woman's time of fertility making them more affordable compared to social risks (sickness, injury or old age, for example). Furthermore, maternal and child health interventions are shown to be particularly cost effective (Memirie et al. 2019).

While ILO standards give high priority to financial protection for maternity care, CWA countries have made varying levels of commitments when it comes to providing maternity care entitlements (see box 9).

▶ Box 9. Different strategies to secure free maternity care

Some countries, such as Armenia, Azerbaijan, Cyprus, Georgia, Israel, Kazakhastan and Uzbekistan, exempt maternal or child health care services from co-payments. Nevertheless, in Georgia, although maternity care is covered with no co-payment, ceillings are in place (up to 500 Georgian lari for normal delivery and 800 lari for caeserean section).

Some countries have waived co-payments during pregnancy for specific population groups. Often policies to exempt or further reduce co-payment amounts for RMNCH care are embedded within broader exemption policies. In Kyrgyzstan, policies are in place to ensure that free access to a comprehensive list of outpatient and inpatient specialist services is guaranteed for pregnant women. In Tajikistan, children and pregnant women also have free access to a range of services, including health monitoring, delivery services and preventive check-ups (including periodic dental check-ups). In Türkiye, children up to 18 years of age and pregnant women are exempt from co-payments for all services covered within the GHIS package, but a co-payment is required for fertility programmes.

Co-payments linked to the gatekeeping function of primary care

Some countries implement a tiered co-payment system that imposes higher expenses when a person bypasses the primary care level to seek care directly at a higher level. This is designed to incentivize people to seek primary care first, which has a range of economic benefits and improves health outcomes. At the same time, when the primary level of care is not functional, co-payments linked to gatekeeping can be a contributing factor to increasing OOP spending.

For example, in Cyprus, PHC services play a gatekeeping role, whereby a referral is needed to access specialist services. If the patient bypasses the referral system, a fee of €25 per visit should be paid. In Kyrgyzstan, registration through family doctors or PHC facilities is mandatory to access free SGBP services as well as referrals to access specialist care. Patients without registration have to pay for the services out of pocket. In Uzbekistan, patients may be charged by public facilities if they seek care outside of their registered area of residence, due to limited benefit portability.

In some countries, co-payments are in place only if the patient uses a specific set of facilities, usually designed to incentivize care seeking in public facilities. In Türkiye, this differs according to the type of facility; for example co-payments for outpatient specialist care amount to 6 Turkish lira in public hospitals, 8 lira (US$1.65) in university hospitals, and 15 lira (US$3.09) in private hospitals.

Other design features impacting financial protection

Qualifying periods may be imposed, limiting financial protection for a defined period of time. For example, Türkiye imposes a 30 day waiting period before accessing benefits under the GHIS scheme. While ILO standards recognize that such periods may exist if deemed necessary to preclude abuse (except in case of emergency), this often has minimal justification in contexts where there is mandatory coverage for all and family or household-based registration as those mechanism should prevent registration only in time of need.

An additional practice impacting financial protection is balance billing (see section 2.3.2.), through which providers can charge patients the difference between bill totals and payments they receive from SHP schemes. For instance, in Georgia, while there are ceillings for the expenses covered by the UHCP, there is no cap on tarifs that hospitals can charge through balance billing, jeopardizing financial protection (WHO 2022b).

Lastly, the level of financial protection granted by SHP is only valid within the designated network of service providers. As mentioned previously, when this network does not meet the needs of the population and when the services provided do not meet the criteria of availability (including waiting times), acceptability, adaptability and good quality, people tend to seek care outside of the designated network, leaving them without adequate protection (see section 1.3). These design considerations all affect the level of financial protection people can enjoy in practice, as explored in the following section.

1.4.2. Effective protection against health care expenses

Comprehensive monitoring of financial protection, allowing for direct comparisons between legal entitlements and effective financial protection in a comparable manner within and across countries, is not available.[21] Rather, most countries produce and analyse data on OOP payments on health based on national surveys conducted periodically, through which it is possible to ascertain the following at country level: i) the proportion of OOP expenditures within overall expenses on health of the country; and ii) how many households are pushed into poverty because of such payments. The latter is included within the SDG framework under target indicator 3.8.2.

[21] The Information systems of SHP schemes may provide data on the actual utilization of services within the dedicated network, but do not include the use of other services. This makes it difficult to assess actual financial protection, within countries and across countries.

▶ Box 10. Limitations in monitoring effective financial protection and the way forward

Monitoring of financial protection requires detailed data, not only on the magnitude of OOP expenditures, but also who is spending (socio-economic status of households) and on which services. Data should allow direct comparisons between legal and effective coverage. In practice, few SHP systems monitor such data and analyse it with this level of detail.

While acknowledging the enormous efforts in data collection and analysis undertaken by countries over recent decades, it is worth noting these indicators are not perfect monitoring tools on financial protection, but rather shed light on the lack thereof.

Furthermore, while indicators of catastrophic health spending reflect gaps in financial protection, they do not provide information on the types of services accessed (essential or elective) or the status of people who access them (whether they are covered or not). The same limitation applies to the monitoring of OOP expenditures. Therefore, it is important to contextualize the analysis to understand to the root cause(s) of such high incidences. More systematic country research is needed, for instance, analyzing high OOP expenditures and poor health outcomes/services by wealth quintiles, geographies, gender and SHP status, and identifying the role of induced demand from the poorly regulated private sector.

Source: ILO 2021b.

Causes of low effective financial protection

Data and experiences from Central and Western Asia show how high levels of OOP spending can still occur, even when population and service coverage are high. Related factors include:

- Gaps in population coverage (see section 1.2).
- Gaps in service provision (see section 1.3): This can be caused by unequal geographical distribution of service coverage, effective or perceived low quality of care and inadequate number of designated service providers. Limited availability or acceptability of designated service providers included in the SHP system causes people to seek care without financial protection or to incur transportation costs.
- Limited benefit package (see 1.3): ILO standards recommend the regular revision and progressive expansion of the range of health interventions covered, according to the changing needs of beneficiaries. When this is not undertaken, eventually the benefit package ceases to be appropriate and people are not financially protected for a large share of services they use. For example, in Uzbekistan the basic benefit package provided for the entire population is limited to primary care, emergency care and health services for a selected number of disorders, while secondary, tertiary and outpatient pharmaceuticals are largely excluded. Similarly, the fragmentation of benefit packages does not foster equity and adequate protection for all.
- Cost sharing: As seen in the previous section, some SHP policies include by design a share of the cost of care to be borne by households. Therefore, co-payments should be avoided when possible and limited to avoid hardship.
- Informal payments: The provider may be unwilling to comply with regulations on co-payments and user fees, and charge additional informal payments. Informal payments for accessing health care are pervasive among Central and Western Asian countries. Such practices are commonly undertaken through under-the-table payments in cash, or in-kind gifts, outside of official reimbursement mechanisms. Informal payments may also be used as a means to bypass formal procedures, and may be linked to an inadequate regulatory framework. In Kazakhstan, informal payments are commonly used to circumvent specific formal procedures and receive what is perceived as "preferential treatment." This perception is rooted in the commonly held belief that such payments will result in a higher quality of care. Similarly, in Kyrgyzstan, informal payments often stem from patients seeking faster access to medical services offered through

the formal referral system. Furthermore, the limited allocation of state budget resources indirectly encourages the practice of informal payments. Azerbaijan serves as an example whereby health care staff members may be underpaid, and the absence of appropriate legal and administrative mechanisms for protecting patients' rights can lead to suboptimal health care service quality. Consequently, individuals may feel compelled to make additional payments to health care providers to secure prompt and high quality services. To eliminate widespread informal payments, authorities in CWA have implemented various mechanisms, including the introduction of formal co-payments to access health care services.

▶ Box 11. Tajikistan: Introducing benefit packages to tackle informal employment

In Tajikistan, underfunded public health care services combined with a shortage of medical professionals resulted in the widespread practice of informal payments (WHO 2020). Tajikistan was ranked among the countries with the highest level of informal payments to health care providers when accessing health services (Habibov and Cheung 2017). This is attributed largely to low public confidence in health services and a belief that better health care services will only be assured through "under the table" payments.

- The Government of Tajikistan has demonstrated a significant commitment to addressing the persistence of informal payments by developing the Basic Benefit Package (BPP) of publicly paid services and revising co-payment rates in 2005. The implementation of the basic BBP and revised co-payment rates were introduced in 2007 in four pilot districts (Jacobs 2019).
- In 2008, two legal acts were adopted: (1) Government Decree on the Procedure of Health Service Provision in Public Health Facilities to the Citizens of the Republic of Tajikistan. The Decree introduced the regulation of health care fees outside of the regions where the BBP was piloted; and (2) Law No. 408 on Health Care Insurance in the Republic of Tajikistan, dated 2008, which provided for the introduction of Mandatory Health Insurance (MHI)
- In addition, the Government introduced various structural reforms, such as capitation-based payments at PHC level, as well as allocating more funds and investment to expand service availability.
- This was followed by efforts to implement the Guaranteed Medical Services Programme (GMSP) in 2017 in pilot regions, targeting vulnerable populations by exempting them from medical service charges, while maintaining a co-payment system for others.

The introduction of co-payments has led to a reduction of informal payments by seven percentage points 2009 and 2013 (WHO 2022d; 2020).

Out-of-Pocket health expenditure, catastrophic and impoverishing health spending in Central and Western Asia

The share of OOP expenditures in Current Health Expenditure (CHE) is often used to paint a picture of the extent to which countries assign individual responsibility for the cost of care. However, it provides little information on the nature of such payments or who in society makes them. Low OOP expenditures can be the result of low population access and low utilization of essential health services, caused by financial and geographic barriers. Analysis of OOP expenditures must be complemented by contextual analysis, including on catastrophic expenditures leading to impoverishment. In some instances, OOP expenditures could be driven by high-income households choosing complementary high cost private services of their choice, especially for elective procedures. In other cases, OOP expenditures are predominantly burdening the poor and the lower middle class.

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The incidence of catastrophic spending measures the share of the population affected by OOP health expenditures representing more than 10 per cent of their household income.[22] Catastrophic spending can adversely affect households anywhere across income distribution levels, but disproportionately affects low-income households. Overall, the incidence of catastrophic OOP spending on health varies significantly in CWA, though gaps in monitoring affect the potential for meaningful comparisions (see figure 19). Kazakhstan, Kyrgyzstan, Tajikistan and Türkiye have incidences of catastrophic spending below 10 per cent; Armenia, Georgia and Israel have incidence levels higher than 10 per cent; and current data are not available for Azerbajan, Turkmenistan and Uzbekistan. Failure to monitor catastrophic health spending in countries where OOP makes up the majority of CHE (see figure 20) indicates insufficient attention to financial protection.

An additional indicator which allows an analysis of the impact of gaps in SHP policies is the percentage of the population pushed into poverty or further into poverty as a result of OOP spending on health (see figure 21). This affects a higher share of the population in Armenia, Georgia and Tajikistan, compared with the rest of CWA. However, for some countries, data are outdated or simply not available.

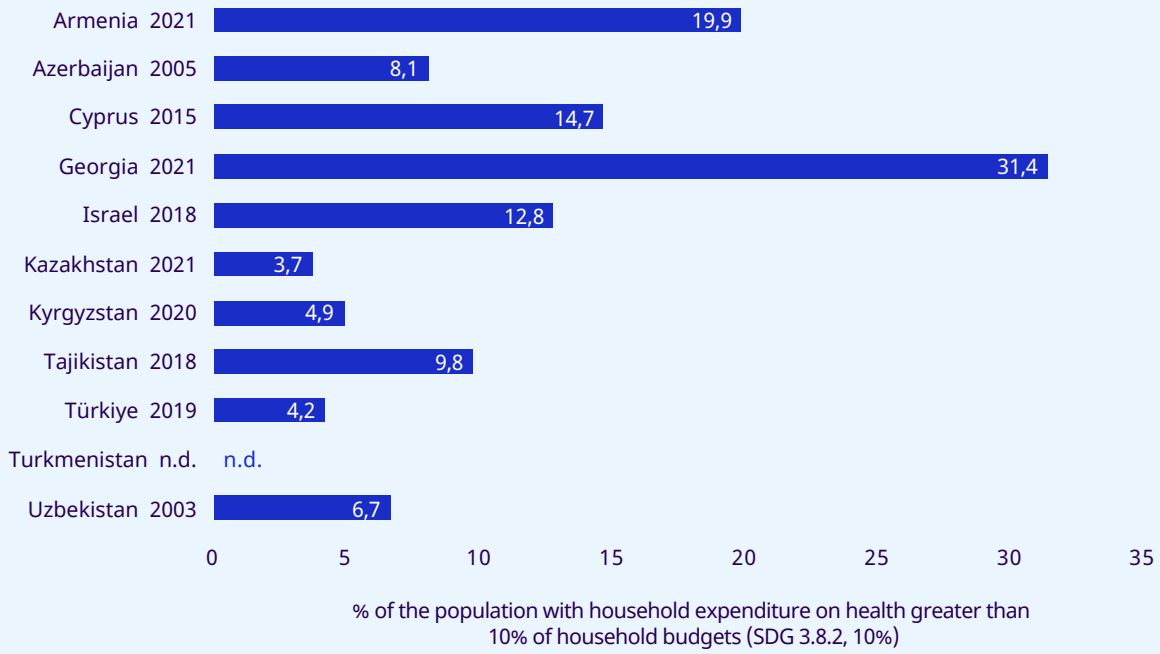
A more granular analysis of catastrophic spending can be facilitated by looking at the poverty risk incurred by concerned households. In Cyprus, Georgia and Israel analysis shows that less than half of the households incurring catastrophic health spending were pushed below or further below the poverty line; in Armenia and Türkiye, this is the case for more than half of such households. This suggests that despite near-universal SHP policies designed to avoid financial hardship when accessing health care, there are pervasive pockets of poverty, and for such populations, even the smallest co-payment or exclusion from the benefit package can translate into hardship (WHO 2023b). This calls for an integrated approach with other social protection policies aimed at reducing inequality and fighting poverty.

[22] Catastrophic spending is a commonly used indicator of poverty risk created by health spending among households. Indicator 3.8.2 of SDG Target 3.8 relates to the proportion of the population with large household expenditures on health as a share of total household expenditure or income. It is assessed as the proportion of the population living in households where out-of-pocket health spending exceeds 10 per cent of household income or consumption (other thresholds exist).

Similarly, looking at the breakdown of OOP payments by type of health care intervention among households faced with catastrophic health spending provides information on adequacy gaps. While in Cyprus, Israel and Türkiye the poorest quintile of such households pay out of pocket for a variety of interventions, in Georgia and Armenia OOP spending is mostly related to medicines, which accounts for up to over 80 per cent of OOP expenditures for such households (WHO 2023b). Such an analysis also shows that OOP spending among households incurring catastrophic health spending reflects gaps in adequacy more broadly. For instance, in Cyprus, Israel and Türkiye, dental care, which is relatively poorly integrated in SHP policies,[23] represents a significant share of OOP spending for concerned households, and in Armenia a substantial share of OOP payments relate to specialist outpatient care. This is translated into unmet needs among the poorest: In Türkiye, the poorest quintile is almost three times less likely to seek dental care than the average. Similarly, unmet needs for prescribed medicines due to costs represent almost 15 per cent among the poorest quintile (WHO 2023b). This reflects a co-payment policy based on a percentage of medicine price rather than a fixed amount, and the fact that prescribed drugs are the only item for which refugees are required to make co-payments.

Lastly, more and better data are needed to allow for in-depth analysis with disaggregation not only by household composition (age, sex) and wealth, but also by geographical location, as OOP spending may affect households differently across different geographies. For instance, in the case of Georgia, there are significant geographical inequities when it comes to OOP spending (ILO 2021e).

Figure 19. SDG 3.8.2 Incidence of catastrophic health spending (at more than 10 per cent of household income or consumption), Central and Western Asia, latest available year

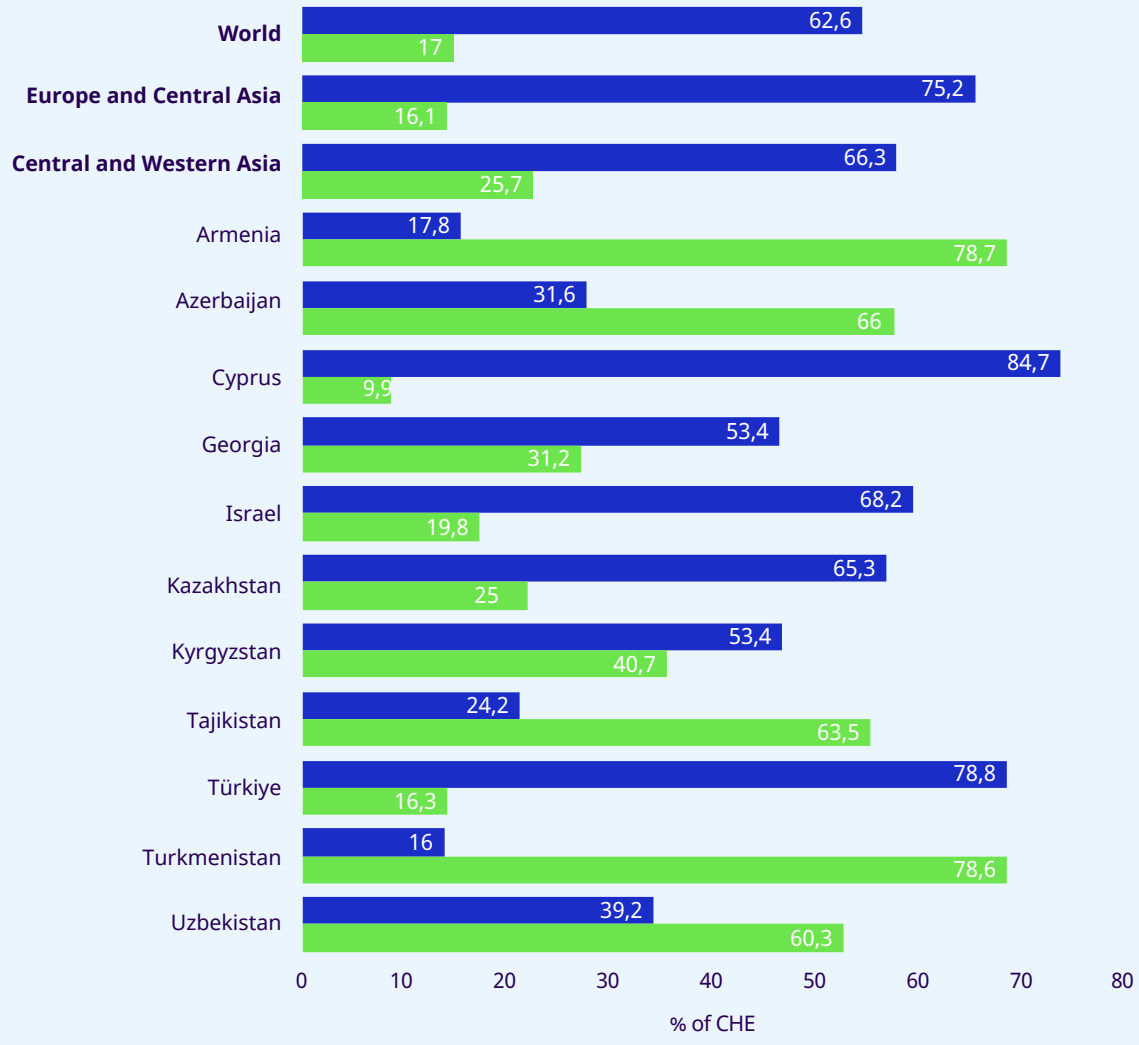


Note: Data on SDG 3.8.2 are not available for Turkmenistan.

Source: Based on data from the WHO Global Health Observatory.

[23] Despite the recent integration of preventive dental care in Cyprus and the provision of subsidized dental care for older persons and children in Israel.

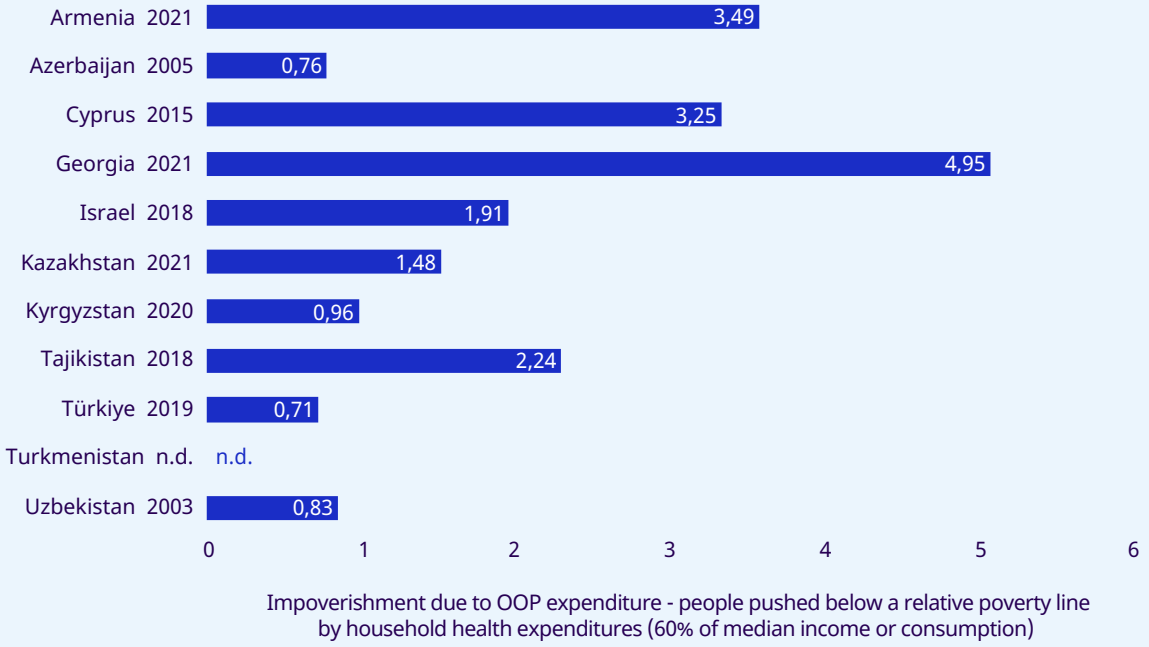
Figure 20. Share of general government and OOP expenditure in total health expenditure, Central and Western Asia, 2021



Note: Global and regional aggregates are weighted by CHE.

Source: Based on data from the WHO Global Health Observatory and WHO Global Health Expenditure Database.

Figure 21. SDG 3.8.2 Impoverishment due to OOP expenditure-people pushed below a relative poverty line by household health expenditures (60 per cent of median income or consumption), Central and Western Asia, latest available year



Note: Data on SDG 3.8.2 are not available for Turkmenistan.

Source: Based on data from the WHO Global Health Observatory.

Some of the root causes of limited financial protection or effective access to health care services are not embedded in policy nor legal design, but rather originate in the implementation of design. As such, there is potential to address these challenges through efficient institutional and financing arrangements, which will be further explored in the following chapter.

Chapter 2. Creating institutional arrangements that foster equity and ensure sustainable financing

Key messages

- The objectives of equity and effective access pursued through SHP schemes need to be at the centre of institutional arrangements, administrative processes and financing choices. To ensure SHP schemes are equitable and play a redistributive role, broad risk-pooling is needed. The latter is supportive of greater purchasing power of health care benefits and administrative efficiency. Most countries in CWA have broad risk-pools for at least a basic level of protection, while some countries maintain separate risk-pools for higher levels of protection.
- A split between purchasing and provision functions is implemented unequally across countries in CWA. Some countries have recently embarked on reforms thereof, while most of the countries in the subregion have historically not had such a split in place. This situation underscores the importance of enhancing the purchasing function of SHP mechanisms and improving the quality of public health facilities. Purchasing health care services in pluralistic health systems requires strong stewardship and a regulatory role for Ministries of Health to guarantee safety and effectiveness across public and private providers.
- Underfunding remains a major barrier to securing adequate social health protection entitlements that are effectively availed of by populations. Current health expenditure in Central and Western Asia represents less than 6 per cent of GDP, which is about half that of the regional average. Public resources represent less than half of current health expenditure in five countries and about four fifths of current health expenditure in only two countries. Reliance on OOP spending and private health insurance reduces social solidarity and maintains inequities in accessing health care. Private commercial health insurance plays a small role in health financing in CWA, with the exception of a few countries where it is mostly used by high-income households who can afford the premiums.
- More public resources are urgently needed to make solidarity in financing a reality, backed by comprehensive legal frameworks developed through social dialogue to ensure sustainable systems amidst changing political priorities. It is estimated that guaranteeing a social protection floor (SPF) comprising access to essential health care without hardship and access to cash benefits, and providing a minimal level of income support along the life cycle would require the mobilization of an additional 2.5 per centage points of GDP in CWA.
- In the subregion, the share of government expenditure allocated to health has increased in recent decades, indicative of some priority given to the sector. The countries in which public spending represents over two thirds of health expenditure use a mix of social security contributions and taxes. Both Cyprus and Kazakhstan have recently mobilized additional resources for SHP through earmarked social security contributions. Few countries have implemented the use of earmarked resources, and largely opt for the use of non-earmarked sources, aside from a few countries with significant levels of social security contributions. As many countries have recently made decisions to enforce greater excise taxes on harmful products for health, there is potential for additional earmarking for health.

Introduction

The pursuit of equity and effective access to quality health services without hardship should be the foundation of all SHP schemes. Achieving this objective requires consideration of a number of dimensions across the health and social protection sectors. This chapter will explore the governance, administration and financing of SHP schemes and how these dimensions relate to overall health and social protection systems. The principles of primary responsibility of the State and participatory governance are enshrined in international social security standards, and the sustainable financing of SHP schemes based on the principle of solidarity is at the core of these standards.

This chapter explores the diversity of governance structures and participatory mechanisms adopted through SHP policies and further assesses the level of integration within the broader social protection frameworks of respective countries. The chapter goes on to explore administrative arrangements that foster inclusiveness, with particular attention to the purchasing function and its influence on service quality and cost containment, before examining trends in SHP financing in Central and Western Asia. Finally, the chapter explores the various pathways that have successfully ensured adequate resource mobilization, with a view to providing guidance for countries that will need to increase financing to achieve comprehensive and adequate coverage in line with the SDG targets of USP and UHC.

▶ 2.1. Governance, stewardship and participation

Providing unimpeded access to quality health services for all should be at the heart of SHP mechanisms. Achieving this goal requires well developed institutions under good governance coupled with robust and effective administrative processes, as described below.

2.1.1. Governance

Social health protection usually goes beyond the mandate of a single ministry or agency. Nevertheless, two elements are fundamental to the overall governance of the SHP system, namely: (i) the stewardship and responsibility of Ministries of Health for the oversight and regulation of the health system (including both public and private provision); and (ii) the governance of bodies specifically responsible for financing access to health care services without hardship for the population.

Stewardship over the health system by the Ministry of Health

Ministries of Health play a crucial role in the overall stewardship of health systems and the six building blocks [24] which provide the basis for delivering SHP benefits through health services, in line with the criteria of availability, acceptability, adaptability and good quality. Generally, the MoH performs essential functions such as developing national health policies, implementing public health interventions, planning the distribution of health care resources throughout the country, approving the training of health care professionals, licensing health care providers, setting quality standards and guidelines, monitoring health system performance, devising medical training standards, and overall system planning (WHO 2019a). The central leadership role of the MoH in governing and regulating the health system as a whole is not always fully acknowledged. A clear delineation of responsibilities and strong MoH capacities and leadership are required to ensure effective governance and regulation of the health sector.

While the Ministries of Health in CWA tend to have similar overall responsibilities, there are differences in the specific areas of focus and the level of involvement in certain aspects of health care management. The strength of regulatory power and effective stewardship over the entire health system differs across countries. For instance:

[24] According to the WHO, the six building blocks of health systems are: leadership and governance, service delivery, health system financing, health workforce, medical products, vaccines and technologies and health information systems.

- The administration of health system is decentralized in some countries, such as in Armenia, Tajikistan and Uzbekistan, where health care facility management is divided between the national MoH and regional or local health administrations. In Armenia, the role of the management of health facilities was expanded to the regional and local departments of health in the 1990s, while the MoH only owned and operated a limited number of specialized medical facilities. In Uzbekistan, both the MoH and regional health administrations have the obligation to monitor and control services provided by the private sector.
- In other countries such as Türkiye, centralization is a key attribute of health system governance, both geographically (limited local autonomy) and functionally. The MoH is responsible for oversight of the health system alongside coordination of health care provision, in both public and private facilities.
- In contrast, in some countries, such as Azerbaijan and Cyprus, there is a division between the regulatory function of MoH and health care provision. The MoH in Cyprus is responsible for the governance and regulation of the national health system, while health care provision is the responsibility of the State Health care Services Organisation (SHSO). Similarly, in Azerbaijan, a separate entity (TABIB) is responsible for managing health care facilities, with the exception of highly specialized tertiary facilities that remain under MoH ownership and operation.
- Georgia stands out by concentrating authority over managing both social health and social protection programmes and benefits within its Ministry of Health, Labour and Social Affairs through different administrative bodies, in addition to exercising regulatory functions, including licensing health care providers, approving health sector regulations and overall health system delivery management.

Governance of social health protection schemes

The governance of social health protection depends largely on the institutional arrangements chosen by each country to administer the SHP mandate. In this respect, the following typology can be observed:

- In some CWA countries, governments have set up autonomous SHP institutions or are in the process of doing so. Such SHP institutions assume functions of managing the scheme and purchasing health services, and may collect contributions and pool risks – the exact delineation of the division of functions with the MoH vary. These intitutions usually enjoy a certain level of financial and administrative autonomy and act under the oversight of one or several line ministries. They occasionally include the participation of beneficiaries and, when applicable, contributors, in particular social partners (workers and employers). This is the case in Azerbaijan, Cyprus, Kazakhstan and Kyrgyzstan. In Kazakhstan, under the oversight of the MoH, the SHIF operates with a degree of financial and administrative autonomy. The SHIF is governed by a board of directors that are appointed by the MoH. In Cyprus, the Health Insurance Organization (HIO) is an independent public legal entity governed by a council, which administers the national health protection programme, and acts as the single purchaser of services. Notably, its organizational structure and the council's composition include tripartite representation. In Kyrgyzstan, the mandatory health insurance fund (MHIF) is responsible for collecting contributions, pooling funds and purchasing health services based on MoH policies. On the other hand, the State Agency on Mandatory Health Insurance (SAMHI) in Azerbaijan, operates separately from the MoH, reports to the Cabinet of the Ministers of the Government and manages the purchase of services according to the needs of beneficiaries.
- Alternatively, a number of countries in the subregion have embedded SHP within health administration itself (usually the MoH). In Armenia, Uzbekistan and Tajikistan, while reforms are under discussion, SHP management is integrated into the mandate of the Ministry of Health. In Armenia, the Social Health Agency (SHA) operates as a department of the MoH, overseeing providers' contracting and payments mechanisms, while major purchasing decisions are centralized within the MoH. Armenia and Uzbekistan have plans to establish an independent entity for SHP management, which are yet to be adopted (Armenia) or implemented (Uzbekistan). In Armenia, there is currently a proposal of the establishment of a new independent purchasing entity, namely the UHI fund, which will consolidate financial resources and integrate SHA functions. In Uzbekistan, the Government has introduced the State Health Insurance Fund (SHIF)

to transition to a single-payer health insurance system, planned to assume nationwide financial administration of the scheme in 2025.

- Lastly, some countries such as Türkiye, Israel and Georgia have embedded social health protection schemes within institutions responsible for the broader national social security system. In Georgia, the Social Service Agency (SSA) is responsible for managing the social protection system, including the UHCP, and operates under the authority of the Ministry of Health, Labour and Social Affairs. In Türkiye, the social security agency (SGK) manages the GHIS alongside social protection cash benefits. Similarly, in Israel, the Social Insurance Institution administers cash benefits and has agreements with health management organizations for mandatory health insurance (Brammli-Greenberg and Waitzberg 2020).

Representation and participation

ILO standards provide guidance on core principles on good governance and underline the need to ensure effective social dialogue and participation (see table 1). The key concept behind these principles is that SHP must not be solely a matter for technocrats and political representatives, but rather include a governance structure that ensures effective social dialogue and participation. This structure shall include tripartite representation from government, employers and workers, alongside organizations representative of the voice of intended beneficiaries, patients and covered populations. This includes different groups of workers' unions, associations of patients, representatives of different population groups as well as representatives of health care providers (ILO 2021b).

In Central and Western Asia, tripartite representation and participation of persons concerned in the governance of social health protection bodies are not commonly observed, with the exception of Türkiye, Cyprus, Israel and to some extent Uzbekistan. In Türkiye, SGK is overseen by an administrative board in which half of its members are appointed by and represent the Government, while the other half are elected by social partners and represent employers, workers, civil servants, pensioners and self-employed persons. This is an important step towards ensuring a commitment to full respect for transparent and accountable financial management. A similar situation is evident in Cyprus, where the HIO is governed by a council with representatives from the Government, employers', workers', self-employed and patients' groups. In Uzbekistan, the supervisory board of SHIF is chaired by different representatives of the State (first deputy of state counselor, members from ministries of health and finance, regional health departments and regional governors) alongside representation from non-governmental organizations (National Association of NGOs of Uzbekistan).

2.1.2. Integration within comprehensive social protection systems

SHP is one element of a broader social protection approach in any country. The integration of SHP schemes within overall health policies, but also the social protection system, not only has great potential for economies of scale and administrative synergies, but also facilitates the development of comprehensive policies:

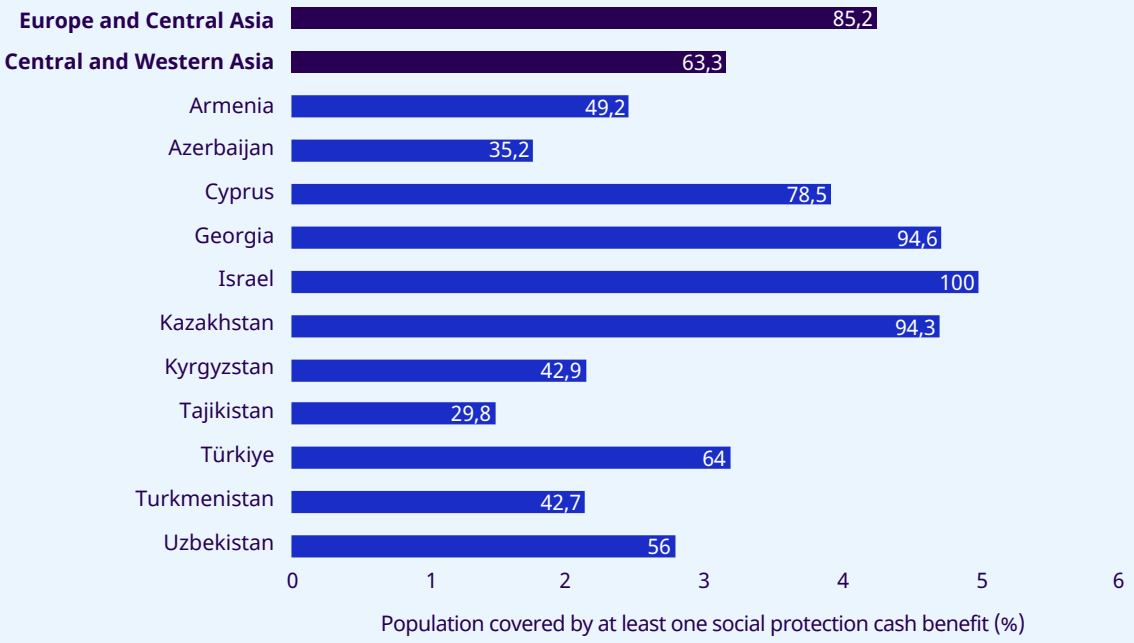
- Firstly, the coordination of policies, administration and delivery of social protection benefits facilitates access to comprehensive protection for beneficiaries, with both access to health care with financial protection and income support throughout the life cycle. The guarantee of income security through sickness, maternity, disability, unemployment or old-age benefits is fundamental to addressing the social determinants of health. In turn, access to health care without hardship also contributes to maintaining households' income protection levels.
- Secondly, such coordination facilitates the extension of coverage and ensures that measures to tackle poverty and inequality have a greater impact. In particular, the use of common identification and eligibility systems across social assistance programmes and SHP schemes eases comprehensive coverage. Countries in the subregion are coordinating their operations to cover vulnerable groups and improving efficiency through integrated processes. In Georgia, Kyrgyzstan, Türkiye and Uzbekistan, the same mechanisms are used for the identification of

social assistance programme beneficiaries for multiple social protection programmes, reducing duplication of work (see section 2.2).

- Thirdly, the integration of social protection systems allows for the achievement of synergies and economies of scale in the administration of social protection. Common functions such as members' enrolment, contribution collection, customer service and support functions (human resources, finances) can be consolidated, leading to increased efficiency in administration.

The integration of policies protecting income are all the more important that impoverishment due to OOP on health care are a function of both health care costs incurred by households but also households' income levels. In this respect, pervasive pockets of poverty and income inequality also influence levels of impoverishment and further impoverishment due to OOP on health care. Furthermore, income insecurity and poverty are known determinants of health inequity, as poverty becomes associated with poor living and working conditions affecting physical and mental health, and delays in seeking health care leading to severity of illness. As illustrated by SDG indicator 1.3.1 (see figure 22), more than a third of the population in the region lacks any form of social protection cash benefit. In six countries, this is the case for more than half of the population. Some countries have made efforts to reach most of the population with at least one form of cash benefit (Israel, Georgia and Kazakhstan), whereas Armenia, Azerbaijan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan are below the CWA average.

Figure 22. SDG indicator 1.3.1: Percentage of population covered by at least one social protection cash benefit (effective coverage), Central and Western Asia, 2023



Note: The data is based on SDG indicator 1.3.1 on the coverage by at least one contributory benefit and coverage by at least one non-contributory benefit. Regional aggregates are weighted by population.

Source: ILO modelled estimates, 2024; World Social Protection Database, based on the SSI; ISSA Social Security Programmes Throughout the World; ILOSTAT; national sources.

Achieving such coordination often requires high level oversight and specific interministerial coordination mechanisms (Schwarzer et al. 2014). Such a coordinated mechanism for contribution collection is in place in Israel and Kyrgyzstan. In the later social security contribution collection for all types of benefits is assumed by a single institution—the social insurance fund— which then redistributes revenues across various institutions responsible for managing social protection schemes, including the MHIF.

Türkiye and Georgia have explicitly recognized the need for integration of policies and programmes across their entire social protection systems, with a single entity responsible for managing different social security programmes. In Georgia, the integration of various programmes plays a crucial rule in the implementation of a comprehensive social protection system overseen by the Ministry of Health, Labour and Social Affairs. Under the Ministry's authority, the Social Service Agency (SSA) centrally oversees various social protection programmes and benefits such as health, pension, disability, child benefit and social assistance schemes, through its 72 branches across the country. Additionally, the SSA manages the UHCP. The agency utilizes robust data and an information management system to forge stronger linkages across different programmes with national and local offices (ILO and UN Women 2020).

Despite efforts, in many countries, coordination and collaboration between health and social sectors is often impeded by misaligned policies, the lack of a formalized collaboration framework, and divergent objectives and organizational cultures. From the perspective of the beneficiary, this may translate into fragmented and inadequate benefits and unnecessary bureaucracy. It also creates a duplication of efforts and costs with regard to administrative processes such as registration, payment of contributions and a grievance and appeals mechanism, leading to complexity in accessing benefits. The next section will explore the efforts taken by countries to improve administrative processes, including coordination with the broader social protection system.

▶ 2.2. Broad risk-pooling and inclusive administrative processes

Participation in the planning, governance and management of social health protection may be hindered by fragmentation, whereby different population groups are covered by different mechanisms, or excluded altogether. ILO standards are results based and therefore non-prescriptive when it comes to the specifics of institutional arrangements each country may choose to administer its SHP. However, it is important for these arrangements to be designed in a way that adheres to a number of core principles included in these standards (see table 1), meeting the objective of equity in access and solidarity in financing across the entire population through broad risk-pooling.

This section looks at the experience of CWA countries in creating broad risk-pools and inclusive administrative processes.

2.2.1. Risk-pooling

Broad risk-pooling enables the redistribution of resources from the wealthier and healthier to the poorer and less healthy, and across generations, based on the values of solidarity and social justice. Equity is strengthened if people are required to contribute based on their ability to contribute (through social security contributions and/or progressive taxation) and can use the benefits based on their health care needs – "contribute according to means and use according to needs". Broad risk-pooling is best achieved when coverage is mandatory, and no one has the possibility to opt out. Risk-pooling may also lead to greater administrative efficiency and strategic purchasing power, fostering the advantages of and efficient management of scarce resources.

A diversity of trajectories in risk-pooling

Countries in Central and Western Asia have followed different trajectories:

- Most countries have a single pool by design, such as Armenia, Azerbaijan, Cyprus, Tajikistan or Uzbekistan. This can foster greater solidarity and redistribution, as long as entitlements are the same or differences reflect a redistributive goal. For instance, in Armenia, the social package makes it possible for a significant share of pooled public revenues managed by the MoH to be

used to grant an enhanced benefit package to specific population groups, namely civil servants, military personnel and employees of certain public institutions.

- Some countries, such as Türkiye, have progressively built a single pool by merging different mechanisms. SHP schemes were previously fragmented in Türkiye, with separate schemes offering different benefits and collecting contributions. Following a reform in 2008, Türkiye merged the different schemes into a single scheme managed by SGK, the agency in charge of the broader social security system. SGK pools revenues from social contributions and government transfers to foster cross-subsidization through one mandatory universal scheme, with the agency acting as a single purchaser for health care services. Importantly, there are no options to opt out, promoting greater risk-sharing, and minimizing behaviors that could undermine the single pool system.
- Some countries, such as Kazakhstan and Kyrgyzstan, still have fragmented risk-pools for higher levels of benefits (beyond the basic benefit package), which reduces solidarity in financing However, these programmes do benefit from government transfers for vulnerable groups. Similarly, the pools are managed by a single institution that acts as a single purchaser nationally.
- Georgia pools the risk of the large majority of the population, excluding only the wealthiest share of the population. While this puts a strong emphasis on the redistributive aspect of the UHCP (being a fully non-contributory scheme), it perpetuates a situation whereby the wealthiest resort to private health insurance and fuel a highly commercialized health services system.
- Turkmenistan is the only country with a fully voluntary system, which is not conducive to broad risk-pooling in nature as it is at risk of adverse selection.

Historically, fragmentation has typically been driven by financial constraints faced by governments, resulting in support initially only being provided to households living below a certain income threshold or starting with groups perceived as able to self-finance, such as companies with salaried workers in the formal sector. Expansion of the risk-pool, especially when funded by government budgetary resources, is often an arena for passionate policy debates, requiring strong political leadership. For example, in Armenia the social package was initially introduced by the Government to improve the attractiveness of employment in the public sector given relatively low wages. However, using considerable resources to finance SHP for this specific group has significant implications for equity in financing (European Observatory on Health Systems and Policies 2013; Harutyunyan and Hayrumyan 2020).

Similarly, resistance to merge funds is often driven by equity concerns (public funds dedicated to the poor would benefit the non-poor due to lower utilization of care by the poor) or fears of undermining benefit adequacy for groups already covered and/or contributing (ILO 2021b). In CWA, fragmentation is mostly linked to the existence of segmentation of rights, with all population groups being legally covered but with additional entitlements for some groups (see section 1.2).

Fragmentation and decentralization

Fragmentation has been driven in some contexts by the legitimate need to strike a balance between central and local responsibilities. Decentralization can play a role in the fragmentation of risk-pools. For example, in Tajikistan, regional and district-level health care is managed by local-level health authorities while financed by two different channels (the Ministry of Health and Social Protection at national level and local level health authorities) which limits solidarity between regions. Kazakhstan shifted from a decentralized system in the early 2000s, which relied on funding at local levels and pooling at regional levels, to a centralized pooling mechanism at national level consolidating the purchasing function (European Observatory on Health Systems and Policies 2014).

Solutions exist to overcome fragmentation in decentralized systems, such as payments equalization between localities, as was implemented in Kyrgyzstan. It is often necessary to strike an adequate balance between functions that are best centralized and those that are best decentralized, in order to provide some flexibility in resource allocation adapted to local health needs and demographic factors.

2.2.2. Administration

While the breadth of pooling has an impact on coverage expansion and equity, it is not the only factor. If not well-designed, administrative processes can be cumbersome and impact on the inclusiveness of SHP schemes. Leaving no one behind should be a central objective of SHP schemes, and a contribution to public health policies. Making SHP inclusive in practice often involves adapting administrative processes and improving the awareness of intended beneficiaries In addition, as underlined in ILO Recommendation No. 202, high quality public services that enhance the delivery of SHP should be a core principle that fosters efficiency in use of collective resources. This section explores administrative practices across key processes.

Awareness, identification, affiliation, and registration

Leaving no one behind means that everyone is accounted for in the SHP system. Nevertheless, in many countries, administrative barriers continue to hinder awareness and, where applicable, enrolment. An important component of effective administrative processes, therefore, is to ensure that universality of coverage is translated into practice by the proper identification and awareness of all those who are covered. When coverage is mandatory, the process of registration, contribution payment and conditions of entitlement need to be clearly specified and advertised. Simple navigation through the system needs to meet the cultural and educational characteristics of the beneficiaries.

In Georgia, the UHCP has different packages of services, levels of co-payment and exemption mechanisms depending on age and income group, creating a complex system that can be difficult to understand or navigate alongside administrative inefficiencies (ILO and UN Women 2020). The scheme also requires a pre-approval procedure for some impatient procedures, which creates an administrative burden on patients. In Kyrgyzstan, affiliation to MHI differs among different groups of populations. Groups included on a non-contributory basis are automatically affiliated while migrants require registration with a different set of administrative procedures and required documentations.

Some countries use national identification systems to expand SHP registration. For example, affiliation to mandatory health insurance is automatic and immediate in Azerbaijan, and anyone with personal identification is entitled to receive health services. The SAMHI utilizes online access to national registers. Notably, with high potential gains and the simplicity of use of such a system, it is important to take into consideration potential confidentiality issues associated with such information and possible gaps in identification (ISSA 2016). In other countries, registration is undertaken in synergy with other SP programmes. For example, in Kyrgyzstan, low-income households and social assistance beneficiaries are automatically enrolled in the MHI scheme. This process is intended to streamline enrolment processes, ensure vulnerable population groups have access to essential health care services and expand coverage to those in need. Automatic enrolment through the integration of health information and civil registration systems holds great potential to support population coverage. Electronic registration using unique ID numbers or centralized databases facilitate population enrolment, as long as these databases are updated for births and deaths. This is the case in Armenia, where a nationwide electronic health information system (ARMED) was implemented in 2017, and connected with the population registry, allowing for real-time checks of patients' personal data. There are ongoing efforts to expand its integration with other government systems.

Some countries have put in place special measures to facilitate enrolment through a yearly registration campaign, such as in Kazakhstan, where residents are encouraged to register with their nearest local primary health provider. Registration is completed through the national e-gov portal and requires completion of an electronic form, provision of identification documents and a personal electronic digital signature. Alternative registration procedures are provided to certain segments of the population, including pensioners, people with disabilities, the unemployed and students, to facilitate their enrolment.

Some countries have run campaigns to increase awareness of rights and relative administrative procedures among the population. In Kazakhstan, a lack of awareness related to MHI entitlements resulted in employers frequently attempting to evade their obligation to pay MHI contributions on behalf of their employees. To address this, through the SHIF, in collaboration with other public agencies and the media, a wide-scale information campaign was implemented to encourage the population to participate

in MSHIS and to improve awareness of the relevant procedures, requirements and rights among the general population and medical professionals. Radio and TV media campaigns and broadcasts are widely used, in addition to information boards with up-to-date and easily accessible information on rights and relative administrative procedures, which are displayed at the point of care.

Contributions and revenue collection

In fully or partially contributory SHP schemes, where applicable, contribution collection is part of administrative processes. It is not always the purview of institutions responsible for SHP to collect contributions. This is sometimes a function undertaken through the tax administration or through a joint mechanism integrated with the broader social protection system, and sometimes a mix of arrangements is in place. This process can be easily automated for formal sector workers when contributions are collected by the employer via payroll. With this set-up, collecting contributions across the full spectrum of contributory social protection programmes and taxation frameworks generates efficiency gains. In Türkiye, contribution collection from contributing population categories is centralized for all social protection benefits, including health care benefits. In Cyprus, contributions are collected from employees, employers, government officials, the self-employed, income-earners as a percentage of their wage or declared income. The Social Insurance Services (SIS), the tax department and the treasury of the Republic are the bodies responsible for collecting or withholding contributions (in the case of salaried employees). Collected contributions and state funds are then transferred and pooled in the Health Care Insurance Fund, managed by the HIO, which in turn purchases health care services. In some countries, contributions are automatically deduced for beneficiaries of some social protection benefits such as old age pensions, for instance in Cyprus.

Collecting contributions from workers who are self-employed, employed in small and medium enterprises, or in sectors not subject to mandatory registration with the SHP system, requires an adaptation of the levels, periodicity and payment procedures, and often requires that subsidies are in place. Such individuals, while they may have some contributory capacity, often have irregular or unpredictable incomes. In addition, automated procedures are more challenging due to the large number of units and diversity in IT systems. In Türkiye, recognizing the need to adapt procedures for the informal sector and individuals with irregular income streams, measures have been implemented to facilitate contribution collection. Initially, a pardon was issued every few years, following which a fixed rate of the monthly gross minimum wage was defined as a contribution rate for all persons in this category. Coordination with tax authorities alongside other procedures were put in place to tackle challenges posed by irregular contributions. Kazakhstan adopted a presumptive tax regime to facilitate formalization, which includes a single payment at a subsidized rate for the MSHIS, social insurance schemes and income tax bundled together (see section 2.4).

The use of new technologies can facilitate and support the adaptation of payment schedules and reduce the cost of contribution collection. In Kazakhstan, the option to use mobile banking for contribution payments alongside the submission of payments in post offices and most banks is offered.

Claim management and third-party payment mechanisms

Payment arrangements in which the purchasing agency pays the providers directly on behalf of patients rather than requiring patients pay and seek reimbursement later to the SHP institution, are essential to removing financial barriers to access health services.[25] Such arrangements are in place in most countries in CWA.

Claims management is at the heart of SHP schemes, for which information systems to manage claims have become central. The SGK in Türkiye purchases health care services, either through transfers on a global-budget basis in the case of publicly owned facilities, or signed purchasing agreements with private

[25] In schemes where beneficiaries are asked to pay upfront and get reimbursed later, this can lead people to sell assets or borrow money to cover health care costs and, in many cases, they might abstain entirely from seeking care. Furthermore, administrative procedures related to managing individual claims could pose further obstacles to health care access, particularly for individuals with lower levels of formal education, those who lack digital literacy or those who face language barriers.

providers. A unified claims management system called MEDULA is used, introducing a virtual third-party payment system which optimizes a standardized claim submission process across all health insurance funds. In Georgia, the SSA has pre-established reimbursement procedures with standardized prices based on level of services provided and disease category. Armenia uses the nationwide electronic health information system ARMED, which facilitates claims submission, management, processing payments and monitoring service provision, and all contracted health facilities are required to register to upon empanelment. In Cyprus, all providers are required to register with the GHS database to enter into a contract with the HIO. Health care providers are reimbursed on a monthly basis, according to their professional category, and providers need to submit their claim via the Provider Portal to be reimbursed.

Delegation of functions to private entities

Some countries, such as Armenia, Georgia and Israel, delegate part of the administration of their SHP schemes to third-party administrators with varying implementation modalities.

In Armenia, civil servants, public schools teachers, health workers of public PHC facilities, and employees of specified public institutions are entitled to what is known as the social package, which complements the BBP with enhanced benefits. Administrative arrangements for the social package differ from that of other benefit packages, as it operates through private insurance companies which are licensed by the Central Bank. The MoH contracts these insurers and covers monthly premiums corresponding to the number of beneficiaries allocated to each insurer. Private insurers act as third-party administrators, in charge of contracting, case management, and claims processing between the MoH and health care providers.

In Georgia, prior to the introduction of the UCHP, the MAP scheme used to be delegated to private health insurance companies, which was abandoned because the profit margin of those companies was high and their management criticized for inefficiencies (ILO and UN Women 2020).

In Israel, the Social Insurance Institution pools resources for the compulsory national health insurance system and reallocates it to Health Management Organizations (HMO), which operate as non-for-profit organizations that register insured persons and provide them with health care benefits within their network of providers (Brammli-Greenberg and Waitzberg 2020).

While delegating administrative tasks to external parties may save resources in the short run as it does not require institutions to build internal administrative capacities, the oversight required for such delegation to work efficiently and remain in line with the public service mission can be challenging. To assess whether these third-party administrations work successfully and are worthwhile for concerned beneficiaries and SHP policies, their impact needs to be monitored as well as their financial impact on the sustainability of the schemes.

Grievance, complaints, and satisfaction monitoring mechanisms

Managing complaints and having a grievance mechanism installed is important for holding institutions accountable and promoting satisfaction among beneficiaries. In line with the ILO Social Security (Minimum Standards) Convention No. 102, there should be systems that ensure "people have a right of appeal in case of refusal of the benefit or complaint as to its quality or quantity" (Article 70). The system also needs to enable consideration of proposals for improvement suggested by all the stakeholders and thereby demonstrate responsiveness of the scheme to the changing needs of beneficiaries.

The adoption of a systematic approach for grievance and satisfaction mechanisms also allows for the establishment of systems that are people-centred, enhancing trust in broader social protection and health systems. Traditional approaches to gathering feedback include complaints boxes, contact with a spokesperson or digital hotlines. However, these are passive tools and limited in their scope and reach. They may not represent the voices of more vulnerable groups and tend to be focused on answering queries rather than assessing satisfaction with various dimensions of health care and social protection services. New technologies hold potential to facilitate submission of complaints.

In Central and Western Asia, some countries lack even basic mechanisms for grievance, complaints and satisfaction assessment. In Armenia, a situational analysis on quality of care conducted in 2019 highlighted insufficient quality resulting from insufficient use of the eHealth system, minimal patient involvement and an absence of data on quality improvement. Similarly, in Azerbaijan, the Appeal Council under SAMHI lacks appropriate legal and administrative mechanisms for the protection of patients' rights to deal with mistreatment, medical negligence or discrimination (Jafarova et al. 2021).

Conversely, Kazakhstan's Social Health Insurance Fund (SHIF) actively collects feedback, aiming to improve the system's responsiveness to patients' needs. Nearly 720,000 requests were received and processed through the SHIF hotline in 2020, including 7,865 complaints. The SHIF has set up several options for individuals to voice grievances and register complaints regarding health care services. These include a patient support and internal audit service placed at the point of care. Additionally, complaints and feedback can be provided through the following routes: The call centre of the regional health department, on the Qoldau mobile app, through a request on Telegram, through the hotline for complaints concerning the fund, and through submitting a request on the SHIF official website (Government of Kazakhstan 2023).

Türkiye has put in place a complaints website [26] for the purpose of evaluating feedback from the population on their satisfaction in terms of the quality of care provided (Öcel 2020). The next section will explore how providers' purchasing policies can play a role in this respect.

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▶ 2.3. Shaping the quality of services through efficient purchasing policies

A key function of SHP institutions is to purchase health services for the populations they protect. Purchasing refers to the contracting by the SHP scheme with providers to deliver health care services to the covered population as defined in a benefit package, and without financial burden. The purchasing function can take various shapes and it is can be more or less separated from the provision function, as it may be the same entity managing purchasing and owning and managing the facilities.

Such a purchasing organization needs to define the extent and nature of the health care provider network (usually defined in the legal framework, see section 1.3) and the ways providers are remunerated, as well as establishing mechanisms to monitor and enforce compliance in order to ensure access to timely and quality services and the efficient use of financial resources. A key task of the purchasing agency is to determine how to buy services, including the design of provider payments and setting levels of payments and terms of contracts (Mathauer et al. 2019). Payments made to providers should ideally be linked to their performance, according to defined indicators of processes (such as waiting times) and outcomes (such as length of hospital stay, re-admissions fatality rates, transfers to other providers). This section explores the purchasing arrangements in CWA countries.

2.3.1. Split between purchasing and provision functions

In some countries, the purchasing function is autonomous from the provision function, while in others it is not. The purchaser-provider split requires that the purchasing and providing functions are separated and managed by different entities, to avoid conflicts of interest (Cichon et al. 1999). The relationship between the purchasing agent and service provider is regulated through contracts. This purchaser-provider split necessarily adds some level of administrative burden for both purchaser(s) and providers. In some contexts, the provider-purchaser split is necessary in order to include private providers in the network, which, together with contractual incentives, is expected to improve service delivery, cost containment, efficiency, quality and responsiveness to patients' needs. In countries where there is no such split, such as in Tajikistan and Uzbekistan (until recently), both functions are usually assumed by the same organization, in most cases the Ministry of Health.

Although not always the case, it is possible to internally autonomize each function to foster better performance even when they are managed by a single entity. For example, in Armenia, although the MoH assumes both functions, the management of service provision is the responsibility of local administrations, while purchasing is centralized and divided between the MoH and the State Health Authority (SHA)[27]—a subordinate department in the MoH.

Although not automatic, the purchaser-provider split is more common where an autonomous purchasing agency is established (such as Azerbaijan, Cyprus and Kazakhstan) or where SHP schemes are managed by a broad social protection institution (such as in Georgia, Israel to some extent, and Türkiye). In Cyprus, the HIO is a single purchaser of services from public and private providers while the State Health Service Organization (SHSO) is responsible for the management of public health facilities. In Israel, the four SHP schemes own and operate primary health clinics, dental clinics and specialist polyclinics, as well as hospitals and rehabilitation facilities in parts of the country, thereby limiting provider contracts to state and other providers, including private providers according to agreed charges. In Kazakhstan, the SHIF is the single public purchaser for both GVFMC and MSHIS schemes, and it purchases services from an array of health care providers, most of which are owned by the local government, while the rest are either owned by the MoH or they are private providers.

The split can also be partial or concern only some services. In Kyrgyzstan, for certain services the Ministry of Health and the Mandatory Health Insurance Fund (MHIF) share responsibilities as purchasers of health

[27] The SHA is responsible for preparing contracts, reporting and dispersing budget, but important purchasing decisions remain the responsibility of the MoH.

care services. The MHIF is specifically responsible for pooling funds and purchasing services under the State-Guaranteed Benefits Package, while the MoH is responsible for purchasing certain high-cost services, and health care is delivered through a network of public and private providers. Conditions for reimbursement and price lists for service types are set by the MHIF, and the relationship with providers is regulated by contracts.

In countries with pluralistic health systems with a strong imbalance towards private provision, governments often need to include private providers within SHP and de facto implements a system with a purchaser-provider split, such as in Georgia and Türkiye. In Georgia, the SSA procures health care services from various service providers, ensuring the involvement of both public and private health care institutions. In Türkiye, the SGK operates as an independent public authority responsible for managing the social health and social protection system of the county. Meanwhile, the Ministry of Health oversees health service provision in public facilities and regulatory functions of the health system. SGK contracts both public and private providers, with no specific contractual arrangement for publicly owned providers. The purchaser-provider split may afford opportunities for strategic purchasing and quality improvement, but it also requires careful management to address potential challenges related to fragmentation and coordination.

2.3.2. Licensing and accreditation in provider purchasing

Regardless of how the purchasing function is structured, it is necessary to define a dedicated network of service providers (see section 1.3.2), as this has a crucial impact on effective access to SHP in practice, including the range of services available, geographical accessibility and cultural acceptability. If the network is too limited, this will directly impact on peoples' rights to SHP. Therefore, the choice of provider (public or private, for profit or not for profit) and their respective regulations are critical features that need to be considered carefully. Countries need to be guided in their choice by licensing and accreditation programmes put in place by the Ministry of Health. With an aim to protect public health and safety, and reach an equitable distribution of health facilities, licensing is the state's regulatory function. Licensing to establish providers is necessary to ensure that providers meet minimum standards, including professional qualifications to practice. In contrast, accreditation requires providers to meet defined quality standards of care that are considered optimal, such as staff-bed and staff-patient ratios, the existence of emergency services, blood banks and supervised laboratories and pharmacies in hospitals, rather than just minimum standards required for licensing (Mate et al. 2014).

Furthermore, when purchasing and provision functions are conducted by two different institutions, contracts are needed, often referred to as an empanelment process. This section provides an overview of the ways in which SHP systems have made use of accreditation and empanelment processes in Central and Western Asia.

Pathways to empanel and accredit health care providers

An important element to improve the quality of care is the accreditation of providers – both public and private. The granting of accreditation may be the responsibility of the Ministry of Health as a regulatory function, or it may be undertaken by an independent authority. Accreditation is a basic condition for the purchaser to select providers to be contracted (empaneled). In Central and Western Asia, while licensing of health facilities is an established regulatory function, only some countries have set up accreditation systems for both public and private providers.

In many countries where public health providers dominate service provision as part of SHP, private providers are included in the network with some specific requirements, such as the need to be properly licensed and accredited by the Ministry of Health. In Kazakhstan, both public and private health care providers are eligible to be contracted by SHIF to deliver the MSHIS. In 2020, the SHIF concluded contracts with health service providers, of which 52 per cent were public and 48 per cent were private. Being accredited in accordance with the Republic's Code on Public Health and Health Systems, alongside other quality measures, is a prerequisite for concluding a contract with SHIF.

Although accreditation serves as a criterion for contracting providers in some countries, in certain cases, simply being licensed is considered adequate for contracting. In Armenia, eligibility for empanelment relies solely on being licensed by the MoH licensing agency. However, the licensing process focuses on the availability of physical inputs, including trained staff and infrastructure, rather than quality standards. A five-year facility license renewal process was introduced as a means of establishing a quality monitoring element. Azerbaijan requires licensing by the MoH for both public and private providers as a prerequisite for inclusion in the MHI network. The Government's increasing recognition of the necessity to enhance the quality of care is reflected in plans to establish an independent accreditation agency. Similarly, in Cyprus the Government is planning an accreditation programme for public and private facilities as part of its National Recovery and Resilience Plan (2021-2026).

In certain countries, accreditation of providers is handled by a dedicated agency, yet is not fully integrated in the process of empanelment of providers under SHP policies. Health care providers in Georgia seeking contracts with SSA only need to commit to reimbursement procedures based on a standardized set of prices, while the State Regulation Agency for Medical Activities (SRAMA) is in place to oversee licensing and accreditation of providers' health care professionals and facilities.

Empanelment of private providers: cost containment and equity considerations

In some CWA countries, health care systems are pluralistic (employing a mix of public and private provision of health care services). This mix of public and private providers varies significantly across countries and within countries across regions (urban and rural) and specialities. In such contexts, SHP policies sometimes need to include private providers to respond to challenges related to service coverage and geographical accessibility. In Kyrgyzstan, there are no public pharmacies, and the number of private pharmacies contracted by the MHIF is increasing every year. In Uzbekistan, contracting private providers to provide laboratory, diagnostic and hemodialysis services is implemented in certain areas of the country.

In countries where the public network of health care service providers delivers the majority of care, private providers might be included on a referral basis only for interventions not available in public facilities or at a patient's own expense, as for example in Armenia, Azerbaijan, Cyprus, Tajikistan, Türkiye and Uzbekistan. In Azerbaijan, access to contracted private health facilities requires the issuance of a referral prior to authorization, which is a pre-condition for payment of the service to private hospitals by SAMHI. However, these conditions combined with relatively low reimbursement schedules cause reluctance among private providers to engage with SAMHI.

To include private providers, some countries apply different kinds of payment methods, while others empanel private facilities on the same basis, using the same payment methods and charges as for public providers. Under balance billing policies, in some countries, a payment schedule for private facilities is defined but allows them to charge additional direct payments from patients (the remainder of their bill), as is the case in Azerbaijan, Georgia and Türkiye. In Türkiye, private health care providers are allowed to charge up to twice as much as the standard charge established by the Health Care Services Pricing Commission (HSPC) of SGK. Similarly, in Azerbaijan, private providers may charge above the price agreed with the SAMHI. Such arrangements can create financial hardship and dual systems wherein those who can afford to pay are able to access a wider range of health care providers.

In countries where health system provision is skewed towards the private sector, this is often a reflection of underfunding of the public health system, long waiting times, choice of physician and a relatively weak stewardship function of the MoH. In Georgia, past policy choices resulted in a heavily privatized and commercialized health system where primary and secondary levels of care, as well as the pharmaceutical sector, are predominantly provided by private entities. SHP schemes can significantly contribute to providing incentives and direction to shape the architecture of health service delivery through channelling demand for such services towards specific types of providers. Similarly, the way providers are paid can influence their behaviour.

2.3.3. Provider payment methods

Achieving universal protection requires efficient ways to make sure that funds are best used to incentivize access, quality and efficiency of health care services, while at the same time meeting health care needs, and limiting moral hazard and cost escalation.

The primary methods of paying providers are summarized in table 4.

▶ Table 4. Provider payment methods

Provider Payment Mechanisms	Definition
Global budget	Prospective payment where health care providers are given a set amount of money to deliver an agreed-upon set of services. In this setting, providers have total flexibility on how they allocate this funding internally.
Line-item budget	Prospective payment where providers receive a given amount of money already allocated to specific items. The budget is not flexible, and expenditure must follow the defined line-items, unless the provider has the prior authorization from the purchaser.
Fee-for-service (FFS)	Retrospective activity-based payment. The provider receives a reimbursement for each individual service provided.
Capitation (per capita)	Providers receive a fixed amount of money to provide agreed services for each registered individual over a fixed period. It is received prior to service delivery.
Per diem	Health care providers are paid a fixed amount for given services per day.
Case-based (e.g., diagnosis-related groups (DRGs))	Providers are paid a fixed amount per case such as for each diagnosis, admission, or discharge.
Pay for performance	Providers are paid on the condition that they meet certain performance thresholds based on predetermined measures.

Source: Kazungu et al 2018.

Each mechanism entails different types of incentives, for instance:

- Case-based payments incentivize increasing the number of admissions to hospitals and reducing inputs to care, often leading to reductions in lengths of hospital stays and an increase in re-admissions.
- Capitation and global budgets are associated with under provision of services and excess referrals to other providers but can improve efficiency in the delivery of services.
- Fee-for-service (FFS) payments are usually associated with an increased number of services provided, since providers are reimbursed for each individual service. FFS payments with a fixed fee schedule, in which services are bundled to some degree and providers are paid based on predefined services regardless of costs, can lead to the provision of unnecessary services.
- Per diem payments tend to increase the length of stay, admissions and bed capacity, but also reduce inputs per hospital day after the initial days.
- Line-item budgets run the risk of under provision of services and minimal incentives to improve efficiency. In particular, they incentivise spending all remaining funds by the end of the budget year which can lead to unnecessary provision of services (Langenbrunner et al. 2009).

Through all of these methods, fees, capitation amounts and global budgets need to be updated regularly to ensure alignment with the agreed cost of living index (health care or general index). Countries usually use a combination of these payment mechanisms, based on negotiations between purchasers and providers in order to maximize their advantages, mitigate risks and avoid delays in payments and budget deficits. Often, a mix of prospective (payment before the service is delivered) and retrospective payment (payment after delivery of service) methods is used. Some systems provide an advance payment to health facilities, subject to later adjustments with the submissions of claims. Advance payment is often conducive to more revenue predictability at facility level and allows for better planning in the development of the providers' services.

Capitation

Capitation is used in several countries, mainly for community based primary health care. To be effective, capitation payments generally require defining a uniform package of services and require patients to use such services at the facility where they are registered for PHC.

Armenia (BBP), Azerbaijan (SAMHI), Kyrgyzstan (MHIF) and Uzbekistan (SHIF) all use capitation as a payment mechanism. In Armenia and Kyrgyzstan, capitation is specifically applied to primary health services based on the number of people enrolled with each provider. However, financial incentives have been provided to family doctors to improve the coverage and quality of service as well as to reduce shortages in health care providers. Capitation payments may be adjusted for risk, with higher payments for young children and the elderly. In Uzbekistan, there are plans to shift from a system based on projected budget to capitation for primary health care facilities. Azerbaijan employs flat-rate capitation for primary care under its MHI scheme, with some performance-based elements. Additionally, the introduction of an age adjusted capitation payment for primary health care in Azerbaijan is being considered. Conversely, Tajikistan lacks a unified system for paying PHC providers, as a result-based approach is used in some districts, while in others a capitation approach is used, and reimbursement rates differ between rural and urban providers.

Fee-for-service

Fee-for-service (FFS) payments are a traditional payment method but known to create incentives to increase the number of services provided. As well as a defined fee schedule, this method requires monitoring of the total amount of payment to providers, which could serve to control volume and cost. Such a fee schedule should define the conditions of payment based on the provider's capacity to deliver the service appropriately and according to the patient's needs (Ikegami 2015). Achieving cost control with this form of payment requires a substantial investment in establishing regulations on conditions for when individual services or drugs can be used, a complex information system and constant adjustment of prices in response to under- or over-use of services.

Azerbaijan, Georgia and Türkiye use FFS as a payment mechanism for specific services and providers. In Türkiye, FFS is used to reimburse private health care providers according to standard fees set by the Health Care Service Pricing Commission (HSPC). In Georgia, private health care providers are remunerated based on a FFS fee schedule. Azerbaijan's SAMHI uses FFS for secondary level outpatient care under the MHI scheme. However, reports suggest reluctance among some private providers to engage with SAMHI, possibly due to the pricing structure for FFS payments, as well as the case-by-case pre-authorization needed for reimbursement. While all these countries share the use of FFS, differences emerge in the strategies and reforms implemented to address associated challenges.

Line-item budgets

Line-item budgets are usually used in countries that do not have a split between provider and purchaser —that is, they have direct provision of care. They guarantee a certain level of continuity in operations, but may not incentivize efficiency or quality of care unless additional measures are implemented, such as complementary pay-for-performance mechanisms. In Tajikistan, hospital payments are made using an input-based model with line-item budgets.

In Armenia, the health system under the MoH historically used line-item based budgeting in its health care facilities. Recently, the system transitioned from line-item based budgeting to more comprehensive, outcome-oriented mechanisms. This shift aimed to address the limitations of rigid budgeting by adapting to evolving health care needs and incentivizing high-quality, cost-effective care. Key drivers included efforts towards increasing the autonomy of providers, a push to enhance efficiency and quality, and an alignment of expenditures with broader health system goals.

Global budgets

Global budgets provide a more flexible option for health facilities compared with line-item budgets, as facilities receive a fixed amount of funds for a certain period to cover aggregate expenditure. Despite the flexibility afforded by global budgets, it has been found that they do not provide incentives to improve efficiency (Lagarde et al. 2010). Global budgets are still used in many countries, primarily for public health care providers.

The purchase of health care services by Türkiye's SSI from public providers of secondary care does not involve contractual agreements when facilities are owned by the Ministry of Health. The SGK transfers funds on a global budget basis to the Ministry of Health for services provided to its beneficiaries. Meanwhile, in Kyrgyzstan, the MHIF contracts different levels of providers for the delivery of the state-guaranteed benefit package based on global budgets which are updated every year. The consolidated budgets account for the expected volume of services, in addition to conditions of payments if the real volume deviates from the projected budget. Payments are complemented with some performance indicators to ensure better quality of the service provided.

Case-based payments

Case-based payments are used in some countries, mainly for inpatient care and with substantial variations in how cases are defined. The diagnosis-related groups (DRG) system is a sub-type of case-based payments, in which the cases are classified into diagnosis-related groups, which are determined largely on the basis of clinical codes (diagnosis and procedure), and these are linked to an amount of payment. Case payments based on DRGs require a sophisticated and computerized medical record system which is not always in place. Case-based payments involve payment for a bundle or a package of services aimed at treating a defined condition. In some cases, this method has been introduced to replace per-diem payment. Per-diem payments tend to increase the length of stay, the number of admissions and bed occupancy rates, but tend to reduce actual services, such as laboratory and imaging tests per hospital day for patients. To avoid unnecessary inpatient days, a lower rate is sometimes applied after the initial days.

Armenia, Azerbaijan, Kyrgyzstan and Uzbekistan employ case-based payment mechanisms. In Kyrgyzstan, case-based payments are specified in contracts between the MHIF and health care providers for hospital services. Payment rates are defined and may include differences depending on geographical location and the level of the provider. National centres have payment rates that exceed the rates of city or regional hospitals by 15-20 per cent. Similarly, Armenia uses case-based payments, particularly for inpatient care, using categories resembling DRG categories. In Uzbekistan, the SHIF utilizes case-based payments for hospitals, accounting for 10 per cent of the hospital budget, classifying cases into DRGs based on clinical codes. This commonality highlights a shared emphasis on effective cost controls and incentivizing high-quality, cost-effective care. Differences lie in the specific contractual details and classifications within each country's approach. In Azerbaijan, the SAMHI pays for inpatient

care for facilities under TABIB, employing case-based and DRG elements, but under global budgets for cost control. Subsidies provided by the SAMHI cover the difference between the budgeted amount and transfers accounted for according to the scope of service delivery. In Cyprus, HIO combines a case-based payment method with a point system designed to contain costs.

Pay-for-performance to complement basic payment methods

Pay-for-performance can be an important means of counteracting disincentives for appropriate care associated with some provider payment mechanisms, especially line-item budgets and capitation. In Kyrgyzstan and Uzbekistan, PHC providers are mainly paid through capitation, which is complemented with a pay-for-performance payment based on pre-defined indicators (Rechel et al. 2023).

Generally, inconsistent and complex reimbursement mechanisms can complicate financial management, resource planning and performance evaluation within a system, as well as sending conflicting messages to providers. For example, in Tajikistan, reimbursement methods for PHC providers differ across districts. Some districts use a results-based model, while others use capitation, which also differs in terms of rates between urban and rural areas. This may have a direct impact on the quality of service delivery.

▶ 2.4. Increasing public resources: A necessity

2.4.1. The essential role of public funding

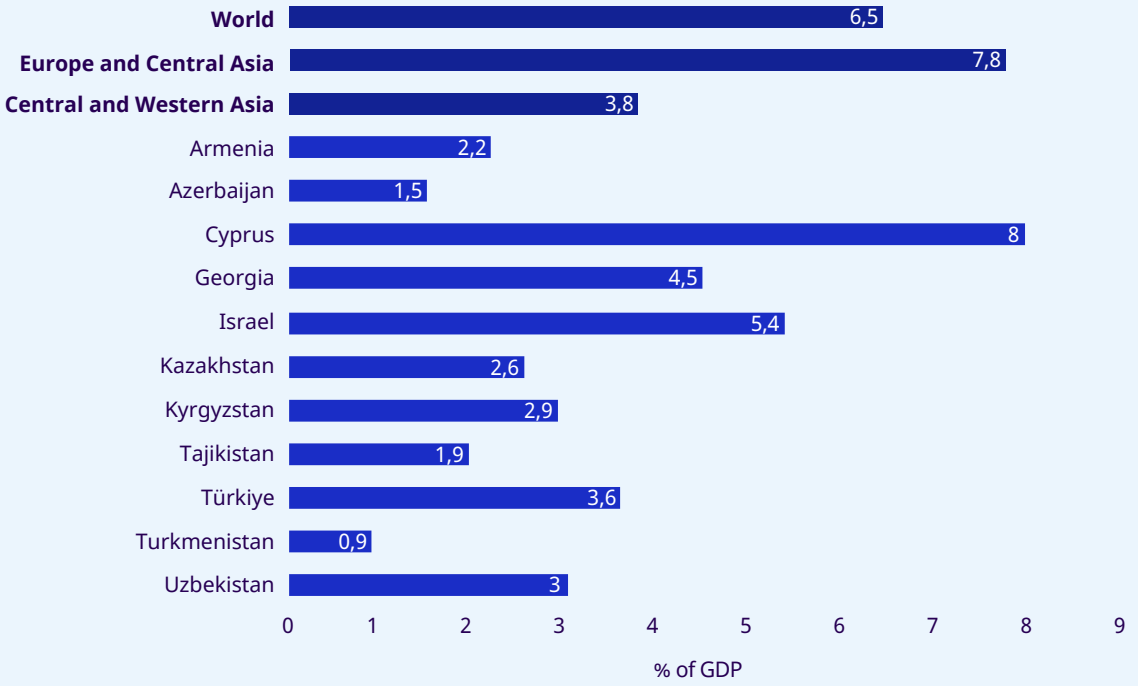
Trends in public expenditure

Public sources are considered the most appropriate to finance health expenditure in line with the principles of solidarity in financing and the overall and primary responsibility of the State embedded in ILO Convention No. 102, and Recommendations No. 69 and 202. The relative share of public resources in national health expenditure is a reflection of collective efforts towards expanding health coverage. The amount of resources allocated to health as a share of GDP also reveals the degree of priority a population is giving to the health sector (see figure 23).

Government health expenditure as a share of GDP is an important indicator that reflects the prioritization of health in a country (Savedoff 2003).[28] In Central and Western Asia, most governments spend less than 5 per cent of GDP on health, and in six countries this proportion is lower than 3 per cent. This suggests that the responsibility for financing of health expenditures falls on households, which is a highly regressive means of financing health care (see figure 24).

[28] While the threshold of 5 per cent of GDP is often referred to as a target for governments' allocation to health in order to progress to UHC, the appropriate level of spending depends on many factors, such as the epidemiological profile, the desired level of health status, the effectiveness of health inputs purchased at existing prices, as well as the relative value and cost of other demands on social resources. A study showed that this target of public spending should be supplemented by a per capita target of US$86 to promote universal access to PHC (Mcintyre et al 2017).

Figure 23. Domestic general government health expenditure as percentage of GDP, Central and Western Asia, 2021

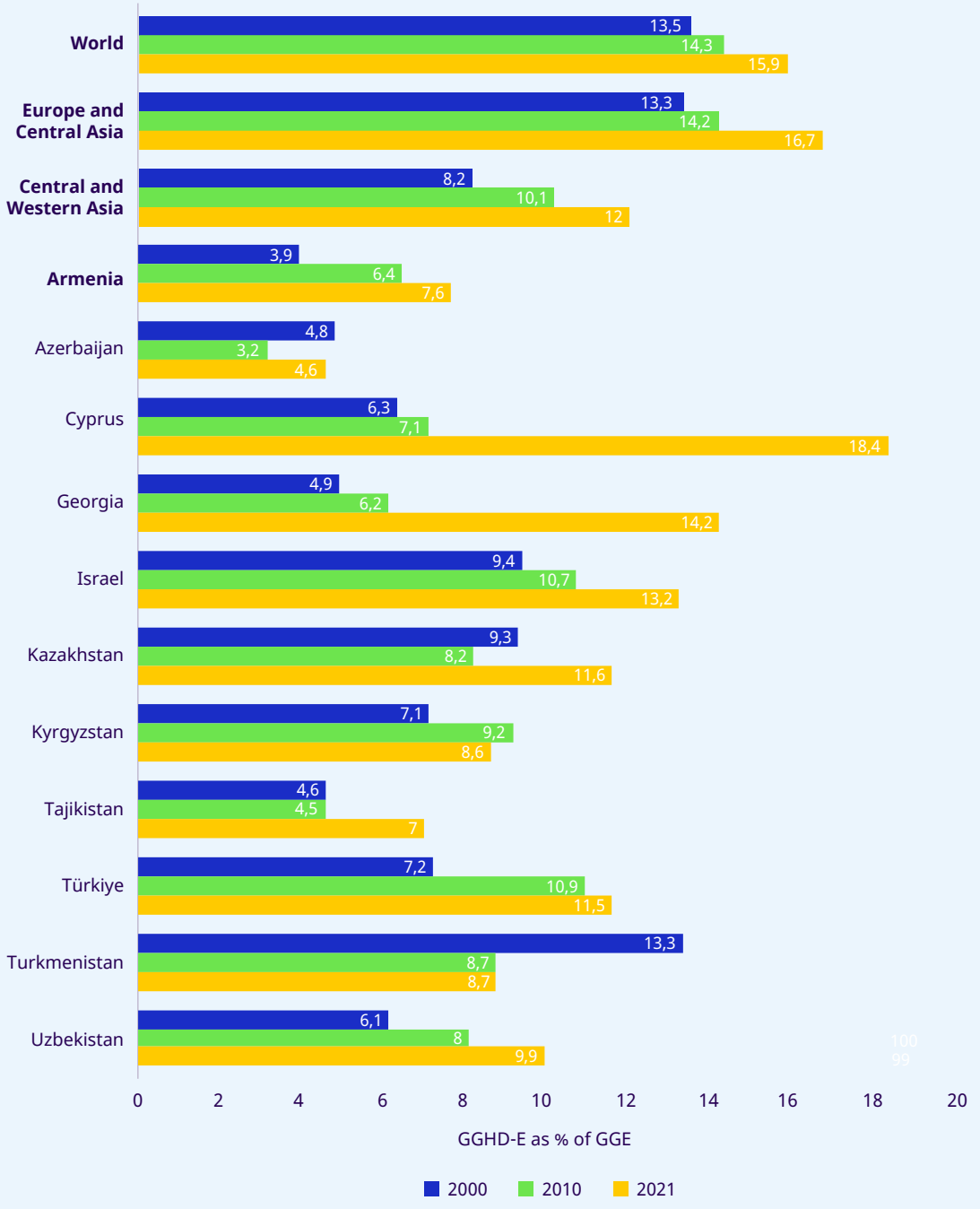


Note: Global and regional aggregates are weighted by GDP.

Source: Based on data from the WHO Global Health Expenditure Database.

Ensuring adequate financing from public sources for UHC requires sustainability and predictability of funding sources. In some countries, over time, multidimensional changes have occurred leading to increased prioritization of health in general government expenditure. Historical trajectories provide helpful insights to better understand weaknesses in current funding mechanisms that keep countries at low and stagnant levels of public spending. Figure 24 shows an overall increasing trend in the share of domestic general government health expenditure (which include public spending on health from all public sources, including social health insurance) in current health expenditure, with the exception of Kyrgyzstan and Turkmenistan. In Cyprus and Kazakhstan, such an increase was largely the result of both countries starting to collect additional social security contributions earmarked for health.

Figure 24. Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE) (%), Central and Western Asia, 2000, 2010 and 2021



Note: Global and regional aggregates are weighted by GGE.

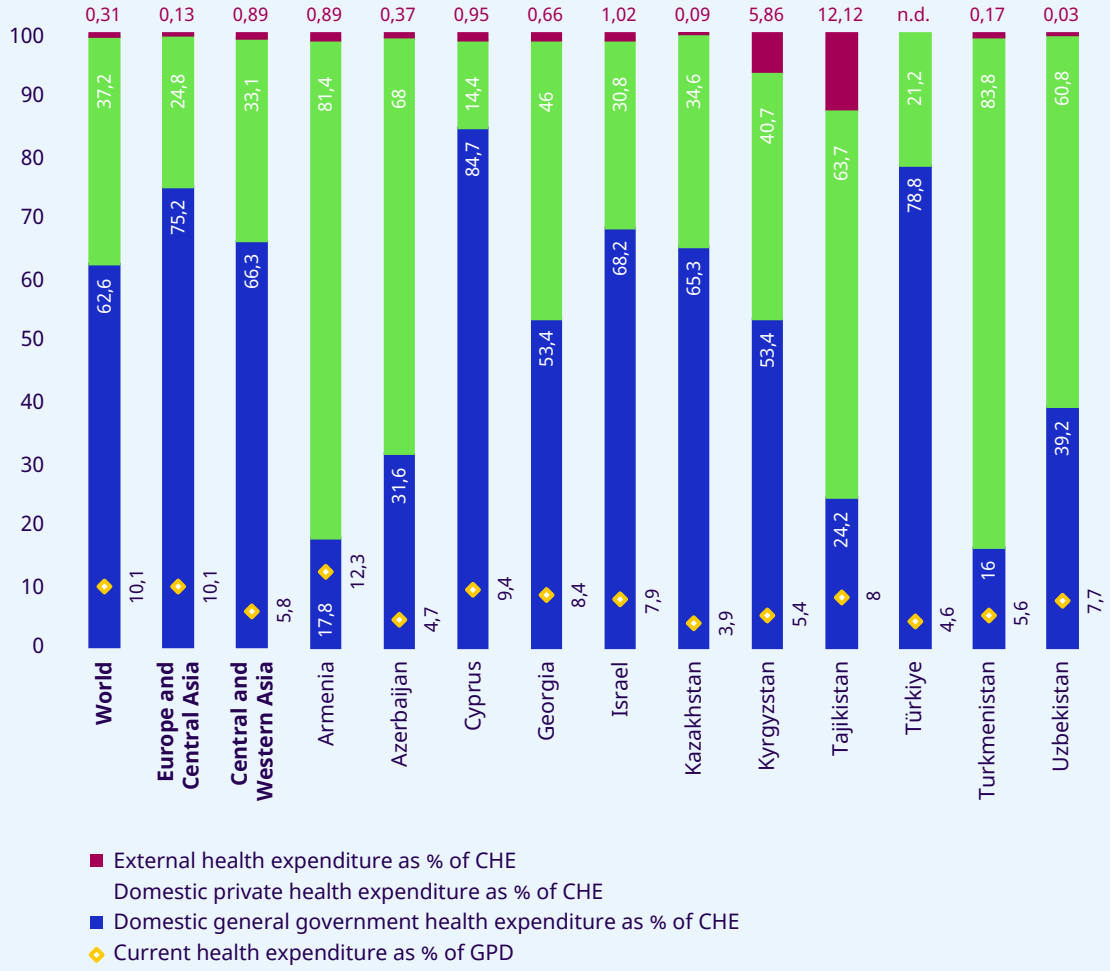
Source: Based on data from the WHO Global Health Expenditure Database.

The importance of public spending in current health expenditure

In CWA, overall public spending accounts for the majority of health spending, in line with global and regional trends. However, the CWA average conceals stark differences across countries. Indeed, public spending accounts for less than two thirds of current health expenditure in seven out of 11 countries (see figure 25). Cyprus, Israel, Kazakhstan and Türkiye are the only four countries that rely on public spending for more than two thirds of CHE, followed by Gorgia and Kyrgyzstan with more than half, and the five other countries cover less than 40 per cent of CHE with public resources. In Armenia, Tajikistan and Turkmenistan, over three fourths of CHE originate from private sources, the bulk of which is comprised of OOP spending on health care by households, as the share of private health insurance in CHE remains minimal.

Domestically sourced public resources can be complemented by external resources. In this respect, ILO standards recognize the important role of international cooperation in the establishment of SHP systems in countries that are particularly resource constrained. However, external resources may be difficult to sustain over time and in CWA overall they play a very small role.

Figure 25. Composition of current health expenditure (CHE) and as percentage of gross domestic product (GDP), Central and Western Asia, data from 2021-2022



Note: Global and regional aggregates are weighted by CHE and GDP for the corresponding indicator.

Source: ILO estimates based on data from the WHO Global Health Expenditure Database.

The limited role of private health insurance

Overall private health insurance, whether of a commercial or non-profit nature, plays a small role in financing health expenditures globally. There are several distinguishing features of private voluntary commercial health insurance that inhibit its ability to contribute to equity or effective financial protection (ILO 2020c; forthcoming). Financial contributions to private insurance are generally individually risk-rated premiums, meaning the amounts to be paid depend on people's health status and identified risks rather than their ability to contribute (Cichon et al. 1999). "Cream skimming" [29] is common practice in private insurance, meaning that older persons or people with pre-existing conditions are generally not eligible to purchase private insurance policies or must do so at a high cost. Premiums also tend to be high because private insurers are generally for-profit enterprises that have shareholders, and their performance is measured by generated profits. As a result, private voluntary commercial health insurance tends to be purchased predominantly by the wealthiest and healthiest groups of the population (ILO 2021b; Mathauer and Kutzin 2018; Normand et al. 2009). Private health insurance may also lead to higher costs of care when provider payment methods and levels are adopted that are less efficient than mechanisms with broad risk-pools. This can be the case where there is a weak separation between private health insurers and private health service providers, such as in Georgia, where private health insurers own a significant share of private medical facilities.

Globally, private voluntary health insurance is predominantly now used to provide supplementary or complementary benefits [30] to those who can afford it. As such, it is not generally seen as a tool to extend population coverage, and impacts mostly on accessing additional benefits or incentives such as choice of provider, often for limited groups within the population. This is sometimes termed "top-up" insurance. As shown in figure 26, in 2021, voluntary health insurance represented more than 5 per cent of current health expenditure in only three countries (Georgia, Israel and Turkmenistan). In Georgia, a comparably higher share (5.8 per cent of CHE in 2021) relates to the exclusion of all those with an annual household income exceeding 40,000 Lari (less than US$15,000 per year),[31] and represents a relatively small group of around 1 per cent of the population (from the publicly-led UHCP system). In Israel, the high share is related mostly complementary private health insurance, as the Government strongly regulates the possibility to offer supplementary features, and coverage of the publicly-led scheme is near universal (Brammli-Greenberg and Waitzberg 2020). Rising or generalized demand for private voluntary health insurance, whether of a commercial or non-profit nature can be a signal of inadequacy in the benefit package offered by public mechanisms, underlining the importance of periodic reviews and progressive expansion of benefit packages as countries grow economically and technologically.

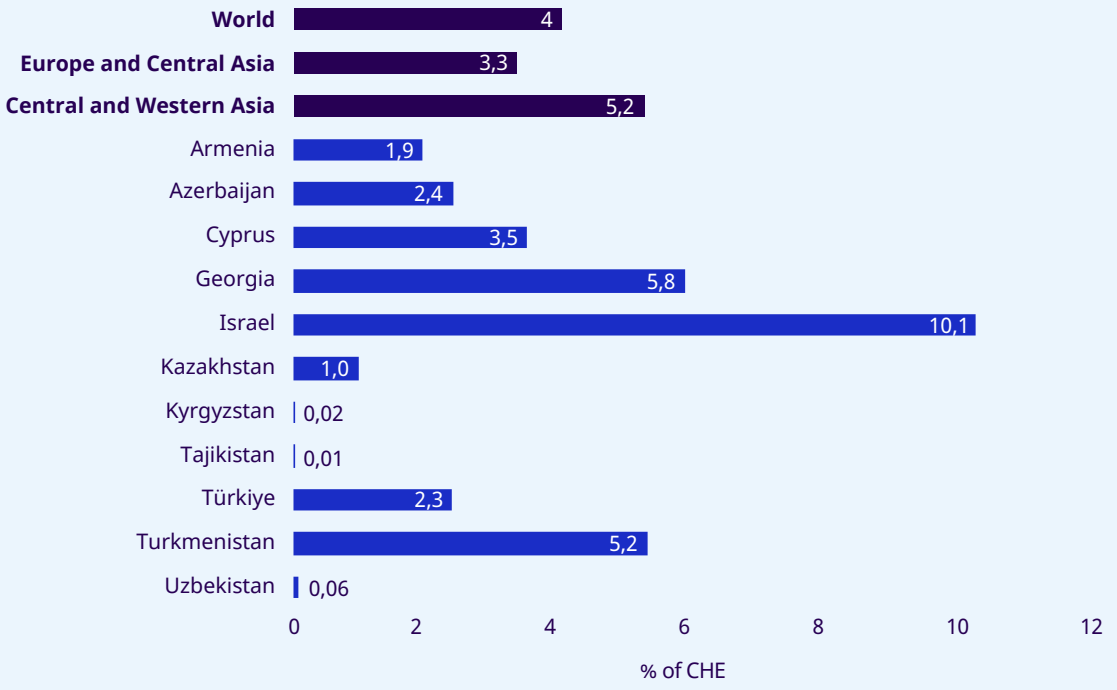
Although private insurance can fill these gaps, it is not a redistribution mechanism as its revenues are not pooled with other social or private insurance schemes. It does not foster solidarity and equity and can contribute to reinforcing inequities in access (ILO 2020c). Government oversight is necessary to control increases in premiums and to assure consumer protection. Strong regulations are also needed to ensure that members are not permitted to opt out of mandatory schemes which would be detrimental to public risk-pooling mechanisms.

[29] The practice of selecting customers based on their good health status or low health risk profiles to enhance the profitability of the insurance company.

[30] *Complementary* benefits can used be to pay for costs of services not fully covered by public schemes (co-payments) or services not included in the benefit package of the scheme (for example, dental and some medication); *supplementary* designates when benefits are used for improved access (for example reduced waiting times or skipping referrals); *substitutive* refers to a design intended to cover excluded population groups or those who can opt out from the publicly-led system.

[31] In 2023, the average annual wage was slightly below 25,000 lari.

Figure 26. Voluntary health insurance expenditure as percentage of CHE, Central and Western Asia, 2021



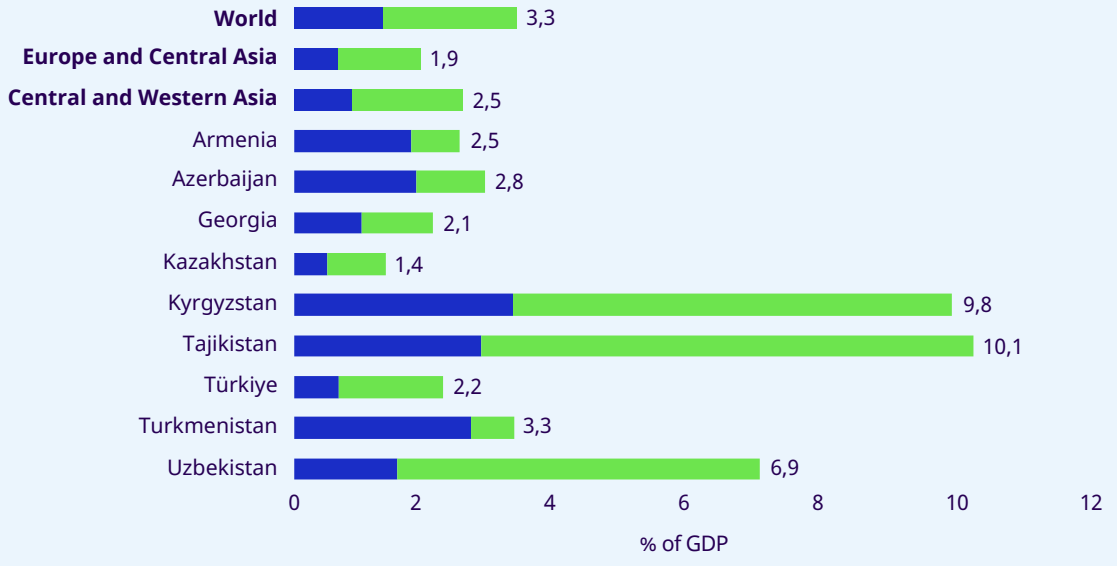
Note: Global and regional aggregates are weighted by CHE.

Source: Based on data from the WHO Global Health Expenditure Database.

The financing gap for social protection in Central and Western Asia

A social protection floor (SPF) should comprise access to essential health care without hardship and provide five cash benefits to enable a minimal level of income support along life cycle contingencies of unemployment, old age, maternity, disability and child maintenance. This is not yet a reality in CWA, and it is estimated that countries in the subregion would need to mobilize an additional 2.5 percentage points above the regional average GDP in order to guarantee a SPF (see figure 27). This is is particularly relevant for CWA countries, considering the low levels of social protection coverage for certain benefits.

Figure 27. Financing gap for social protection benefits (five cash benefits) and essential health care benefits per year, as a percentage of GDP, Central and Western Asia (excluding high-income countries), 2024



Note: Social protection cash benefits include minimum levels of cash support in cases of unemployment, old age, maternity, disability and child maintenance. Global and regional aggregates are weighted by GDP. Global estimates are based on data from 133 low- and middle-income countries. The breakdown does not take high-income countries into account.

Source: Cattaneo et al. 2024.

The financing gap would be much larger if the goals of universal, adequate and comprehensive protection were to be met, suggesting an urgent need to find fiscal space for social protection and health care. The following section will explore ways that countries in the subregion have sought to create such a space.

2.4.2. Options for mobilizing additional public resources

Arguments that SHP is unaffordable are becoming less and less compelling. In fact, countries cannot afford not to have SHP, and must invest in robust and shock responsive social protection systems in order to facilitate an equitable path to economic recovery from COVID-19, and face the changes brought about by the climate crisis. As incomes rise, resources are available, and national policies, laws and institutions need to adapt to ensure that these resources are allocated to meet national commitments to provide adequate social health protection. This can be achieved by increasing fiscal space, namely the available resources resulting from the active exploration and utilization of all potential sources of revenue by a government (Ortiz et al. 2019). There are various ways to create fiscal space for SHP, and a mix of financing options are usually explored.

This section highlights that political will drives fiscal space mobilization for health, social protection and SHP more specifically. It then provides an overview of possible strategies to allocate more public revenues thereof, including:

- Increasing the efficiency of existing allocations through efficiency gains (which are often required before more resources can be obtained).
- Raising additional public revenues through: i) expanding the tax base for progressive taxation on enterprises and households; ii) introducing additional taxes, such as earmarked additions to VAT and new taxes on specific commodities; iii) exploring other complementary measures to generate revenues; iv) and then securing the prioritization of health within the government budget.
- Raising additional public revenues through health taxes, which may generate public health gains in itself, and also has shown potential in other regions to be earmarked for health and social policies.
- Raising additional earmarked revenues through social security contributions.
- Mobilizing external resources for health.

The feasibility of using some of these methods may be greater in some countries than others, as this is highly contextual and reliant on the political economies and historical trajectories of countries.

Political will drives fiscal space mobilization

Strong and stable political will is crucial to successful strategies to legislate and implement SHP, and to allocating the resources needed. Ultimately, the budget allocated to health care and assuring social protection for all hinges on political ideology rather than the level of development (GDP per capita) or the size of the budget of the country (government spending as a percentage GDP) (Ortiz et al. 2019). Figure 28 shows public revenues (which include both revenues from general taxation and social security contributions) as a percentage of GDP in CWA countries. CWA countries have a tax-to-GDP ratio of at least 10 percentage points below the OECD average, suggesting that efforts need to be made to collect more public revenues (OECD 2021). Without such efforts, the pot available for public policies is limited and competition tends to emerge between social policies on health, education and social protection, undermining their synergetic impact.

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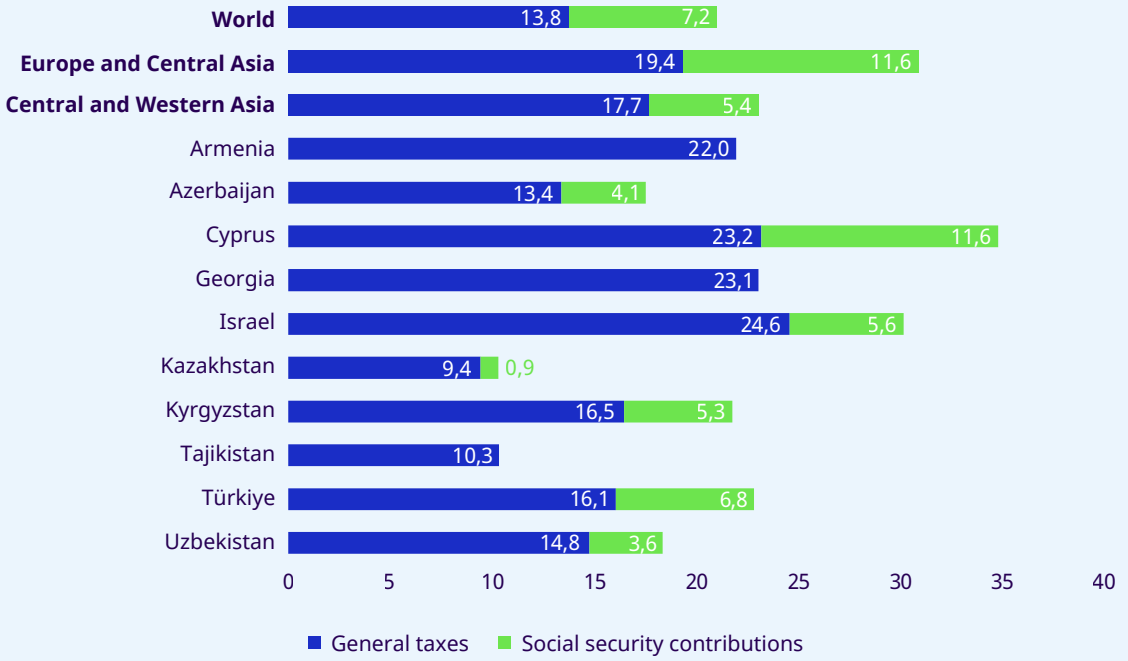
Figure 28. Government revenues (tax and social security contributions) as percentage of GDP, Central and Western Asia, latest available year from 2020 to 2022



Note: Data on tax revenue and social contributions as a percentage of GDP are not available for Turkmenistan. Data for social contributions are from 2021 and tax revenue from 2020 to 2022: Tajikistan and Uzbekistan (2020); Armenia, Azerbaijan, Cyprus, Israel, Kazakhstan and Kyrgyzstan (2021); Georgia and Türkiye (2022). Global and regional aggregates are weighted by GDP.

Source: Based on data from the World Bank World Development Indicators.

With strong political will, raising public revenues is not out of reach. Appropriate fiscal reforms are necessary not only to increase the share of public revenues, but also to reduce income inequalities by improving progressivity and compliance in tax collection (ILO, forthcoming). This requires decreasing reliance on indirect taxes, which are most often regressive in nature and to enforce direct taxation. Several middle-income countries have successfully mobilized public resources to extend SHP coverage to their populations in a sustainable manner that is embedded in legislation.

Among the options available, earmarked revenues play an important role in financing SHP. The arguments for and against earmarking are numerous. Earmarking policies may vary according to country contexts, political priorities and budget processes to ensure positive results. Fiscal and public financial management impacts of earmarked revenues for SHP must be carefully analysed. However, earmarking enables Ministries of Health and social security institutions to benefit from stable revenues. It protects institutions from the risk of insufficient allocation and ad hoc decisions rather than appropriate planning in cases where policy and budget processes are not well aligned or competing political interests are at play, and contributes to increased accountability. Earmarking revenues in the form of social security contributions and health taxes or other taxes contributes to these objectives. At the same time, a financing mix remains necessary to ensure SHP mechanisms, regardless of their institutional set-up, have sufficiently diversified revenues to guarantee their sustainability and equity.

Making efficiency gains

Reducing fragmentation and improving administrative processes

When public funds for SHP are limited and both population and service coverage are incomplete, increasing efficiency is essential. Evidence suggests that a significant share of health spending could be spent more efficiently. In OECD countries, up to one-fifth of health spending could be better used (OECD 2017).

The reduction of fragmentation across health care purchasing agencies can constitute a strategy to improve efficiency. For instance, Türkiye created a national health insurance scheme through a merger of several fragmented schemes with a view, among other objectives, to improve efficiency (see box 12).

▶ Box 12. Schemes merger in Türkiye: Rational, process and results

Türkiye's former SHP mechanisms faced inadequate and inequitable financing throughout the late 1990s to the early 2000s. Fragmentation across five different insurance schemes with different benefit packages, as well as low public spending on health, was a dominant characteristic of the SHP mechanisms. Recognizing the need for change, towards maximizing solidarity, the Government of Türkiye initiated the Health Transformation Programme (HTP) in 2003.

As part of the HTP, the General Health Insurance Scheme (GHIS) was established between 2008 and 2010 in line with the Social Insurance and General Health Insurance Law, consolidating various existing insurance funds into a unified system under the management of the Social Security Institution (SGK). In 2008, three schemes – the Social Insurance Organization (Bağ-Kur)[32] and the Government Employees Retirement Fund – were transferred to the SGK, followed by the Active Civil Servants Health Insurance scheme and the Green Card schemes in 2010 and 2012, respectively.

Despite facing political hurdles, the merger was made possible through the commitment of the Grand National Assembly and the dedication of the HTP team. The implementation of GHIS resulted in significant improvements in health equity and financial protection (Menon et al. 2013). OOP payments decreased from 29 per cent to 19 per cent of CHE between 2000 and 2008 and reached a stable rate below 18 per cent by 2020 (World Bank, n.d.). Moreover, the consolidation of insurance schemes enhanced coordination within the health care system through a unified information system.

More strategic purchasing of health care, including shifting provider payments from line-item budgets or fee-for-service towards prospective payment mechanisms, and efficient procurement of pharmaceuticals, also hold potential to generate efficiencies and cost control (see section 2.3).

Streamlining administrative processes can be achieved through simplified and integrated modalities across the social protection system, such as in Georgia, through the SSA, or in Kyrgyzstan, through the unified social fund. In Georgia, the SSA acts as a purchaser of health care and an administrator of social development programmes such as voucher schemes (including for health care), social assistance, pension and guardianship, with the aim of creating greater coordination and economies of scale when it comes to administrative costs. Some countries have also made strides in implementing measures based on new technologies. For instance, Armenia plans to expand the utilization of its existing eHealth system, ARMED, as a pivotal component of its efforts to enhance effectiveness and expedite primary health care reforms (see box 13).

[32] Bağ-Kur refers to the scheme designed for self-employed people, artisans, and organized groups, affiliated to the Ministry of Labour and Social Security until May 2006 (Bazyar et al. 2020).

▶ Box 13. ARMED in Armenia

In 2017, Armenia launched and implemented ARMED – a nationwide electronic health information system. ARMED currently operates in around 560 health care facilities, six private insurance companies, as well as the State Health Agency (SHA) under the MoH. While all MoH-contracted health facilities use ARMED for streamlined claims submission in the provision of the Basic Benefits Package (BBP) services, the system is also accessible to individual patients to use when accessing public and private providers. The establishment of ARMED is in line with the three-year action plan of the Armenian Government, which aims to advance the eHealth system, introducing the full-scale implementation of electronic drug prescriptions and referral modules. ARMED's integration with the population registry enables real-time verification of patients' personal data.

The economic case for health promotion and disease prevention

Health promotion is implemented through population-based activities that usually focus on addressing behavioural risk factors, such as diet and physical inactivity, mental health, injury prevention and reproductive health, empowering people to take control over their own health. Primary prevention helps to detect or prevent the onset of disease and secondary prevention aims to avoid increased severity of diseases. It includes population-based and individual-based interventions such as immunization programmes, nutritional and food supplementation, and evidence-based screening programmes for early detection of diseases (Caron et al. 2023). Not only do these interventions contribute to the achievement of the right to health, there is also an economic case for action as more diseases and more serious diseases incur high costs. The inclusion of promotion and preventive services in SHP benefits with an allocated budget for these activities is clearly an effective cost-saving mechanism. It also contributes to ensuring a healthy and productive population.

Evidence of the cost-effectiveness of prevention is apparent in efforts to control tobacco and alcohol consumption, improve the quality of people's diets to prevent obesity, and promote physical activities. Efforts to prevent traffic accidents and tackle environmental chemical hazards are also of importance in this context. A combination of interventions is likely to generate additional health benefits, while still remaining cost effective (WHO 2015c). In Central and Western Asia, NCDs are a major health concern, and health promotion and disease prevention interventions can play an effective role in reducing their prevalence (see section 1.3). Through GVFMC, Kazakhstan has implemented universal access to health promotion and disease prevention free at the point of access for the entire population. These services include early screening activities; promotion of healthy behaviours and reducing health illiteracy; preventive vaccinations; pregnancy monitoring and follow-up; clean water and sanitation measures for infectious diseases; and diagnosis and prevention of HIV and tuberculosis (see section 1.3.1). The adoption of an integrated approach, including raising awareness on unhealthy lifestyles, better management of NCDs and early detection and screening of diseases, alongside ensuring access to primary health care services, can dramatically reduce associated costs of treatment (WHO 2022e). A combination of measures involving fiscal policies, regulation and improved access to information on health are needed and should be part of a broader strategy to create fiscal space.

Raising unearmarked revenues through tax base expansion and securing the prioritization of health

Increased public resources may not benefit the health sector unless high policy priority is given to health and appropriate laws are in place. When legislation stipulates explicit entitlements related to SHP, this facilitates the extension of coverage to vulnerable populations who are not able to contribute, and prioritization of health in public resource allocations. Armenia, Azerbaijan, Cyprus, Kazakhstan, Kyrgyzstan, Tajikistan, Türkiye and Uzbekistan have all set concrete UHC goals in laws and regulations, which should be used to justify budget allocations once more public resources are mobilized.

Widening the tax base through formalization

The size of the informal economy varies widely among Central and Western Asian countries (see section 1.2). For example, while the economy is almost fully formalized in Cyprus, and represents less than a third of employment in Türkiye, it represents over 50 per cent of employment in Armenia, Georgia and Kyrgyzstan. Sizeable informal economies reduce the tax base, especially for taxation mechanisms that are proportional or progressive, such as income taxation for households and enterprises. As such, countries that have high rates of informal employment also tend to have limited capacity to mobilize public resources through income taxation and social security contributions.

Supporting the formalization of the economy is a necessity to ensure equity and decent work for all, but also a prerequisite to broaden taxes on profits and income. ILO Recommendation No. 204 on the Transition from the Informal to the Formal Economy outlines strategies and policies countries can develop to support this path. The formalization of the economy is a long-term process requiring a complex mix of well-coordinated interventions, which mostly fall outside of the health sector, underlining the need for inter-sectoral engagement. Assessment and diagnostics of factors, characteristic causes and circumstances of informality form the basis of developing and implementing a legislative and regulatory framework to address informality, based on tripartite consultations. This must be accompanied by the formulation and implementation of national employment policies promoting decent, productive jobs. It should be noted that even when registered, the self-employed tend to report an underestimated income. To facilitate the effective and timely transition from the informal to the formal economy, including for the most vulnerable workers, it is necessary to create incentives for compliance. Moreover, law enforcement and effective sanctions are needed to address tax evasion and avoidance of regular payment of social security contributions.

▶ Box 14. Türkiye's efforts towards the formalization of Syrian workers

Türkiye has been host to a large share of Syrian refugees since the Syrian Civil war in 2011. The Turkish Government has granted refugees access to education, health care, social services and the labour market. Recognizing the need for long-term approaches, from 2016, the Government granted refugees the ability to acquire work permits through their employers.

Prior to 2016, the Government already had a number of programmes in place to incentivize formalization (Asik et al. 2022). This included a social security contribution subsidy, which was made available for a limited period of time to formal businesses seeking to formalize one or more of their workers in informal employment. The Government decided to include refugees in this programme as part of increased efforts to improve refugees' living and working conditions, within the Refugee Response Programme. Spanning from 2017-2021, the initiative facilitated formal employment for thousands of individuals from both refugee and host communities. Programme incentives were provided for employers to cover work permits and social security contributions for 2,340 Syrian refugees. This resulted in the formal employment of 4,500 individuals from refugee and host communities (ILO, n.d.).

Efforts are needed to foster the transition of small business units and self-employed workers from the informal economy to the formal economy. Indeed, formalization often comes at a cost and specific hurdles (business registration costs, taxes on profits/income, social security contributions and remuneration of family members working in the enterprise where applicable), which may be perceived as higher than the immediate returns for small business units (long-term returns can include access to public markets, technical and vocational education and training, improved worker retention and so on). Some countries have created presumptive tax regimes and centralized one-stop-shops for business registration and tax compliance obligations. This often requires tax authorities to agree to put in place a unified package that is often subsidized for some categories of business units. For instance, Kazakhstan put in place a presumptive tax regime for the self-employed, which included a consolidated taxation package to incentivize formalization and social security contributions (including, but not limited to contributions to the MSHIS).

▶ Box 15. Extending coverage to informal workers through Unified Cumulative Payment (UCP) in Kazakhstan

The informal economy accounts for a significant proportion of the overall labour force in Kazakhstan (63.2 per cent). The Government has taken steps to reduce the informal economy and adopted a simplified mechanism that merges the various tax obligations and social security contributions (social health insurance as well as long-term benefits such as pensions) into a single payment – the Unified Cumulative Payment (UCP). Self-employed workers can therefore make a unified contribution at a lower overall rate than if they were to pay separately for each component of the package.

Source: ILO 2018.

Introducing other taxes

The introduction of taxes for previously untaxed sectors can provide additional revenues to finance social spending, including for SHP and other policies. More countries are considering introducing financial sector tax schemes, including financial transaction taxes (FFTs). FFTs can be defined as a minimal tax levied on various kinds of financial instruments and services, such as shares, bonds, foreign currency transactions, derivatives, bank debits and credits, and other kinds of financial services (Ortiz et al. 2019). Despite increasing calls to implement FTTs, this mechanism is not widely adopted among Central and Western Asian countries, with only Cyprus and Türkiye imposing FTTs (Asen 2021; Dowd 2020; Ortiz et al. 2019).

Property taxes are commonplace in OECD countries, but represent a small share of GDP in most developing countries. They offer a stable source of income, are difficult to evade and do not penalize the poorest, as the property tax burden usually falls on middle- or high-income households. In addition to existing land tax, property tax was introduced in Kyrgyzstan in 2009 for companies and individuals (Ortiz et al. 2019).

Taxation on natural resources and extractive industries channelled to social spending offers additional revenue streams and should be explored further, especially in the context of the climate crisis. However, taxation on natural resources is volatile due to fluctuating global market prices and changing consumption patterns, and should therefore be combined with other resources. Other innovative taxes on sectors not previously taxed include environment protection taxes and lottery taxes. In the context of the climate crisis, such instruments should be explored more closely, including as a way to finance social health protection schemes (ILO, forthcoming).

Using revenues from public companies

Some countries in Central and Western Asia have a wealth of natural resources, and some have used the revenues generated by their public exploitation for health. Azerbaijan has relied on oil and gas revenues from its public companies, which are particularly susceptible to external shocks related to price fluctuations, as a primary source for health financing. Notably, in 2010 the country experienced fluctuations in health expenditures, alongside a decline in government health spending, which was partially linked to the volatile nature of oil prices. In response, a multifaceted system was established, with revenues from oil and gas complemented by levies on alcoholic beverages and tobacco products, as well as social security contributions.

Additional options

International and regional collaboration to tackle corruption, tax evasion and illicit financial flows may be useful. For example, Tajikistan has taken substantial steps in enhancing tax compliance and reducing tax evasion among businesses through strategies such as mainstreaming tax payment services to reduce administrative burdens (Wilkes and Goroshko 2023). Transnational cooperation between tax authorities promoting policy dialogue, and better detection of tax avoidance are essential. As part of these efforts, the OECD launched the Istanbul Anti-Corruption Action Plan, which was developed with the involvement of Kyrgyzstan and Tajikistan, and aims to diminish corruption in Central Asia by implementing a subregional peer review programme, in compliance with the UN Convention Against Corruption (The Royal United Services Institute 2017).

Additionally, governments can use both fiscal and monetary policies to create and maintain social protection and health sector investments. As discussed earlier in this section, fiscal policies comprise government revenues and expenditures, and monetary policy deals with money supply and interest rates. With macro-prudential policies in place to regulate capital flows, alongside the public provision of social goods such as health care and education, moderate budget deficits and inflation can be accommodated by countries; this indicates that inflation and deficit thresholds are policy choices, which allows governments a level of flexibility to design monetary and fiscal policies that facilitate employment and social protection (Ortiz et al. 2019). In this respect, not all countries in CWA have the same maneuvering space; for example, Armenia and Georgia had inflation rates below 3 per cent in 2023, whereas in Kazakhstan and Kyrgyzstan inflation was over ten percentage points (IMF 2024).

Raising earmarked revenues from social security contributions

Social security contributions are explicitly earmarked to cover health spending and alleviate the burden of health care costs for households by redistributing and pooling. Social security contributions to social health insurance schemes are earmarked nominal financial contributions made to a dedicated fund or institution which enjoys autonomy over the administration of those funds. Social security contributions may be collected from workers, employers and governments. In the case of social security contributions for health, they are also often raised from other social insurance benefits such as old age pensions, work injury pensions, unemployment benefits, maternity benefits, disability benefits and pensions.

Social security contributions for health should be calculated in such a way that each individual pays according to their capacity to contribute, with entitlements to benefits that are equal for all, in line with the principle of solidarity in financing and according to need. Contributions are redistributive in nature in that they allow transfers from high-income to low-income workers, and from the healthy to the sick or to those unable to work, and across generations. Social security contributions, as per guidance provided by ILO standards, should be set in a way that ensures equity and solidarity, and should therefore be progressive (ILO 2021b; 2020c; forthcoming).

Historically, models of financing to guarantee access to health care without hardship were referred to as the Bismarck and the Beveridge models, in reference to the national models of financing chosen by Germany and the United Kingdom. The source of funding and the way services were procured, either through direct provision or contracting providers, were the features that distinguished these two models. In the case of the Bismarck model, employers, workers and the government made mandatory contributions to a social health insurance scheme under participatory governance, which funded access

to public and private health care providers for the covered population (workers, pensioners and their dependents). In the case of the Beveridge model, access to free or largely subsidized health services was guaranteed for the whole population within a network of public providers directly financed and managed by the MoH. This distinction does not accurately reflect the reality of financing and institutional arrangements adopted in most countries, including in CWA. Furthermore, the distinctions that have been historically made between these two models have been poor predictors of outcomes in terms of effective and adequate SHP (ILO 2021b; 2020c; forthcoming).

In CWA, social security contributions for health are raised in six out of eleven countries and two additional countries are discussing or have passed legislation thereof. This includes the four countries where public spending represents at least two thirds of CHE, and where coverage is mandatory for the entire population without opt-out options. In Cyprus and Kazakhstan, recent increases in public spending on health were possible with the additional collection of social security contributions for health. Commentators have noted that such an outcome is only possible if such contributions take the form of additional resources, and are accompanied by an overall prioritization of the health sector, as opposed to being seen as a way to cut existing government budget allocations. Ultimately, in practice, the use of resources from social security contributions for health needs to be combined with other resources, and must be seen as a complement, not a substitute to adequate allocation of government resources within a broader financing mix. The financing mix of general government budget allocation and earmarked revenues from social security contributions can take several forms, as follows:

- Tax revenues and social security contributions can be used to cover different cost items. For example, many countries use social security contributions to pay for service utilization, while using taxes to provide supply-side subsidies to cover certain cost items, such as human resources or capital costs. This is the case in most CWA countries that raise social security contributions for health.
- Tax revenues can be used to subsidize social security contributions for health from specific categories of the population, and sometimes co-payments can be waived (section 1.2), as is the case in Cyprus, Türkiye, Azerbaijan and Kazakhstan.
- Tax revenues can be used to provide either population-based interventions or the entire primary level of care, while social security contributions can be used to finance higher levels of care, such as in Kazakhstan and Kyrgyzstan. As highlighted in sections 1.2 and 1.3, this needs to be carefully designed because entitlements for both should be made universal in order to guarantee equity in adequate access to health care without hardship.

As a predictable source of revenue, social security contributions can play an important role in financing SHP. The scope of this potential role varies from country to country and depends on two important factors. Firstly, this potential is particularly high where social security contributions play a significant role in funding social policies more broadly – specifically, in countries where contributions are an established source of revenue for broader social protection policies (for example, in Türkiye), or part of a strategy to include social protection as part of a broader package of policies aimed at formalization (for example, in Kazakhstan). Secondly, this potential can only be realized if the aim is indeed to raise additional resources and not to simply shift existing allocations from other sources. Furthermore, it is crucial that when revenues from social security contributions are used, mechanisms for coverage do not use contributory capacity as a means to restrict eligibility (see section 1.2). Social health protection should be for all members of society, regardless of their capacity to contribute, in line with ILO Recommendation No. 69.

Raising revenues from health taxes

Several countries are taking action to increase excise taxes on products that are harmful to health, specifically alcohol, tobacco and sugar (or sweetened beverages), with the immediate aim of reducing the consumption of such products, and an expected trickle-down effect on revenue generation in the short run (Saxena et al. 2023; WHO Regional Office for Europe 2017; 2FIRSTS.ai 2023). For example, Turkmenistan implemented increased excise taxes on both alcohol and tobacco in 2024, following the guidance provided by the WHO Framework Convention on Tobacco Control. The country had already taken action on other fronts to tackle tobacco consumption, with some success compared to its neighbouring countries (Boyarov 2023; The Times of Central Asia 2024a). Kazakhstan is also looking at increasing taxes on harmful products (alcohol and tobacco) as well as some luxury products, though the Ministry of National Economy is anticipating that the related reduction in consumption and costs of administering the reform may offset the additional revenues it can generate (The Times of Central Asia 2024b; Tobacco Reporter 2024). Taxes on sweetened beverages are also present in Azerbaijan, Tajikistan and Türkiye, with targeted excise taxes for such products (World Bank 2023).

Some countries in Central and Western Asia remain far behind the average levels of taxation of such products and there is therefore room to generate additional revenue (as a budgetary objective), while influencing behavior towards harmful commodities (as a public health objective) such as tobacco and alcohol.

It is suggested that governments take both equity, solidarity in financing and long-term financial sustainability into account when designing excise tax policy frameworks to avoid imposing a double burden on populations with low incomes, as tobacco, alcohol and poor quality food tend to be primarily consumed by lower income populations rather than the better-off (ILO 2021b; Ortiz et al. 2019). In Armenia, the first country to adopt by the WHO Framework Convention on Tobacco Control after the fall of the Soviet Union, there is evidence that applying higher taxes on tobacco could have a redistribution effect, averting not only deaths but also cases of poverty (Postolovska et al. 2017).

The collection of consumption taxes does not automatically translate into additional financing for health, unless earmarked for this purpose (Wilkes and Goroshko 2023). While an increase in excise taxes is being considered by a number of countries in the subregion, the allocation of these taxes to health and social policies is not guaranteed. For example, Türkiye introduced excise taxes on tobacco in 2008 and, despite positive outcomes in terms of reduced rates of adult smokers, the additional revenues were not earmarked for health financing (WHO 2014). In other cases, these revenues can be allocated to health policies and sometimes directly support financial protection of the population against health care costs. For example, the Government of Uzbekistan plans to fund the newly established State Health Insurance Fund (SHIF) by collecting revenues from both the state budget and excise taxes imposed on unhealthy products such as alcohol, tobacco, sugary foods and trans fats.

Mobilizing external resources

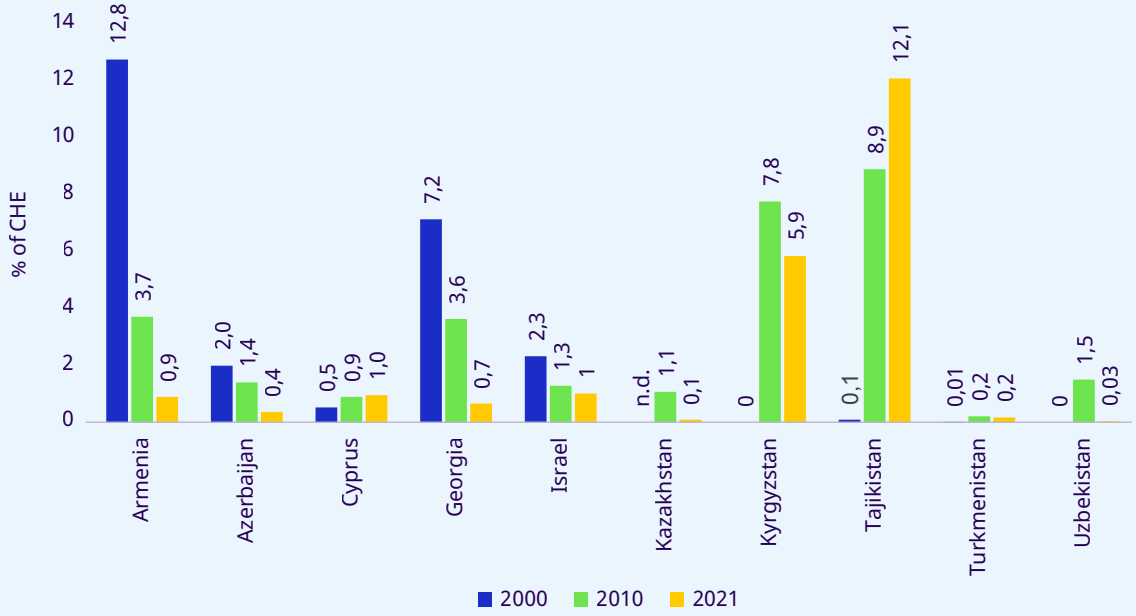
External assistance from international organizations or donors cannot be regarded as a sustainable financing source. Nevertheless, it can be an important source of revenue to support developing countries during periods of transition. In Central and Western Asia, some post-soviet countries benefited from support from external donors in facing the financial difficulties resulting from a drastic change of institutional landscape. Azerbaijan, for instance, received donor funds to support the country's transition from a Soviet Semashko health system to a primary health care system with emphasis on community-based PHC. Donor aid was used to support projects to improve the accessibility and quality of PHC, including introducing innovative techniques in reproductive health and drug development, as well as modernizing financial management (European Observatory on Health Systems and Policies 2005; Oxfam GB 2008).

In Central and Western Asia, the share of external funding of CHE has been gradually diminishing, though it continues to hold significance in some countries as an additional funding source to supplement domestic revenues (see figure 29). Armenia has witnessed a declining trend in external health

expenditure as a percentage of CHE, which plummeted from 12.8 per cent in 2000 to approximately 0.9 per cent in 2021. The country previously relied on external sources to support capital investments in regional health infrastructure, and over the past 25 years it has seen the construction or renovation and equipping of more than 170 primary care facilities and roughly 20 regional hospitals. While several neighboring countries have exhibited a similar decline in external financial support, Tajikistan presents a contrasting picture, with a noticeable increase in external health expenditure from 8.9 per cent in 2010 to 12.1 per cent in 2021. These funds have been directed towards the refurbishment and construction of health care facilities that had deteriorated, particularly in regional and district hospitals, which have suffered from underinvestment.

The use of external funding is likely unsustainable over time, and a progressive increase in domestic public resources needs to be ensured. Kyrgyzstan has seen a reduction in public spending on health, which is partly attributable to the decline in external resources. The country graduated from low-income country to lower-middle income status in 2014, resulting in a diminishing role of external donors, while public spending shifted to other areas (European Observatory on Health Systems and Policies 2021).

Figure 29. Trends in external health expenditure as a percentage of CHE, selected countries in Central and Western Asia, 2000, 2010 and 2021



Note: Data on external health expenditure as percentage of CHE are not available for Türkiye.

Source: Based on data from the WHO Global Health Expenditure Database.

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Way forward

Country trajectories in Central and Western Asia show that there is no one-size-fits-all solution available to make SHP a reality for all and more broadly move towards UHC and USP. Success has more to do with political and societal commitments, historical trajectories and the application of guiding principles in line with international social security standards, rather than with specific financing or institutional models.

While this holds true, to a certain extent, countries face common challenges. Foundational to SHP are the principles of solidarity and equity, premised on the idea that everyone, rich or poor, should have access to the same provision of health care. In practice, too many countries in central and Western Asia rely on direct payments from households to finance health care, which reinforces inequality. Those who can afford it tend to access health care outside of SHP entitlements where such entitlements are either too limited or not well implemented. While most countries have put in place policies to protect the poor and vulnerable from health care costs, reducing impoverishment and fostering health equity requires greater synergies with social protection policies that support income security. A stringent social protection system is needed to tackle pervasive pockets of poverty and inequalities, and to prevent the development of dual systems that fuel rising inequalities. A renewed commitment based on broad risk-pooling and solidarity in financing is needed to reinforce the social contract that make societies whole.

Investing in prevention and primary care is an urgent priority to meet the needs of populations increasingly affected by non-communicable diseases (NCDs) and health security issues. This requires greater investment, not only in strengthening health systems and reinforcing SHP entitlements, but also in expanding social protection cash benefits, especially in cases of sickness and maternity, which is an area facing significant coverage gaps in Central and Western Asia. Extending the duration and quality of life of populations will result from scientific breakthroughs in health technology, alongside effective and

equitable access to health care without hardship, as well as actively addressing the social determinants of ill-health along the life cycle. The compounding effects of deprivations people experience throughout their lives, in terms of lack of access to appropriate health care and periods of income insecurity and poverty, impact their health status. Comprehensive social protection encompasses both access to health care and measures to secure income security in case of sickness, maternity, old age, unemployment, disability, loss of primary income earners, work accidents or disease, as well as support to families and children to prevent poverty and ensure an adequate standard of living. Only with this broad range of benefits and services, can comprehensive USP play a key role in addressing the social determinants of health.

Adopting a PHC approach and addressing the social determinants of health and wellbeing is a cross-sectoral goal. To achieve this, it is necessary to raise the profile of health and care workers to ensure their availability and close coordination, and secure the quality of services they provide, now and in the future. SHP and social protection systems as a whole should support this much needed shift. To do so, significant silos between health and social protection policies need to be overcome. At the intersection of health and social policies, SHP institutions are particularly well placed to play a central role in this process. This can result in the mobilization of a greater share of public resources and contribute to redistribution in a mutually reinforcing way.

SHP policies, and more broadly social protection and health systems, need to be prepared to cater to the needs of a growing number of older persons who have lost some level of autonomy. With rapid ageing, there is an increasing need for long-term care services that are provided in such a way that is respectful of the dignity of older persons and supportive of ageing in place. To ensure equity, it is also essential that the costs of such services are born collectively. As underscored during the International Labour Conference in June 2021, long-term care must be considered as an integral part of social protection systems, and decent working conditions for workers in the care economy need to be secured. This should also be considered an investment with significant returns, as it is an employment-intensive and growing sector of the economy, which must comply with decent work standards.

Increased investment in robust and adaptable rights-based SHP systems is urgently needed. The clock is ticking, with only a few years remaining to achieve the 2030 Agenda, including targets 1.3 and 3.8. The prioritization of public investments to guarantee access to health care without hardship, as part of nationally defined social protection floors and systems, is central to delivering on the promise of the 2030 Agenda, and crucial in order to leave no one behind. Shifting gears towards achieving the SDGs by 2030 is essential to enabling people and societies to address the profound transformations associated with demographic, epidemiologic, technological and climate changes. By making progress towards the promise to achieve USP and UHC by 2030, and by protecting and promoting human rights, states can strengthen the social contract.

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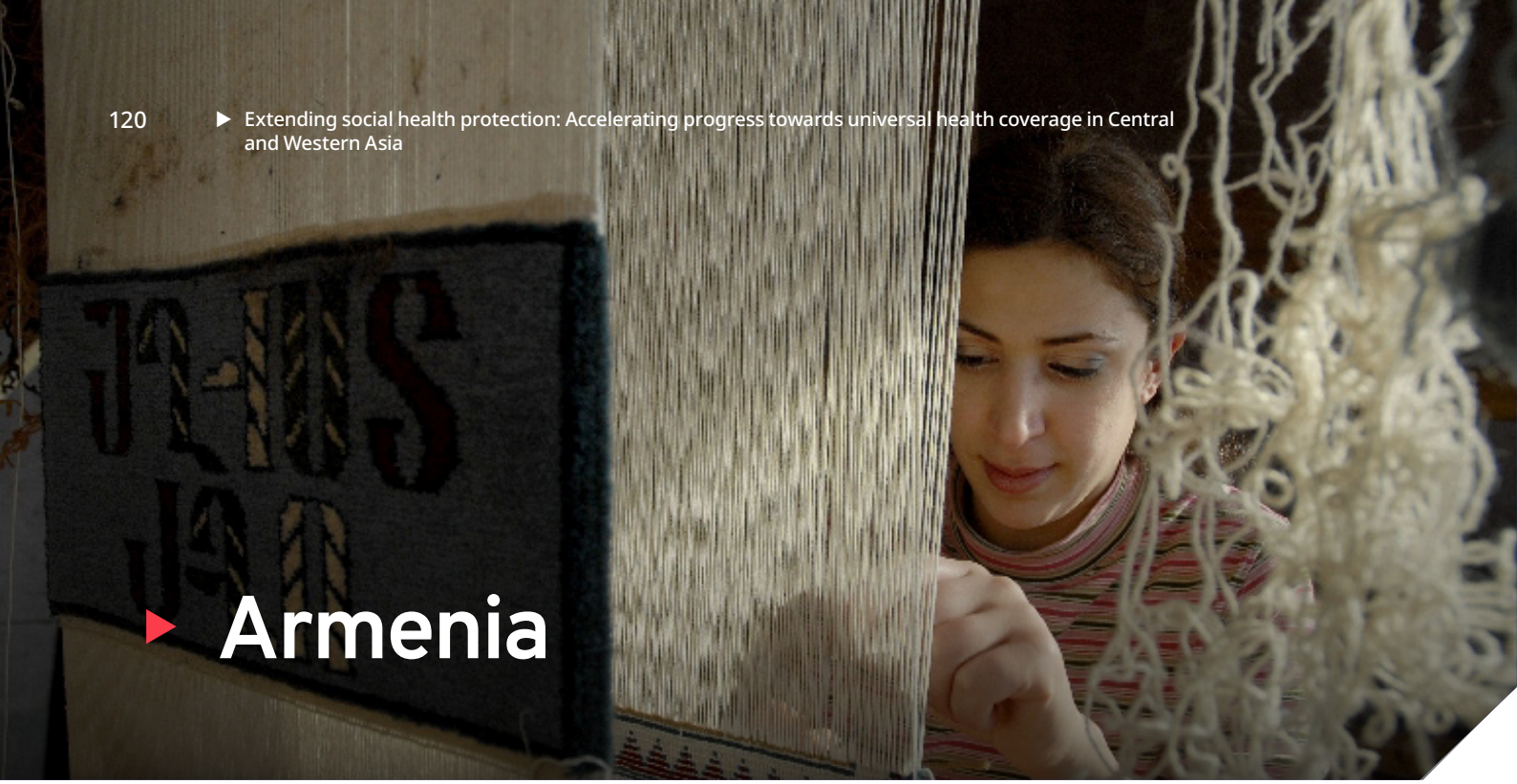
2

Country profiles



Armenia

This country profile was prepared by Artiom Sici, Salma El Gamal and Mathilde Mailfert with the support of Yesle Kim (ILO). It benefited from the review, inputs and quality assurance of Saro Tsaturyan (health systems and health financing expert).

1. Introduction

Armenia is one of the 15 republics (state formations) of the former Soviet Union, characterized by typical features of socio-economic development in other countries in the region. The population of Armenia is 2.96 million people in 2021 (UNECE 2021). According to the UNDP Human Development Report 2021-22, Armenia ranked 85 out of 191 states, with a Human Development Index (HDI) of 0.759, placing it among the countries with high levels of human development (UNDP 2022). In the early 1990s, after independence, the economy of Armenia experienced a deep crisis of recession. The country's GDP almost halved from U$9.8 billion in 1990 to US$4.97 billion in 1993 (World Bank Database, n.d.). Economic growth has been recorded since the second half of the 1990s, with GDP reaching US$8.15 billion in 2000, and US$43.52 billion in 2021 (World Bank Database, n.d.). According to the World Bank classification, based on GNI per capita (Atlas method), Armenia advanced from a lower middle-income to an upper middle-income country in 2017 (World Bank 2018). In 2023, GDP at purchasing power parity per person amounted to 20,781 international dollars (World Bank Database, n.d.).

The Government of Armenia introduced a Basic Benefits Package (BBP) financed by general taxation in 1996. The BBP covers several vertical health programs, which provide mostly free-of-charge, publicly funded medical services for all Armenian citizens, including PHC services, emergency care, oncology, maternal and childcare and treatment of HIV/AIDS and TB.

The BBP also identifies socially vulnerable and other distinct categories of the population, for whom most of the hospital services are covered for free, with some exceptions. These categories include the disabled, children under 18, pregnant women, and those eligible for the Family Benefit Programme (FBP). Armenia has a very high share of out-of-pocket (OOP) spending on health, which comprises population spending on outpatient medicines, formal co-payments for certain services under the BBP, direct payments for services not covered by the BBP and informal payments (European Observatory on Health Systems and Policies 2022).

In addition, since 2012, a so-called social package covers certain categories of population through mandatory enrolment into private health insurance subsidized by the State.

▶ 2. Context

Armenia built its health and social health protection systems based on plans and programmes that existed in the era of the Soviet Union, the main features of which included a high degree of centralization and free medical care for the entire population, with a heavy emphasis on secondary and tertiary care (the Semashko heath care model was widely applied in the former republics of the Soviet Union).[33] However, due to a deterioration of the economic situation in the early 1990s following the dissolution of the Soviet Union, the effectiveness of the state health care system significantly decreased, leading to a decline in the accessibility and the quality of medical care (ILO and UN Women 2021).

The health care system of Armenia has undergone significant organizational and legal reforms over the last two and a half decades. The Government introduced several key health care reforms in late 1990s, including reforming the primary health care network, financing of social health protection and optimization of the hospital network (Lavado et al. 2020). Between 1990 and 2021, the total number of hospital beds was reduced by 58 per cent (from 30.5 thousand to 12.7 thousand) and the number of hospitals decreased by 32 per cent (from 183 to 122), while the number of PHC facilities did not change significantly (503 to 487) (National Institute of Health of the Republic of Armenia 2022a).

With the adoption of the Law on Medical Care and Services to the Population in 1996, institutionalizing the universal nature of access to health care in Armenia, the BBP, alongside new provider payment mechanisms, was introduced. Line-item based budgeting and direct financing of health facility maintenance costs were replaced with the model of service purchasing through output-based financing of inpatient health facilities and per-capita funding of primary health care. A major step in social health protection reforms was the establishment of the State Health Agency (SHA) in 1997 as an independent public body charged with the task of purchasing of all publicly funded outpatient and inpatient medical services on behalf of the population (European Observatory on Health Systems and Policies 2022). The initiative of the Family Doctors Programme, implemented in 1996, aimed at improving provision of integrated primary health care services and prevention of chronic diseases, which also marked a critical change in the health care system (World Bank 2005).

While most basic medical services under the BBP are free for all, the population has to pay to access inpatient services available at public and private medical facilities, except for vulnerable groups (Tonoyan and Muradyan 2012).

In February 2023, the Government approved the first sector-wide policy document for health (Health Sector Development Strategy 2023-2026)[34] and a concept note for the introduction of a universal health insurance (UHI) system in Armenia.[35] The UHI proposal aims at expanding population coverage by introducing a payroll health tax for the working population which will provide them with the same package of services currently guaranteed for only socially vulnerable categories of population under the BBP. The Government also plans to gradually expand service coverage for already covered groups, closing existing gaps between service packages for different categories of BBP beneficiaries (Lavado et al. 2020). According to latest Government declaration, the entire population is expected to benefit from the UHI scheme from 2027 onwards (Aiypkhanova 2023).

[33] Named after the first minister of health of Soviet Russia, Nikolay Semashko, this system of health care organization was characterized by its centralized, integrated, hierarchically organized structure with the Government providing state-funded health care to all citizens. It provided universal access to health care and was broadly a "benefits in kind" system.

[34] Government of Armenia Decree No. 174-L on Approval of Health Care System Development Strategy of the Republic of Armenia for 2023-2026 and the Resulting Action Plan, dated 9 February 2023, available (in Armenian) at: https://www.e-gov.am/gov-decrees/item/39848/

[35] Government of Armenia Decree No. 133-L on Approval of the Concept Note for Implementation of Universal Health Insurance, dated 2 February 2023, available (in Armenian) at: https://www.e-gov.am/gov-decrees/item/39809/

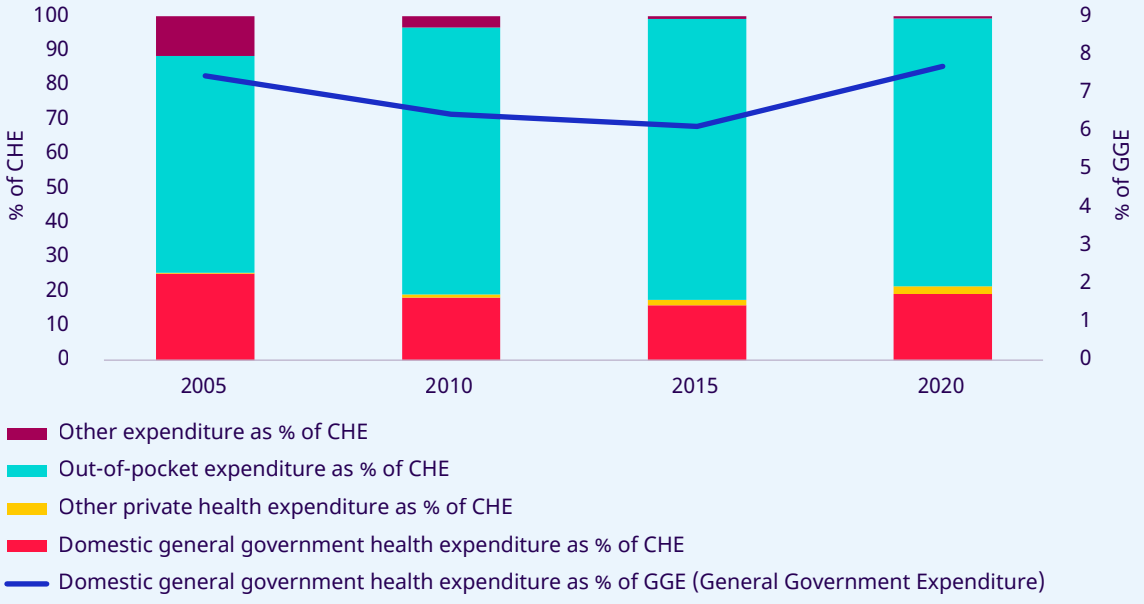
▶ 3. Design of the social health protection system

Financing

From 2014-2019, public health expenditure varied between 5.5 per cent and 6.2 per cent of the total government budget expenditure and 1.2-1.6 per cent of GDP (European Observatory on Health Systems and Policies 2022). In 2021, health spending increased to 7.5 per cent of total budget expenditure and 2.3 per cent of GDP, primarily due to additional public spending to address the COVID-19 outbreak (European Observatory on Health Systems and Policies 2022). In 2021, Current Health Expenditure (CHE) per capita was US$577, from which US$454 (or 79 per cent) comprised household private spending for health. In the same year, public expenditure in Armenia on health care amounted to 17.8 per cent of CHE (compared to 12.4 per cent in 2019), while private spending accounted for 81.4 per cent (down from 86.6 per cent in 2019), and external sources accounted for 0.9 per cent. OOP payments were the main source of health spending (accounting for 78.7 per cent in 2021 and 84.8 per cent in 2019), and voluntary health insurance (VHI) accounted for a small portion of total health expenditure (1.9 per cent) in 2021 (National Institute of Health of the Republic of Armenia 2022b).

The public budget (including for health) is generated from general tax revenues and is consolidated through the treasury of the Ministry of Finance. Around 80 per cent of the health budget is used for the procurement of BBP services and the remaining 20 per cent is used to finance public health programmes, centralized procurement of medicines and so on. The budget is managed by the MoH, mainly through the State Health Agency and directly through its financial-economic department (Dale et al. 2018; European Observatory on Health Systems and Policies 2022).

Figure 30. Composition of current health expenditure (CHE) in Armenia, by source of financing, 2005-2020



Source: Based on data from the WHO Global Health Expenditure Database.

Governance

Between 1997 and 2001, the SHA was directly subordinated to the Government of Armenia and acted independently from the MoH. In 2002, the SHA was made a part of the MoH structure, and in 2011, it was further incorporated into MoH. SHA is now de-facto a department of the MoH. The head of the SHA is appointed by the Minister of Health. The SHA prepares contracts with the providers, processes the reporting and disbursement of funds from the budget and conducts audits, while all major purchasing decisions are made by the MoH, including authorization of the contracts with providers (European Observatory on Health Systems and Policies 2022).

On the provision side, the MoH is responsible for developing and implementing health care policy in the country, and directly manages a limited number (around 20) of health care facilities and institutions, some of which are multi-profile or specialized medical centres. The decentralization of health care system which took place in the 1990s expanded the role of municipal (regional) governments (Armenian et al. 2009). Health departments of regional (marz) administrations and local (community) authorities currently manage most public health facilities in Armenia, including regional hospitals, urban polyclinics and rural PHC centres (European Observatory on Health Systems and Policies 2022).

The MoH approves health sector regulations, such as service delivery standards, protocols and guidelines (mainly developed by the National Institute of Health) and exercises its regulatory functions by licensing health care providers through its Licensing Agency (Chukwuma et al. 2020a). Sanitary and epidemiological surveillance services in the country are organized through the National Centre for Disease Control and Prevention, which is also subordinated to the MoH (Farrington et al. 2016).

While the management of the health system is decentralized, its financing is consolidated at national level. The MoH acts as the sole purchaser of budget-funded medical services. Both public and private health facilities (around 500 in total) are contracted by the MoH under the same legal framework to provide BBP services (European Observatory on Health Systems and Policies 2022; Chukwuma et al. 2020a).

Governance arrangements are different for the social package programme of the BBP, which is delegated to private insurance companies licensed by the Central Bank to provide health insurance services in Armenia. Under this system, the MoH signs contracts with insurers and provides proportional monthly payments based on the number of beneficiaries allocated to each insurer. Insurers then sign contracts with health care providers approved by MoH for delivery of medical services to beneficiaries. The benefits package under the scheme is approved by the Government, while the price list for the covered medical services is approved by the MoH.

Legal coverage and eligibility

The Constitution of 1995 (amended in 2015) guarantees social protection rights, as well as the right to health care. Article 83 states that "everyone shall, in accordance with law, have the right to social security in cases of maternity, having many children, sickness, disability, accidents at work, need of care, loss of bread winner, old-age, unemployment, loss of employment, and in other cases." Additionally, article 85 of the Constitution states that "everyone shall, in accordance with law, have the right to health care. The law shall prescribe the list of free of charge basic medical services and the procedure for the provision thereof."[36]

More specifically, article 13 of the Law on Medical Care and Services of the Population of 1996[37] stipulates that all residents have the right to receive medical care and services "regardless of nationality, race, gender, language, religion, age, state of health, disability, political or other views, social origin, property or other status, in accordance with the procedure established by the Constitution, this law and other laws, as well as international treaties of the Republic of Armenia." The Law also notes that everyone has the right to receive medical care and services on free or preferential terms within the framework of

[36] Constitution of the Republic of Armenia, amendments adopted 6 December 2015, available at http://www.parliament.am/parliament.php?id=constitution&lang=eng#2

[37] The Law on Medical Care and Services of the Population dated 4 April 2006, available (in Armenian) at: https://www.arlis.am/DocumentView.aspx?DocID=153795

health protection and improvement programmes approved by the Government, while medical care can also be provided outside the scope of these programmes through medical insurance benefits, personal payments, and other sources not prohibited by law. The Government approves the annual health protection and improvement programmes annually and submits them along with the draft budget to the National Assembly as an integral part of the budget (Chukwuma et al. 2020a; Dale et al. 2018).

The list of socially vulnerable and special categories of the population (as well as covered medical services for different categories of beneficiaries, but also purchasing, contracting and provider payment mechanisms), is approved by the Government. The main legal act regulating the BBP is Government Decree No. 318-N of 4 March 2004, which regulates provision of BBP services for the general population.[38] This Decree approves the list of socially vulnerable and special categories of population. It currently includes 22 categories (see box 16).

▶ Box 16. Socially vulnerable and special categories of the population in Armenia

- Beneficiaries of the family benefit scheme with a vulnerability score of at least 28.01
- Disabled people with high degree of functional limitation
- Disabled people with severe degree of functional limitation
- Disabled people with moderate degree of functional limitation
- Children (0-18 years)
- Participants of Great Patriotic War and their equivalents
- Pregnant women and new mothers (42 days after childbirth)
- Young people (aged 18-23 years) left without parental care
- People undergoing medical tests for assessment of the degree of functional limitations
- People of conscription age (for inpatient expertise and treatment)
- Military service personnel and their family members, retired military service personnel
- Rescue service personnel and their family members, retired rescue service personnel
- People in custody
- People in care in orphanages, retirement homes and temporary shelters for homeless people
- Oppressed people (for example, victims of political repression during the Soviet period)
- People involved in recovery works after the Chernobyl disaster
- Victims of human trafficking
- Asylum seekers and their family members
- People discharged from military service due to mutilation, injury and disease which occurred during military service who have not been recognized as disabled after a functionality assessment
- People discharged from military service due to mutilation, injury and disease occurred during military service, during the first three months of treatment, before referral for medical and social expertise
- Members of national olympic teams and olympic family sports teams
- People referred for forensic tests

In addition, medical care for military service personnel and their family members under the BBP is regulated by the Government Decree No 806 of 25 July 2013.[39]

Another segment of the covered population includes beneficiaries of the social package—a programme that was introduced by the Government in 2012. This service package is part of the BBP, in that it is funded from the government health budget and covers civil servants, teachers at public schools, health workers

[38] Government of Armenia Decree No. 318-N on Free and Preferential Medical Care and Services Guaranteed by the State, dated 4 March 2004, available (in Armenian) at: https://www.arlis.am/DocumentView.aspx?DocID=175656

[39] Government of Armenia Decree No. 806-N, dated 25 July 2013, available (in Armenian) at: https://www.arlis.am/DocumentView.aspx?DocID=161119

at public PHC facilities and employees of other specified public institutions (dependents are not covered under this programme). The provision of medical care for social package beneficiaries is regulated by Government Decree No. 375-N of 27 March 2014. [40]

Another important component of the BBP is the provision of publicly-funded medicine for vulnerable categories of the population and patients with certain medical conditions, which is regulated by Government Decree No. 642-N of 30 May 30 2019. [41]

Benefits

The BBP was first introduced in Armenia in 1996. Since then, the BBP has been periodically revised and expanded, based on available budget resources allocated to the health sector. The MoH is responsible for defining the benefit package. While the initial BBP composition was informed by evidence, including on efficacy of services, the country's burden of disease and cost-effectiveness of services, as well as their financial implications, subsequent revisions do not follow a defined process (Chukwuma et al. 2021). Under the BBP, residents are entitled to outpatient care (including primary care and some specialist visits, but excluding dental care), emergency care and care provided through hospital vertical programmes.[42] Access is free, with the exception of a few services (services for sexually transmitted diseases, oncology and hematology diseases), for which a co-payment might be required for non-vulnerable populations (Lavado et al. 2020).

Co-payments are also applied for inpatient care (percentage co-payments), diagnostic tests (fixed co-payments),[43] dental care treatment and outpatient prescribed medicines (percentage co-payments).[44] Some co-payments for hospital services vary between Yerevan and other regions due to differences in provider costs and tariffs. Overall, the co-payment amount can vary from 10-15 per cent to more than 50 per cent of the total service cost.

In addition, people included in socially vulnerable and special categories (comprising around 50 per cent of the population), as well as military staff and their family members, are entitled to other types of available inpatient care, some dental care and additional (so called hard-to-reach) diagnostic tests (such as CT, MRI and PET CT). These groups are exempt from co-payments.

In recent years (since 2019), BBP coverage has expanded significantly. Notably, co-payments for cancer surgeries were abolished and coverage for children has been expanded from 7 to 18 years. Moreover, the threshold score for beneficiaries of the family benefits scheme was lowered from 30.01 to 28.01 to enable more people to benefit from the scheme, and additional services were added to the list of vertical programmes available to the whole population, including outpatient emergency care in hospitals and palliative care, as well as urgent surgical treatment of acute myocardial infarction (coronary stenting), treatment of acute or subacute ischemic brain strokes and surgeries for ruptures and (or) exfoliation of aortic aneurysms (ILO and UN Women 2021; Lavado et al. 2020).

[40] Government of Armenia Decree No. 375-N, dated 27 March 2014, available (in Armenian) at: https://www.arlis.am/DocumentView.aspx?DocID=171451

[41] Government of Armenia Decree No. 642-N, dated 30 May 2019, available (in Armenian) at: https://www.arlis.am/DocumentView.aspx?DocID=179755

[42] These include services for intensive care; tuberculosis treatment; treatment of psychiatric and narcological diseases; treatment of communicable diseases; health services for people of conscription and pre-conscription age; childbirth; hemodialysis services; surgical treatment of oncological diseases; outpatient emergency care in hospitals; palliative care; urgent surgical treatment of acute myocardial infarction (coronary stenting); treatment of acute or subacute ischemic brain strokes; and surgeries for ruptures and (or) exfoliation of aortic aneurysms.

[43] Government of Armenia Decree No. 375-N, dated 27 March 2014, available (in Armenian) at: https://www.arlis.am/DocumentView.aspx?DocID=171451

[44] Government of Armenia Decree No. 642-N, dated 30 May 2019, available (in Armenian) at https://www.arlis.am/DocumentView.aspx?DocID=179755

Inpatient medicines are free for BBP-covered services, with certain exceptions or caps. The cost of outpatient medicine is subsidized by the Government for certain categories of the population based on social status criteria or medical conditions. Depending on social status, beneficiaries can obtain the medicine prescribed by their PHC providers either free of charge, or with a discount of 50 per cent or 30 per cent. Patients with the following medical conditions are also entitled to receive free medicine: Tuberculosis, mental illnesses, cancer, diabetes, epilepsy, myocardial infarction, periodic fever syndrome, heart valve defects, malaria, chronic renal failure, phenylketonuria, respiratory disease syndrome in premature infants, HIV/AIDS, hormonal medicines and viral hepatitis C (Lavado et al. 2020).

▶ Table 5. Social categories of the population eligible for fully or partially subsidized outpatient medicine in Armenia

	Categories
For fully subsidized outpatient medicine	• Persons with disabilities with high, severe or moderate degree of functional limitations • Children with disabilities (up to 18 years old) • Participants of the Great Patriotic War and their equivalents • Children left without parental care, and children of those left without parental care (up to 18 years old) • Children of families with many children (with 4 or more children under the age of 18) • Family members of military service personnel who passed away while defending the Republic of Armenia, or during the fulfillment of official duties • Children of families with persons with disabilities (up to 18 years old) • Children up to 7 years old) • Beneficiaries included in the Family Benefit Scheme with a vulnerability score of 28.01 and above • Different categories of military hostility victims
For partially subsidized outpatient medicine (50% discount)	• People involved in Chernobyl disaster restoration work • Oppressed people (people who were subject to political repression during the Soviet period) • Single non-working pensioners • Non-working pensioner households (households without any working members) • Children (7-18 years) with a single parent
For partially subsidized outpatient medicine (30% discount)	• Non-working pensioners (part of a household with other working members, including children)

Source: Lavado et al. 2020.

Provision of benefits and services

In 2021, Armenia had 487 institutions (371 public and 19 private) providing primary health care and 122 hospitals (80 public and 42 private), and there were 12.7 thousand hospital beds, 14.5 thousand medical doctors and 16.6 thousand nurses available in the country. Around one third of these resources are concentrated in the private sector, including 4.3 thousand doctors (or 34 per cent of the total number of doctors), 4.8 thousand nurses (29 per cent), and 4.1 thousand hospital beds (32 per cent) (National Institute of Health of the Republic of Armenia 2022a). To be eligible for applying for a BBP-funded contract (also informally referred to as "state order"), medical institutions must hold a license for the medical services which the provider is seeking funding from the state budget for (Chukwuma et al. 2020a).

In rural areas, PHC services are provided by rural ambulatories or family medicine centres, whereas in cities those services are provided by polyclinics, which are outpatient facilities that host both PHC providers such as family doctors, general practitioners and pediatricians along with the standard set of

specialists and diagnostic services under one roof. Polyclinics currently exist as independent facilities only in the capital Yerevan, as well as in Gyumri and Vanadzor, while in other urban settings they are included under the structure of regional medical centres (typically, along with a hospital and maternity centre). Some rural ambulatories also include FAPs (Feldsher/midwife health posts), which are not legally considered to be separate health facilities, and exist only in villages where a nurse is present. Usually, PHC is provided to people at their place of residence (Lavado et al. 2020; European Observatory on Health Systems and Policies 2013). On average, one PHC doctor serves 1,500 to 2,500 persons and one paediatrician serves 700 to 800 children (Atun et al. 2005).

Inpatient services are provided by a mix of public and private hospitals and medical centres. Regional hospitals, which mainly provide secondary specialized services, are under public ownership and are managed by marz (regional) administrations. Yerevan-based hospitals are managed either by Yerevan municipality or the MoH, and also include private facilities. They provide both secondary and tertiary level (narrow and specialized) inpatient services (European Observatory on Health Systems and Policies 2022).

People need to register with a PHC provider in order to access BBP-covered health services. Access to BBP-covered diagnostic tests, outpatient specialist services and inpatient care requires a referral, and access to covered outpatient prescribed medicines requires a prescription from PHC providers (Chukwuma et al. 2020a).

BBP-covered medical services are provided as benefits in kind. If patients opt to visit either a private clinic not contracted by the MoH or a different primary care facility (other than the one where they are registered) they must pay the full cost of the service. Health facilities (both public and private) providing BBP services are contracted by MoH on an annual basis and operate under the same contracting and reporting arrangements regardless their ownership status (Chukwuma et al. 2020a). PHC services are financed on a per capita basis, according to the number of people enrolled with each provider, while hospital services are mainly financed on a case-by-case basis, based on claims that facilities submit to SHA through a a nationwide electronic health information system called ARMED (European Observatory on Health Systems and Policies 2022).

ARMED was launched in 2017 and currently operates in around 560 health care facilities, six private insurance companies and the MoH/SHA. All health facilities that are contracted by the MoH for the delivery of BBP services are connected to ARMED to facilitate claims submission and management, but the system can also be accessed by individual patients, as well as by other public and private users. In February 2021, a three-year action plan for further development of the eHealth system was approved by the MoH, including a full-scale implementation of electronic prescription and electronic referral modules, as well as disease registries. ARMED is connected with the population registry, which allows a real-time check of patients' personal data. Further integration with other electronic government systems, such as the civil registration and vital statistics database of the Ministry of Justice and the social status registries of the Ministry of Labour and Social Affairs, is ongoing (European Observatory on Health Systems and Policies 2022).

For the social package programme, insurers have to contract all providers under the same terms and conditions for delivery of medical services to beneficiaries, essentially acting as third-party administrators of the system. Thus, insurers perform only certain key functions: Contracting of providers, case management and claims processing. Both public and private health care providers report the number of cases, including both outpatient and inpatient, to insurers monthly, and receive payments based on the reported volume of services. The actual amount of monthly payments from the MoH to insurers reflects the approved budget, which is fixed by the contract for each insurer, and is not linked to the actual volume of medical services provided. If an insurance company spends less than the total amount received from the MoH, the company makes a profit. However, if they receive more claims from health care providers than initially anticipated, they have to settle those claims at their own risk (Chukwuma et al. 2020b).

▶ 4. Results

Coverage

Armenia's health care legislation guarantees the provision of PHC and basic hospital medical services to all. However, in practice, access to services is limited, primarily due to financial barriers to care and a shortage of medical specialists in the regions.

In theory, the BBP covers PHC services for the entire population. However, most beneficiaries still have to bear direct costs of seeking health care. It is likely that many forgo basic health care due to an inability to cover the cost of co-payments and informal payments. According to the 2019 Integrated Living Conditions Survey, even among vulnerable groups, effective coverage is relatively low (28.6 per cent of children aged 0-4 years; 21.9 per cent of Family Living Standards Enhancement Benefits beneficiaries; 11.8 per cent of persons in the lowest consumption decile; and 52.3 per cent of persons registered as disabled) (ILO and UN Women 2021).

While coverage is low among all age groups, coverage among children is highest (17.5 per cent), likely due to the fact that all children up to the age of seven and several other groups within this demographic are considered vulnerable and are therefore exempt from BBP co-payments. Coverage among working-age persons is the lowest (8.3 per cent) and increases only slightly for older persons (9.5 per cent). This could also be attributed to the fact that unemployed pensioners are classified as a special group under the BBP. Notably, a greater share of the male population is covered by the BBP (11.3 per cent) compared with the female population (9.8 per cent), despite the fact that all women of reproductive age are considered a special group (ILO and UN Women 2021).

Adequacy of benefits/financial protection

Due to limited effective coverage in Armenia, financial protection when accessing health care services is very limited. As a result, OOP payments are among the highest in the world. OOP as a share of current health spending was 78.7 per cent of CHE in 2021, down from 84.8 per cent in 2019 (see figure 30), but still far above the average for upper-middle-income countries (44.1 per cent of CHE), obstructing the affordability of health services for the population. OOP spending includes costs for outpatient medicines, formal co-payments for services under the BBP, direct payments for services not covered by the BBP and informal payments (European Observatory on Health Systems and Policies 2022).

Historically, in a context of low wages, informal payments have been requested by medical staff (Chukwuma et al. 2020a). The implementation of formal co-payments for certain BBP services in 2011 was one of the measures aimed at reducing and gradually eliminating informal payments in the health sector. However, a lack of coverage of inpatient care for the non-vulnerable population and outpatient pharmaceuticals for all remain the main drivers of high OOP payments in Armenia (ILO and UN Women 2021; European Observatory on Health Systems and Policies 2022).

In addition, the country has relatively high rates of catastrophic spending on health, at 23.2 per cent of the population with household expenditures on health greater than 10 per cent of total household income, and 5.5 per cent of the population with health expenditures greater than 25 per cent of household income in 2020 (WHO, n.d.). High catastrophic spending in Armenia pushes households into deeper poverty, with the highest risk among low-income residents, residents of rural areas and informal economy workers, leaving them with inadequate financial protection for accessing care (WHO Regional Office for Europe 2019).

Responsiveness to population needs

Accessibility and availability

Since 2000, Armenia's universal health coverage index has increased by almost 1.5 times, from 45 points to 69 points in 2019 (WHO, n.d.). While this is higher than the global average (64 points), it is still below the European average (77 points) (WHO, n.d.). In 2021, there were 49.1 doctors, 56.1 nurses, 42.9 hospital beds per 10,000 people, and 16 hospitalizations per 100 residents (National Institute of Health of the Republic of Armenia 2022a).

Despite seemingly satisfactory national staffing rates in Armenia, there are considerable differences in the provision of medical care between the capital city and other areas. Around 37 per cent of the total population lived in Yerevan in 2021, and 74 per cent of all doctors were based there. This can be partially attributed to the concentration of most tertiary-level specialized hospital services in Yerevan. However, the imbalance in medical workforce distribution can also be explained by lower salaries in the regions and poor living and social conditions compared with the capital city (European Observatory on Health Systems and Policies 2022). The number of nurses per 100,000 persons in Armenia is below the Europe and Central Asia regional average and above the Central and Western Asia subregional average, whereas the number of physicians is slightly below the regional average and above the subregional average.

Hospital beds are distributed unevenly across the country. With 44 per cent of the hospitals and 65 per cent of hospital beds located in the capital city, Yerevan has a higher density of hospital beds than other regions. Secondary level hospital care, such as general surgery, maternity and OBGYN, and general therapeutic and pediatric services are available in all 122 hospitals across the country (National Institute of Health of the Republic of Armenia 2022a), while patients who need more hi-tech or specialized services are typically transported to Yerevan, where specialized hospital care and the provision of certain technology-based diagnostic procedures (such as CT or MRI) are predominantly concentrated (European Observatory on Health Systems and Policies 2022). Ambulance services are fully covered by BBP, including an air ambulance service to promptly evacuate patients in need of urgent treatment to medical centres in Yerevan.[45]

Prior to 2018, health infrastructure investments were mostly financed by development partners. Since 1998, more than 170 regional PHC facilities (rural ambulatories and family medicine centres) and around 20 regional medical centres (hospitals) were renovated and equipped, mainly through support from World Bank credit programmes and other donors. Further renovation or construction of health facilities are included in the current Government Programme 2021–2026 to be financed from the state budget. This includes the target to renovate more than 30 health centres and provide them with updated equipment (European Observatory on Health Systems and Policies 2022).

However, there are still issues with the development of infrastructure and the availability of modern medical equipment. Most polyclinics still only have basic medical equipment for medical check-ups, such as X-Ray machines or lab equipment, which are often outdated. As such, the types of pathologies that can be diagnosed at PHC level are limited. The modernization of health care facilities is a crucial priority that the Government should consider to enhance the quality of medical services (JICA and Nomura Research Institute, LTD 2019).

While most of the dental clinics in the country and some of the largest multi-profile hospitals in the capital city Yerevan are private, the rest of the health service delivery system (especially in the regions) is still publicly owned and managed. In 2021, around 71 per cent of all doctors and nurses were employed by publicly owned health facilities, in which more than two-thirds of the total hospital bed capacity in the country was concentrated (European Observatory on Health Systems and Policies 2022).

[45] Government of Armenia Decree No. 318-N on Free and Preferential Medical Care and Services Guaranteed by the State, dated 4 March 2004, available (in Armenian) at: https://www.arlis.am/DocumentView.aspx?DocID=175656

Quality and acceptability

Armenia lacks a comprehensive system of health care quality monitoring and management. A 2018 study showed that among preventable deaths in Armenia, the majority (53 per cent) were due to low quality of care rather than non-utilization of services (Kruk et al. 2018). A situational analysis of quality of care in Armenia carried out by the Asian Development Bank (ADB) through two surveys in 2019 (which were reflected in the strategy for improving health services, approved by the MoH in April 2022),[46] found that there is insufficient leadership to address quality concerns. In particular, it was noted that there is an absence of an overall governance structure, insufficient use of the eHealth system, minimal data for quality improvement, little patient involvement, and insufficient knowledge and skills on quality management among facility managers and health workers. While hospital epidemiologists are tasked with monitoring and reporting nosocomial infections, ensuring compliance with guidelines on infection prevention and control, and investigating reasons for cases of high infection rates, nosocomial infections remain underreported.

A system to license health facilities is in place, and this function is performed by the MoH through its licensing agency. However, the licensing process focuses mainly on availability of physical inputs (trained medical staff, infrastructure and equipment) but does not include any quality standards. Facility licenses used to be issued without fixed renewal terms, but this regulation has been recently revised; from now on, licenses have to be renewed every five years, which will help to establish quality monitoring elements (Chukwuma et al. 2020a; 2020b).

In addition, insufficient staffing in the regions and overloaded family doctors, who may have more than 3000 patients (compared with the standard of 2000), negatively affects the quality of services. Similarly the low wages of doctors, especially in regional health facilities, makes it difficult to recruit highly qualified specialists for health care institutions who can provide high-quality medical care services to the population (JICA and Nomura Research Institute, LTD 2019).

As a result, the population is often reluctant to use PHC services, mainly because of the perceived low quality of services. Data from the Integrated Living Conditions Survey 2021 indicated that 61.9 per cent of non-poor respondents and 63.2 per cent of poor respondents cited self-treatment as the main reason for not visiting a PHC facility, suggesting that there are issues related to trust and quality of care. Lack of financial means was the second leading reason for not seeking PHC (among 15.7 per cent of poor respondents and 13.5 per cent of extremely poor respondents). Distance to the nearest PHC facility (remoteness) was cited by only 0.1 per cent of non-poor respondents, while other groups did not mention it at all (Statistical Committee of the Republic of Armenia 2022).

Patients often bypass PHC services, with a tendency to use secondary and tertiary health care when their health situation is already aggravated, requiring highly specialized and urgent medical interventions; as such, health conditions among the population can be exacerbated (Chukwuma et al. 2020b).

In Armenia, life expectancy at birth increased from 70.7 years in 1990 to 76.5 years in 2019 (Statistical Committee of the Republic of Armenia 2022). The infant mortality rate per 1000 live births in Armenia fell by more than 60 per cent between 2000 and 2019, from 27 to 10.5 per 1000 live births (European Observatory on Health Systems and Policies 2022). The most recent national data on infant mortality suggest that in 2021, this figure was 6.9 (National Institute of Health of the Republic of Armenia 2022a). The maternal mortality rate (MMR) per 100,000 live births decreased from 43 in 2000 to 26 in 2017 (World Bank, n.d.). However, as the absolute numbers of births and maternal deaths in Armenia are relatively low, national data on MMR may exhibit major fluctuations from year to year, for example from 8.0 in 2017, 21.9 in 2018, 33.3 in 2019, 22.0 in 2020 and 43.7 in 2021 (Statistical Committee of the Republic of Armenia 2022). To address this issue, the MoH publishes the triannual moving average of MMR, which was 33.0 for the period 2019-2021 (National Institute of Health 2022). Immunization coverage rates for routine childhood vaccinations remain high (above 95 per cent) and the overall mortality rate in Armenia is the lowest among countries of the Commonwealth of Independent States (European Observatory on Health Systems and Policies 2022).

[46] Ministry of Health of Armenia Order No. 1614-L of 20 April 2022 on Approval of the Strategy and the Action Plan for Improving the Quality of Health Services.

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▶ 5. Way forward

Overall, Armenia exhibits positive trends in health outcomes. However, the country lacks an adequate social health protection system to provide financial protection to all, and improvements need to be made to the efficiency of the country's health care system performance and management to increase quality. It is necessary to strive towards increasing the availability of services nation-wide, ensuring financial protection of the population and reducing OOP payments, thereby improving access to health services.

The Government's overarching goals for social health protection are achieving financial risk protection to increase affordability of health services, including increasing public health spending, and improving the quality of health care. The Government's reform priorities are laid out in the Government Programme 2021–2026, the Health Sector Strategy 2023–2026 and the Concept Note for Universal Health Insurance (UHI), which were approved in February 2023. From 2027, the Government plans to increase financial resources for health to a minimum of 4 per cent of GDP to fully roll out UHI and implement activities dedicated to strengthening the health care system and improving its infrastructure.

One of the critical actions planned in the reform is the establishment of a compulsory health insurance system for formal workers in the country. The new scheme should cover the formally employed population as well as vulnerable population groups [47] under the centralized and publicly managed health insurance fund (which should pool social contributions and tax-based funding). The new insurance system is planned to be implemented in stages, starting in 2024, pending the approval of corresponding laws by the National Assembly.

The implementation of the UHI proposal assumes creation of a new independent purchasing agency (the UHI Fund), which will pool financial resources and incorporate the current functions of SHA into its structure, thereby relieving the MoH from its double role as both a provider and a purchaser of publicly funded medical services. It is hoped that the UHI fund will act as strategic purchaser under the new

[47] All the categories of the population covered by BBP under vertical programmes or other health budget programmes, including socially vulnerable population groups, children, people with certain diseases, and others.

scheme, contributing to achieving better quality of care for patients and greater financial transparency among providers (Lavado et al. 2020).

In parallel, the Government will need to make unprecedented efforts to expand coverage to the informal sector, which constituted 50.2 per cent of total employment in 2021, while working towards formalization (ILOSTAT, n.d.). In turn, efforts towards the formalization of the informal economy will provide more fiscal space for financing social health protection.

Moreover, the Basic Benefits Package of services needs to be streamlined and made more comprehensive to close existing coverage gaps between different population categories and services. The current segmentation of the BBP is not only detrimental to the objective of equity, it lacks also of clarity for beneficiaries. In addition, as the inclusion and exclusion of services in the BBP does not follow any established policies or procedures and is mainly ad-hoc in nature, a cost-benefit analysis and use of health technology assessment (HTA) methodologies for BBP design need to be introduced.

In order to expand social health protection coverage, further comprehensive reforms in the health sector are needed, not only through investments in infrastructure and human resources at the local level and increasing public health expenditures, but by also radically improving health care system management.[48] The Government already plans to further expand the use of existing eHealth systems, improve staff capacity, modernize health care institutions and introduce primary health care reforms. The goal is to increase coverage, ensure access to medical care, improve medical services and ensure financial protection of the population.

▶ 6. Main lessons learned

- Armenia's social health protection system is inadequate to provide acceptable financial protection to all. The population's high OOP payments, which the Government endeavors to reduce, limit equal access to health services, Moreover, the quality of provided medical services remains an issue. These challenges are mainly caused by insufficient funding, limited and outdated infrastructure and gaps in the availability of qualified personnel in rural areas. The digitalization of the health information system, which was initiated in 2017 and is gradually expanding, is an encouraging step.
- Since Armenia's social health protection system is largely dependent on state budget allocations, the low financial government budget flows into the health care system have adverse effects. Nevertheless, the Government is committed to identifying sustainable financial resources to cover the budget deficit.
- Despite the aforementioned challenges, Armenia has managed to maintain relatively good health indicators, including on life expectancy, and satisfactory levels of childhood vaccination and infant and maternal mortality rates.
- Universal legal coverage is a prerequisite but does not guarantee effective coverage for all, as observed by low coverage rates among the population. Countries wishing to reach universal health coverage need to take efforts to raise awareness on entitlements, expand financial protection for services included in the benefit package, as well as increase quality and acceptability of services.

[48] A positive step towards this was the adoption of a health care quality improvement strategy and an action plan developed by MoH in April 2022, which provides for the establishment of a central unit under the MoH responsible for coordination of activities related to quality of care across the country and the implementation of measurable quality indicators and their monitoring systems in all health facilities.

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Azerbaijan

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1. Introduction

Azerbaijan is an upper middle-income country with a population of around 10.2 million people as of 2022 (The State Statistical Committee of the Republic of Azerbaijan 2024). According to estimates, around 56.4 per cent of the population lives in cities and around 43.4 per cent reside in rural areas (UN Department of Economic and Social Affairs 2018). Following a deep recession from 1990-1999, rapid economic growth propelled by extensive oil and gas revenues was recorded from 2000-2011.[49] However, a sharp drop in the prices of oil from 2014-2015, as well as the impacts of the COVID-19 outbreak, caused economic growth to slow substantially and a stagnation of GDP. GDP per capita at purchasing power parity was 17,764 international dollars in 2022 according to World Bank data. Azerbaijan has a large informal economy, accounting for close to 50 per of the GDP (Bayramov et al. 2021; Valiyev 2020). Estimates suggest that in 2019, approximately 33 per cent of all workers were employed informally (Novruzov 2021).

A substantial reduction in poverty has been achieved since the early 2000s due to fast economic growth, with the poverty rate decreasing from close to 50 per cent in 2001 to around 6 per cent by 2012 (calculated at national poverty lines) (World Bank 2022c). In 2021 Azerbaijan's Human Development Index (HDI) was 0.745, ranking the country in 91st place globally (UNDP 2022).

Since the 1990s, notable improvements have been made in reducing the prevalence of maternal and infant mortality, yet the rates remain comparatively high (26 per 100,000 live births in 2017 and 16 per 1,000 live births in 2022) (WHO et al. 2019; World Bank 2022b). Simultaneously, between 2000 and 2019, there was a substantial increase in life expectancy at birth, from 64.9 to 73.1 years, according to the World Bank. Unfortunately, the outbreak of the COVID-19 pandemic has negatively affected health outcomes, bringing life expectancy down to 66.9 years in 2020 (The State Statistical Committee of the Republic of Azerbaijan 2024).

[49] The oil and gas industry makes a major contribution to the economy, accounting for close to 90 per cent of the country's total export revenues and more than half of the general government budget (60 per cent in 2018) (Bayramov et al. 2021; OEC, n.d.)

After independence, social health protection coverage for the population of Azerbaijan was limited, which impacted financial protection. Finally, after a series of structural reforms to health care provision organisation and a first pilot from 2017-2019, a Mandatory Health Insurance (MHI) scheme implemented by the Government was rolled out throughout the entire country and official data indicated 100 per cent coverage in April 2021 (The State Agency on Mandatory Health Insurance, n.d.-c). There are high hopes that this rollout will advance progress towards universal health coverage. In parallel, the MHI has facilitated further development of primary health care and allows for better provision of services for diagnosis and treatment of non-communicable diseases, which had become an increasing concern for the country.

▶ 2. Context

At the beginning of the 1990s, military conflict and mismanagement of the economy resulted in the collapse of public finances. The heavily reduced national budget could not support the relatively vast health care infrastructure of Azerbaijan. To mitigate the financial shortfall, health care providers turned to user charges, which were applied in state facilities as a general rule, with the exception of certain population groups [50] who were exempt from official payments (WHO et al. 2010). Increases to official OOP payments together with limited public funding were not sufficient to cover health care costs, leading to a growth in unofficial payments, including for services formally exempt from payments (WHO et al. 2010). Revenues of health care providers were not stabilised by the growing direct payments, because the utilization of health services was reduced due to the strain of the economic recession on the population and the high level of OOP expenses. In the late 1990s, efforts to break the vicious cycle of falling revenues, increasing OOP expenses, falling demand and falling revenues led to the adoption of a universal social health insurance scheme, initiated in 1999 with the adoption of the Law on Medical Insurance (Jafarova et al. 2021). However, its implementation was delayed due to the complicated political and economic environment, the high prevalence of informal employment, which was estimated at 58.3 per cent in 2001 (Novruzov 2021), and the inability of a large proportion of the population to contribute (Bayramov et al. 2021). As a result, the reform of the national health protection system occurred gradually.

In 2007, the Parliament established the State Agency for Mandatory Health Insurance (SAMHI). To prepare for the introduction of mandatory health insurance, the "National Concept on Health Financing Reform" was signed by the President in January 2008, defining a formal state-guaranteed basic benefit package of services. Following this, all services provided at public health facilities were supposed to be fully state funded. In parallel, the Government invested in the improvement and optimization of the health care system, including strengthening primary health care and improving the availability and regulation of health services (WHO et al. 2010). However, user charges are still applied for many specialist services and pharmaceuticals, thereby severely limiting financial protection. The combination of official user charges alongside unauthorised OOP payments contributed to an increasing prevalence of private health care financing. From 2016-2018, public health expenditure in Azerbaijan as a share of total health expenditure did not exceed 30 per cent (WHO, n.d.).

Indecision on how to deal with the public underfunding of the social health protection system and resulting low financial protection lasted almost two decades, until the Presidential Decree No. 765 of 15 February 2016, which saw Mandatory Health Insurance (MHI) finally launched as a pilot in two regions of the country (Mingachevir and Yevlakh). The SAMHI began to serve as an independent public entity for "accumulating revenues to finance medical services within the benefit package and acting as purchaser of these services" (The State Agency on Mandatory Health Insurance, n.d.-c). The scheme provides a package of basic and specialist health services to the population. In the following five years, the MHI was expanded to other regions and, although the COVID-19 pandemic slowed its rollout, it was extended to the entire country by April 2021 (Aiypkhanova 2021; Jafarova et al. 2021).

[50] Exempt groups include children, pensioners, students, military personnel and conscripts, women during pregnancy and postpartum, disabled patients, refugees and IDPs, those involved in national sports teams and prisoners.

▶ 3. Design of the social health protection system

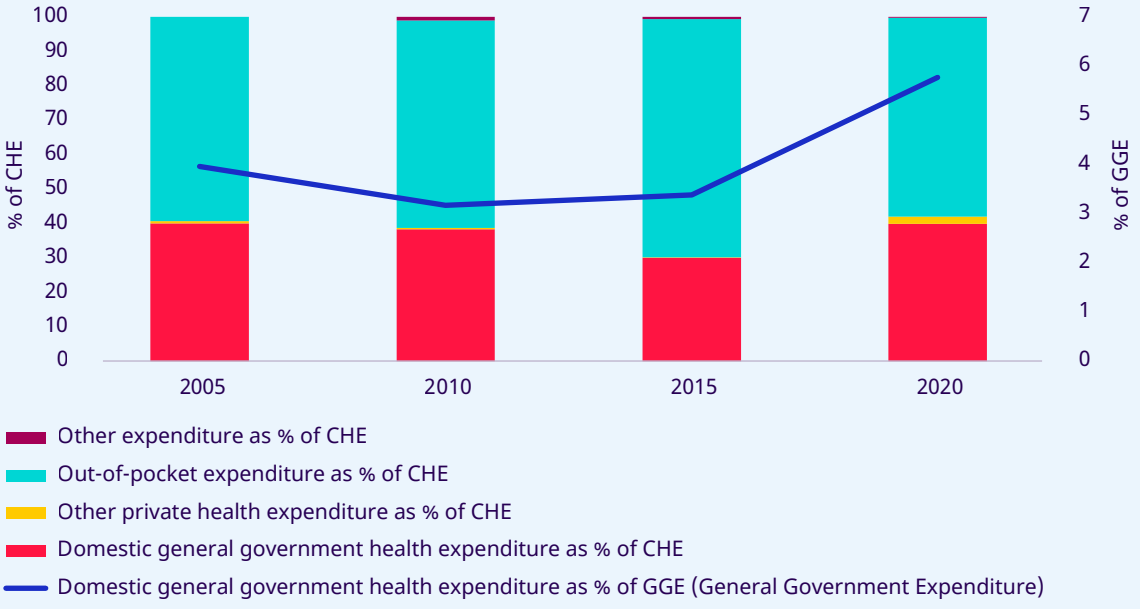
Financing

Since the 2000s, domestic general government health expenditure remained below 5 per cent of general government expenditure, indicating low prioritization of health in the national budget. Total government expenditure allocated to health in Azerbaijan stood at 3.9 per cent of general government expenditure in 2020 (or 1.6 per cent of GDP).

The tax-to-GDP ratio was 14.2 per cent in 2019 and social contributions represented 10.3 per cent of government revenue in 2021 according to World Bank estimates (World Bank, n.d). Notably, oil and gas revenues have played a significant role in financing social sectors in Azerbaijan (including social health protection and the health care sector). This constitutes a risk due to vulnerability to external shocks arising from oil price fluctuations (Garnett 2022).

Despite ongoing reforms and the gradual rollout of MHI since 2016, the latest available data indicates that OOP expenses remain the main source of health expenditure (see figure 31). In 2020, OOP payments accounted for around 65.2 per cent of the CHE, with the remaining 34.5 per cent covered through domestic general government health expenditure (WHO, n.d.). Based on this data, the share of OOP payments in CHE in Azerbaijan is greater than in most other countries in the region, and is two times higher than the average across upper middle-income countries (WHO, n.d.).

Figure 31. Composition of current health expenditure (CHE) in Azerbaijan, by source of financing, 2005-2020



Source: Based on data from the WHO Global Health Expenditure Database.

At the time of writing, national health account (NHA) data are only available for years prior to 2021. However, considering that the rollout of MHI was only completed in 2021, and that the collection of mandatory payments was postponed to January 2021, it is difficult to get a sense of the significance of the contribution of the newly introduced MHI to the reduction of OOP spending.

Since 2021, the majority of public financing of health is channelled via MHI. According to the law, the SAMHI should be mainly funded through social contributions, except for persons whose contributions are covered by the State budget. Payments are generally to be made on a monthly basis. In accordance with the Medical Insurance Law of Azerbaijan of 1999,[51] contribution rates are as follows:

- Two per cent of the salary for employers and for individuals performing works (services) on the basis of civil-law contracts for salaries of up to 8,000 Azerbaijani manat (AZN), or approximately US$4700 a month. Salaries above 8,000 manat are taxed by 0.5 per cent. For employed persons, MHI contributions are automatically deducted from the monthly salary amount and transferred to SAMHI (Jafarova et al. 2021).
- Four per cent of the minimum monthly wage for individuals (individual entrepreneurs, private notaries and members of the Bar Association) registered as taxpayers under the Tax Code, except in cases of temporary suspension of entrepreneurial activity or other taxable operations. Currently the monthly minimum wage in the country is 250 manat (US$147), for which the monthly contributions for MHI makes amounts to 10 manat (US$5.8). The payment has to be transferred by no later than the 15th day of the subsequent month. Penalties apply in case of non payment, including a fine of 30 per cent to 70 per cent of the unpaid amount (the payment of the insurance premium by a person who committed the breach for the first time exempts the person from administrative liability) (BM Morrison Partners 2021).

Unemployed persons and certain categories of self-employed persons were exempt from the obligation to pay MHI contributions until 1 January 2024, and the State has been paying on their behalf (BM Morrison Partners 2021; Jafarova et al. 2021).

According to the Law, the State also covers MHI contributions for the following categories of the population (Jafarova et al. 2021; The State Agency on Mandatory Health Insurance, n.d.-b):

- Children under 18;
- Students under 23 engaged in vocational education, secondary special education or full-time education in higher education institutions;
- Persons in military service;
- Persons receiving labour pensions in accordance with the Law No. 54-IIIG of 2006 on Labour Pensions (old age, disability, survivors);
- Persons appointed by the Parliament of Azerbaijan or any other public executive body with relevant mandate;
- Persons elected to paid office.

With the aim to provide social health protection to all residents, and taking into account difficulties in collecting contributions from the unofficially employed, fixed annual contributions (almost 100 manat) were paid from the state budget for all residents in 2023. The extension of a grace period until 2027 is under discussion among the Government.

Other sources of funds for the SAMHI include excise taxes from gas, alcohol and tobacco products, which are levied through the general tax directorate. Revenues of the MHI approved for the year 2023 are presented in table 6.

[51] Law No. 725-IQ of 28 October 1999 on Medical Insurance, available at: https://www.ilo.org/dyn/natlex/natlex4.detail?p_isn=64874&p_lang=fr

▶ Table 6. Revenues of the MHI approved for 2023, mil AZN (as of 2023, US$1.00 = ANZ 1.7)

Type of revenue	Amount, mil. AZN	Share % of MHI revenues
Allocations from the state budget	1 264.8	52.8
• Mandatory medical insurance of the population at the expense of the state budget	1 134.1	47.4
• Funds allocated to government programmes and measures in the field of health	129.7	5.4
Insurance contributions paid by the employer and the employee for mandatory health insurance	764.7	32.0
Duties on import and domestic consumption of automobile gasoline, diesel fuel, liquid gas, excise duties on alcoholic beverages and tobacco products	122.3	5.1
Other revenues	26.5	1.1
The amount allocated from the unused funds of the mandatory medical insurance fund in previous years to the expenses of the current year	215.9	9.0
Total	**2 393.2**	**100**

Source: Decree No. 1949 of the President of the Republic of Azerbaijan, dated 30 December 2022.

Governance

The Ministry of Health of the Republic of Azerbaijan oversees the overall functioning of the health system, develops and implements relevant public health interventions and programmes, sets standards, develops guidelines and monitors health care delivery and health outcomes.

The MHI is governed by the Law on Medical Insurance of 1999 and the subsequent amendment of 2018 (Law No. 1441-VQD),[52] which provide the legal basis for social health insurance in Azerbaijan (Jafarova et al. 2021) . In addition, Decrees No. 1125 of 24 November 2016 and No. 1592 of 6 September 2017 of the President of the Republic of Azerbaijan institutionalize and regulate the SAMHI, the legal entity under public law responsible for implementing and managing the insurance scheme (The State Agency on Mandatory Health Insurance n.d.-c). Finally, Decree No. 418 of the President of the Republic of Azerbaijan institutionalizes the Administration of the Regional Medical Divisions (TABIB) responsible for management and supervision of medical facilities involved in the provision of health care services under the MHI (The State Agency on Mandatory Health Insurance, n.d.-d).

Under the existing framework, the SAMHI is the dedicated public legal entity for the implementation of the MHI and has the following goals (The State Agency on Mandatory Health Insurance, n.d.-c):

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

[52] Further amendments include Decree No. 520 of the President of the Republic of Azerbaijan on the Statute of the State Agency for Mandatory Health Insurance, dated 7 February 2019; and Decree of the President of the Republic of Azerbaijan on Measures to Ensure Implementation of Mandatory Health Insurance in the Republic of Azerbaijan, dated 20 December 2020.

The SAMHI manages the purchase of services according to the needs of MHI beneficiaries and acts as an independent body that reports to the Cabinet of the Minister of the Republic of Azerbaijan (Jafarova et al. 2021). The SAMHI has representation in all regions of the country through its eleven branches that coordinate the implementation of the MHI locally.

TABIB is the second major public entity involved in the management of health services. Following the reform, it assumed the responsibility for management of most of the public medical facilities which were previously under the supervision of the Ministry of Health (highly specialised providers of tertiarily level services remained under the MoH) (Jafarova et al. 2021). The Supervisory Board of TABIB is appointed by the President of the Republic of Azerbaijan and consists of the Chairman of the Board of the SAMHI, the Deputy Minister of Health of the Republic of Azerbaijan, the Deputy Minister of Labour and Social Protection of the Population of the Republic of Azerbaijan, the Deputy Chairman of the Board of the State Agency for SAMHI, and the Health Workers Trade Union. The current management of TABIB's activities is carried out by the Executive Director appointed and dismissed by the Supervisory Board of TABIB and the Executive Director's three deputies.[53]

The division of functions between the SAMHI and the newly created organization – TABIB – has been underway since March 2023. The ongoing reform risks duplicating the functions of SAMHI and TABIB and may lead to uncertainty for health care providers regarding the respective roles played by the Ministry of Health, SAMHI and TABIB.

Statutes of TABIB were approved by the Decree of the President of the Republic of Azerbaijan, dated 1 May 2023, and describe TABIB activities as follows:

- Carry out the management and control of the activities of medical institutions;
- Ensure the quality and availability of medical services provided in medical institutions;
- Ensure the coordination of the activities of medical institutions;
- Ensure the improvement of the quality of medical services provided in medical institutions and the adaptation of these services to modern requirements.

TABIB is very strongly engaged in the management of providers, deciding on recruitment of managerial matters, purchasing most of the supplies and undertaking planning for investments. However, increasing the autonomy of hospitals is under consideration.

Legal coverage and eligibility

The universal right to protection of health is enshrined in the Constitution of Azerbaijan.[54] Article 41 (I) states that "everyone has the right to protection of his/her health and to medical assistance." Furthermore, under article 41(II) the Government has the obligation to promote access to health care services and health insurance: "The State takes all necessary measures for development of all forms of health services based on various forms of property, guarantees sanitary-epidemiological safety, and facilitates various forms of medical insurance."

According to the Law on Medical Insurance, the MHI scheme applies to all citizens of the Republic of Azerbaijan, including foreigners who officially reside in the country (permanently or temporarily) and whose salary originates from the Republic of Azerbaijan, foreigners and stateless persons who are granted refugee status in the Republic of Azerbaijan, as well as stateless persons under the protection of the Office of the UN High Commissioner for Refugees (Jafarova et al. 2021). These categories of the population have to pay contributions to the MHI scheme (The State Agency on Mandatory Health Insurance, n.d.-c). Foreigners temporarily residing in the country with health care needs are covered for emergency care.

The MHI does not apply to detainees or persons serving prison sentences (with the exception of persons serving sentences in correctional institutions of precinct type), or stateless persons without official status (ICMPD and MOBILAZE 2018). The prison population in most cases receives health care provided by the

[53] Decree of the President of the Republic of Azerbaijan dated May 2022, available (in Azerbaijani) at: https://its.gov.az/page/tabib
[54] The Constitution of the Republic of Azerbaijan of 1995, available at: https://www.stat.gov.az/menu/3/Legislation/constitution_en.pdf

health system under the Ministry of Justice. Services for detainees and prisoners that are provided by public health care institutions are financed by the SAMHI, according to an agreement between the SAMHI and the Ministry of Justice.

In line with the Health Insurance Law, workers in the informal economy should be enrolled when they fall under the category of individuals registered as taxpayers, and their mandatory contribution is then set at a fixed rate of 4 per cent of the official minimum monthly salary (Bonilla-Chacin et al. 2018). For others, voluntary affiliation to the MHI is possible; however, proof of identity is necessary in compliance with existing national regulations. The percentage of workers in the informal economy that are paying MHI contributions is very low. With the aim to extend social health protection to all residents, and taking into account the difficulties in collecting contributions from the unofficially employed, the State budget pays fixed annual contributions (almost ANZ 100) for all residents. Policies to increase tax compliance are currently under discussion.

Benefits

At the initial pilot stage, the MHI covered 1,829 medical services as part of its benefits package (The State Agency on Mandatory Health Insurance, n.d.-c). In 2020, the Cabinet of Ministers passed a Resolution (No. 5 of 10 January 2020) which increased the number of services to around 2,500.

The benefits package is explicitly defined and currently includes the following categories of services (The State Agency on Mandatory Health Insurance, n.d.-c):[55]

- Emergency (including ambulance services);
- Primary health care (family physician);
- Outpatient services;
- Inpatient services;
- Instrumental diagnostics;
- Physiotherapy;
- Laboratory;
- Pregnancy and delivery;
- Urgent vaccinations;
- Scheduled child vaccinations;
- Surgeries;
- Specialised long-term health care.

Persons affiliated with the MHI can immediately access the MHI benefit package. No official co-payment is imposed on services provided by public health care institutions that are on the Positive list, yet private health institutions may charge patients above the price agreed with the SAMHI. Extra charges are covered by OOP payments or, very rarely, private health insurance, the latter supporting only around 1 per cent of the population.

Certain health needs are addressed under specialized publicly funded national programmes, rather than through the positive list of health services. The management of tuberculosis, AIDS and diabetes are examples of public health programmes whereby health services and medicines (inpatient and outpatient) are covered. Lists of medicines that are financed by national programmes are determined by the Ministry of Health annually. Each of the programmes has a special budget fixed by the Ministry of Finance and administered by the SAMHI.

The benefit package does not cover most dental services, organ transplantation, cosmetic procedures or plastic surgery. Medicines other than those provided during inpatient treatment and/or covered by publicly-funded national programmes are also excluded (The State Agency on Mandatory Health Insurance, n.d.-b). This is a significant limitation to financial protection since a sizable share of OOP payments is associated with medicines.

The benefit package is reviewed on a regular basis in close consultation with the MoH. However, there is no clear agreement on the division of responsibilities between the Ministry of Health, the SAMHI and

[55] Full list of services is available (in Azerbaijani) at: https://its.gov.az/page/benefits-package-1

TABIB with regard to the design and approval of the benefits package. The current benefit package is designed according to the clinical practice in Azerbaijan, but officials at the SAMHI have begun to look into international practices in cost-benefit analysis, health impact assessment and health technology assessment.

Maternity and sickness benefits are available under a social insurance scheme for workers residing in Azerbaijan, including self-employed persons, members of collective farms, landowners and foreign citizens. The maternity benefit is equal to 100 per cent of the average gross monthly earnings of the insured in the last 12 months, for 70 days before and 56 days after the expected date of childbirth. The sickness benefit is equal to 60 -100 per cent of the insured's average gross monthly earnings in the last 12 months (depending on the length of total employment years) for up to six months in a calendar year (ISSA 2021).

Provision of benefits and services

Under the MHI, health care services can be sought at any local health facility registered with TABIB. Such facilities include primary health facilities, clinics, secondary and tertiary hospitals, as well as specialized medical institutions (research institutes, laboratories, and so on) and are available in all districts of the country – the full list is accessible on the official SAMHI website and is regularly updated as new facilities become registered.[56] Currently, the freedom to choose provider is limited by integrated health care provision. Most municipalities (rayons) have one health care provider/public hospital with units providing inpatient and outpatient services at primary and secondary level. If a particular service cannot be accessed from the local health care facility registered with TABIB, patients are referred to another appropriate health care provider contracted by the SAMHI.

The MHI requires a referral procedure for accessing specialized medical services. All beneficiaries are advised to register with a family doctor (beneficiaries have the right to choose family doctors within the limits of the local health system capacity) by submitting an application and a copy of their identity card at a local public primary health facility. The regulation prescribes that family doctors are the first point of contact for MHI beneficiaries (except in emergency cases), whereby patients are referred for further diagnosis/care after an initial consultation, but there is no strict enforcement of this regulation (Garnett 2022). Patients may choose to access health services directly (bypassing consultation with family doctors), which has not resulted in the imposition of a co-payment or other sanctions since the end of the MHI pilot phase (2018-2019) due to equity concerns, difficult administration and COVID-19. Co-payments (5 manat or US$3 per visit) for services with no referrals will be reintroduced in 2024, according to information provided by the SAMHI.

Public health institutions are predominant in most regions with the exception of the capital city, Baku. The Azerbaijani Government is trying to strike a balance between the development of public and private hospitals by pre-authorization of referrals to private hospitals. The pre-authorization by SAMHI of a referral to a private hospital is a precondition for the reimbursement of the service by MHI. Limitations of public institutions in providing the service in question is the main criterion for pre-authorization. No caps exist for MHI paid services pre-authorized by SAMHI. There are plans to introduce strategic purchasing of health services that may transform contractual relations between the SAMHI and providers based on case-by-case decisions (World Bank 2022a).

For certain types of services, waiting periods may apply. The existing regulations mandate that the duration of the waiting period is (The State Agency on Mandatory Health Insurance, n.d.-b):

- No longer than 14 days from the date of referral issued for specialized outpatient care;
- No longer than 14 days from the date of referral issued for instrumental diagnostic and laboratory examinations;
- No longer than 20 days from the date of referral issued to the insured person for scheduled inpatient care, except for cochlear implantation and intra-articular endoprosthesis replacement.

[56] An exhaustive list of medical facilities registered with TABIB is available (in Azerbaijani) at: https://its.gov.az/files/17/TEBIB%20SIYAHI-%20yeni.pdf

In emergency cases, medical care is provided immediately according to the medical indications (The State Agency on Mandatory Health Insurance, n.d.-b).

The SAMHI uses the following payment mechanisms for the facilities under TABIB: flat rate capitation for primary care (incorporating performance-based elements), fee-for-service for secondary level outpatient care, per case payment for inpatient care and budgeting. Currently, funding from the SAMHI covers the difference between the budgeted amount and transfers accounted according to the scope of service delivery. The introduction of age-adjusted capitation for primary health care and diagnostic-related groups (DRGs) for inpatient care, as well as reduced reliance on subsidies, are considered to be likely developments in the future.

An official licence issued by the Ministry of Health is a precondition for contracting health care providers (public and private). Services included in positive lists are reimbursed according to prices fixed by the Cabinet of Ministers.

All private health care providers are eligible to have contracts with the SAMHI but some do not express an interest in doing so or fail to present invoices after concluding the general contract. Case-by-case pre-authorisation of services and relatively low prices used by the SAMHI are the main causes of reluctance among private providers to engage with MHI.

As of 2023, annual contracts between the SAMHI and public providers include general information and the annual budget. The budget is executed regardless of the number of services provided during the year. Strategic purchasing of services that may include mutually agreed upon mid-term objectives, as well as the scope and structure of services to be provided during the year, are currently under discussion. Piloting of strategic purchasing may start in 2024.

▶ 4. Results

Coverage

Since 2021, the MHI scheme has been implemented throughout the entire country (The State Agency on Mandatory Health Insurance, n.d.-c). Until 2024, the MHI scheme cover all permanent residents of the country, since the law provided for the inclusion of residents that should pay but are currently not paying MHI contributions. The separation of payment of contributions from access to services is under discussion.

Based on existing regulations, affiliation is automatic and immediate for the following groups (Jafarova et al. 2021; BM Morrison Partners 2021; The State Agency on Mandatory Health Insurance, n.d.-c):

- All salaried workers in Azerbaijan (citizen and foreigners);
- All persons registered as taxpayers in Azerbaijan;
- Those who are paying contributions;
- All persons who are exempt from paying MHI contributions and whose contributions are covered by the State.

In practice, anyone with personal identification documents should be able to access health services.

Therefore, official information suggests near universal population coverage. However, coverage might be limited for the following reasons:

- According to the latest available estimates, there were over 250,000 migrants in Azerbaijan in 2019 and around 5,771 refugees in 2023 (United Nations population division 2020; UNHCR 2023). The total international migrant stock is relatively small compared to some other countries in the region and has been declining in recent years. It is estimated that immigration to Azerbaijan is largely driven by labour migration (ICMPD and MOBILAZE 2018). However, the process of obtaining work permits might be challenging for some migrants in view of quotas.

- There have been reports of irregular migrants in the country. In 2016, more than 26,000 cases of illegal stays in Azerbaijan were registered (ICMPD and MOBILAZE 2018). Additional research is needed to obtain precise knowledge and to fine tune polices related to health problems caused by irregular migration.
- In addition, there might have been a spike in the number of displaced persons as a result of the recent conflict in Nagorno-Karabakh. It is not clear what measures have been put in place by the SAMHI and other relevant institutions to ensure that there are social health protection mechanisms accessible to these people.

There is no official register of those insured by MHI in Azerbaijan. The reasons for the decision not to proceed with such a register are as follows:

- Given the size of the informal economy, it might be challenging to ensure registration of all eligible persons (Bonilla-Chacin et al. 2018). Data also indicates that only about one in five economically active people were registered as taxpayers in 2019 (Valiyev 2020), which is the condition for mandatory affiliation (for those who are not employees).
- The existence of a grace period implies that national documents of personal identity may serve the purpose of identification of eligibility to receive benefits provided by MHI. The assumption is that the entire (10 million+) population of Azerbaijan is covered by MHI (as of 2023).
- The SAMHI has online access to national registers of the population.

Adequacy of benefits/financial protection

Prior to the introduction of the MHI, the population of Azerbaijan incurred high financial costs for accessing health services, which placed financial pressure on households, exacerbated the risk of poverty and discouraged health care utilization. A population survey conducted in 2015 revealed that households spent on average 12.5 per cent of their consumption on health, with as many as 23 per cent of households reporting catastrophic health expenditures (Bonilla-Chacin et al. 2018). A major share of these costs was associated with pharmaceuticals, laboratory exams and payments to health care personnel (both formal and informal) (Bonilla-Chacin et al. 2018). The Ministry of Health, in cooperation with WHO, started implementing a project on a National System of Health Accounts (SHA) at the end of 2022.

The MHI has already reduced informal payments and increased utilization of health services but there is more to be done. The country still needs to substantially increase the number of outpatient visits and admissions to hospitals. During the piloting of MHI from 2017-2020 and the initial phase of the national MHI rollout from 2021-2022, the SAMHI and TABIB aimed at the reduction of informal OOP payments by increasing public health financing and upgrading the operational capacities of health care providers. This included the development of the national IT system, upgrading of labs and purchasing of ambulances. Given that the impact of these investments was reduced by COVID-19, the growth of service consumption and productivity of the health sector remain among the main objectives of the country.

During the height of the COVID-19 pandemic, there were reports suggesting that health providers (both public and private) use bureaucratic barriers to artificially complicate access to free services for patients and take direct payments to facilitate admission to health facilities (Jafarova et al. 2021). There were also cases of illegal restrictions on the provision of MHI services imposed by private hospitals and administrative complications in streamlining the referral process (Jafarova et al. 2021). While the situation might improve in the future as the MHI practices gradually become the new norm, there is a risk that the MHI may struggle to resolve the underlying issues that cause the high prevalence of informal payments in health – low salaries of health care workers and suboptimal quality of management of health care providers (Bonilla-Chacin et al. 2018).

While it is too early to draw definitive conclusions from the MHI introduction, an initial assessment revealed the persistence of informal payments for MHI covered services (Baku Research Institute 2022).

On the positive side, the benefits package includes a broad range of medical services that are of high relevance to the needs of the population. Over 730 laboratory services, 950 surgical services, 500 outpatient services and 250 inpatient therapeutic services are included (The State Agency on Mandatory Health Insurance, n.d.-a). Many of these services are important for the prevention, management and clinical treatment of NCDs, which are of growing concern to the population.

However, the current package does not cover the cost of medicines (except for medicines provided as part of inpatient services and outpatient medicines covered by national health programmes) which has been the major driver of OOP health spending among the population. According to 2015 survey data, up to 80 per cent of OOP spending is associated with the purchase of pharmaceuticals (Bonilla-Chacin et al. 2018). While outpatient medicines for the most vulnerable are supposed to be provided free of charge through targeted social assistance and health promotion programmes, data suggests that these medicines are rarely accessed at no cost to patients. Similarly, as private providers are allowed to charge above the price that is reimbursed by the SAMHI, this extra charge can be substantial. Such arrangements can potentially create dual systems.

Responsiveness to population needs

Availability and accessibility

According to the WHO, the UHC service coverage index was 65 in 2019, compared with 43 in 2000. However, it remains below the average index of 77 for upper middle-income countries in 2019, and the CIS average of 71. Skilled birth attendance was 100 per cent in 2020, which reflects the progress made in maternal and child health over the past two decades.

Following the rapid growth of the national economy driven by oil revenues, significant investments were made in health care infrastructure. Between 2005 and 2015, some 600 health facilities were upgraded or renovated, and a number of new regional hospitals were built (Bonilla-Chacin et al. 2018). However, primary health care facilities – which should be the first access point for patients under the MHI – remain underdeveloped in many rural areas of the country (Vatansever et al. 2020).

A shortage of qualified health personnel (physicians) also poses a challenge and was reported to have recently worsened due to the combined impact of low salaries and retired physicians not being replaced (Vatansever et al. 2020). Indeed, the country experienced a significant drop in the number of health staff nationwide between 1991 and 2020. The number of nurses and midwives halved from 11.3 per 1,000 people to only 5.5 per 1,000 persons, and the number of physicians fell from 3.8 to 3.2 per 1,000 persons (The State Statistical Committee of the Republic of Azerbaijan 2024). The country needs to consider increasing the training of medical professionals to cope with an ageing population and improve the quality of health services.

According to national statistics, the number of hospital beds in the country gradually decreased from 99.9 to 38.8 per 10,000 inhabitants between 1991-2022 (The State Statistical Committee of the Republic of Azerbaijan 2023). The considerably high number of hospital beds strained the health system, given low bed occupancy rates of 25-30 per cent (WHO et al. 2010). The old model of health care financing implemented during the Soviet era, in which funds were allocated based on historical expenditure and the supply of beds and health workforce spending, has been replaced by a model that meets the needs of the population. This shift implies improved efficiency in the use of medical resources (Garnett 2022). Hospital capacity was reduced from 10 to 4.8 in 2014. The decrease corresponds to the reduction of the average length of stay (ALOS), but the considerable gap in terms of availability and quality of health services between the capital and remote areas of the country, with most tertiary-level facilities still located in Baku, is of concern (Bonilla-Chacin et al. 2018; Jafarova et al. 2021).

National statistics report higher infant mortality in urban compared to in rural areas (The State Statistical Committee of the Republic of Azerbaijan 2022). Difficulty in identifying place of residence is one of the main reasons for this pattern, which contradicts international practice. The quality of health statistics needs to be improved to better understand such regional health inequalities.

The higher nurse to physician ratio in rural areas compared with the capital is an indication of regional efforts to reduce regional health inequalities. For example, a hospital department providing invasive cardiology was opened in the south of the country (Lankaran region) in January 2023. There are no medical universities outside the capital of Baku. The decentralization of medical training may be considered a tool to increase equity in the country.

The implementation of MHI has already contributed to the growth of provided services and the productivity of the sector (The State Agency on Mandatory Health Insurance 2021). Prior to the MHI

introduction, health care underutilization had been reported as a challenge in Azerbaijan, particularly in rural areas (Footman et al. 2013). Indeed, outpatient contacts amounted to only 4.7 per person per year in 2017, which is well below the average of seven per person among countries of the Commonwealth of Independent States in 2020 (WHO Europe 2023). The shortage of medical personnel, financial barriers due to high levels of formal and informal co-payments, low quality of services caused by underfinancing of health care, and the lack of financial incentives to increase productivity are reasons for underutilization (Vatansever et al. 2020). This has consequences for health care access patterns, such as seeking health services in foreign countries (for example in Israel, Russia and Türkiye) (Safarova 2016).

According to the SAMHI, utilization of health services has already increased since the MHI rollout. In 2021, 4,053,636 citizens benefited from medical services in the medical facilities where MHI was applied, 25 per cent of whom were children (0-17 years old). An increase in the surgical activity of medical institutions was also observed; compared with 2020, inpatient surgical operations in 2021 increased by 10 per cent (The State Agency on Mandatory Health Insurance 2021). The increase in utilization continued in 2022 as MHI transactions replaced OOP payments and demand for health services grew (see table 7).

▶ Table 7. Services covered by MHI in Azerbaijan

№	Indicators	2021	2022
1	Population	10 130 114	10 156 400
2	Number of visits to the doctor, including preventive visits	21 694 189	27 666 955
3	Inpatient admissions	413 284	464 115
4	Average length of stay in hospitals, days	6.2	5.1
5	Number of surgical operations	127 539	179 199

Source: The State Agency on Mandatory Health Insurance 2022

In the future, the implementation of proper services utilization assessments (by age, gender, region and social group) would be desirable to understand trends and patterns of health care access under SAMHI.

Quality and acceptability

The quality of services is also affected by the shortage and under-qualification of health care personnel, which is closely linked to the underfunding of health care. The quality of health services has been identified as a problem, partly due to weak regulation and protection of patients' rights. Medical errors occur quite often, and there is a lack of medical advocacy, which makes it difficult to adequately protect patients from mistreatment, medical negligence or discrimination (Jafarova et al. 2021; Vatansever et al. 2020). Observers note that there is currently no position on the protection of patients' rights held by either the SAMHI or TABIB, and that the Appeal Council under the SAMHI does not seem to monitor the protection of patients' rights (Jafarova et al. 2021). In 2020, the Cabinet of Ministers adopted rules for examining the quality of medical services, but these rules do not make direct reference to patients' rights and almost exclusively focus on medical services (Jafarova et al. 2021). The absence of appropriate legal and administrative mechanisms for the protection of patients' rights can have a negative long-term impact on the acceptance of formal health care procedures among MHI beneficiaries and can perpetuate the practice of informal payments to doctors and self-treatment.

56 per cent of individuals expressed satisfaction with the health system in Azerbaijan in a 2013 study (Footman et al. 2013). However, a study that examined the relationship between the quality of public health services and willingness to pay higher taxes for health care highlighted the negative effects of informal payments (Habibov et al. 2019).

Licensing of health care providers is the responsibility of the Ministry of Health. Licensing is mandatory for public and private health care providers. The Government realizes the need to improve the quality of

health care provision and is planning to establish an autonomous agency for the accreditation of health care providers (Mehman 2024).

Over the last 30 years, the share of the child population has substantially reduced, while that of the elderly population has increased (Verdiyeva 2019). The ageing of the population is transforming health needs, from paediatric and obstetric care to NCD care. The development of long-term care in institutions and at home is one of the challenges facing the health care system. At the same time, the development of long-term care represents an employment opportunity for the Azerbaijani population.

▶ 5. Way forward

With the MHI rollout completed throughout the country, Azerbaijan has taken an important step towards extending legal population coverage. Nonetheless, more data will need to be gathered to ensure that no population groups are excluded from effective coverage, including the informal sector. In addition, to ensure that the benefits of the MHI are maximized and equally shared, a range of additional further measures need to be considered.

Azerbaijan lags behind most EU countries as well as neighbouring countries (Kazakhstan, Russia and Türkiye) in terms of health service utilization. However, the country has the human resources (doctors and nurses) and physical infrastructure (hospitals and outpatient clinics) to raise the level of health care provision to that of neighbouring countries. The piloting of health financing reform in Mingachevir and Yevlakh has provided evidence that in just two years (2017-2018), service utilization can increase by up to 30 per cent. The strategic plan of the SAMHI for the period 2022-2024 includes goals to increase the number of annual outpatient visits from 3.8 in 2020 to seven in 2024. Hospital discharges are also set to increase.

The next couple of years are likely to serve as a test of MHI's financial sustainability. A large proportion of insurance contributions are currently subsidized by the State budget, and the MHI contribution rates are comparatively low (Bonilla-Chacin et al. 2018). The benefit package is quite comprehensive, which might imply significant expenditure if the demand for and supply of services increase. Azerbaijan will likely be confronted by the necessity to increase the contribution rate or subsidies from the state budget, or both. The partial substitution of OOP payments by public financing channeled via MHI is an important element of social health protection reform in Azerbaijan.

Furthermore, even if the resources are growing and the gap between needs and supply is closing, there is still a risk that the financial protection of the population will remain insufficient, as MHI does not cover the cost of outpatient medicines, and irregular health care practices persist, including informal means of accessing services, illegal co-payments and self-medication with antibiotics. Many of these issues are due to broader systemic issues, such as insufficient quality of services, gaps in availability, shortage of qualified personnel, low trust in health care providers and lack of mechanisms to protect patients' rights. These problems are in turn closely linked to the issue of health system underfunding, which the MHI seeks to resolve.

The country is focused on reducing financial barriers in accessing health care, yet it has so far not focused on whether the benefit package responds to the epidemiological profile of the country, which also impacts financial protection. The international community may assist the Ministry of Health, the SAMHI and TABIB in the development of skills needed to apply modern tools necessary for optimal priority setting and allocation of health resources (such as health technology assessment, health impact and cost-benefit analysis).

In addition to necessary increases in tax-based funding, increasing the progressivity of MHI contribution rates is necessary to ensure SAMHI sustainability. However, this redesign should be informed by willingness and ability-to-pay studies, to ensure beneficiaries' uptake.

MHI provides an opportunity to enhance the efficiency of health care by applying output-oriented pricing, contracting and remuneration of services. Development of these techniques, including strategic purchasing, is under way and expected in MHI management starting from 2024. The empowerment of public health care providers to make the majority of managerial decisions provides an opportunity for sustainable progress.

The shortage of the health care workforce must be mitigated by increasing the training of doctors and nurses as well as increasing recruitment of technical professionals. Long-term planning for personnel is needed to cope with population ageing and growing expectations of the population regarding the quality of health services. Moreover, given that most tertiary services are currently concentrated in Baku, regional health inequalities should be tackled through partially deconcentrated provision of health services, and efforts must persist to assure accessibility of health services within the limits of the "golden hour" of treatment.

Strengthening the regulatory framework around patients' rights and redressal mechanisms regarding the MHI administration is another important measure that could be taken. Appropriate guidance and legal provisions could be adopted, and dedicated bodies could be created within the SAMHI and TABIB to oversee and monitor relevant activities in this area (Jafarova et al. 2021).

▶ 6. Main lessons learned

- The design of MHI management, with a separate agency (TABIB) managing providers of health services is an important innovation that might improve the management of health providers and ultimately the level of service quality.
- With significant budgetary contributions to the MHI scheme, there is a risk that it could become excessively reliant on government funding, which is vulnerable to external shocks from fluctuations in oil prices. A review of contribution rates, including introducing progressivity and careful consideration of willingness- and ability-to-pay of beneficiaries, could be considered.
- Financial stability and sustainability of the MHI also depends on the prioritization of health in the Government budget. In addition to the potential revision of contribution rates, alternative financing sources can be considered. Additional funding sources could include excise taxes on products that are known to have health-harming effects. However, more information is needed on the potential regressive nature of these sources in Azerbaijan.
- The introduction of social health insurance schemes should be accompanied by measures aimed at strengthening the performance of the health system at large. While in the case of Azerbaijan substantial investments were made in improving the health care system prior to the rollout of the MHI, these investments fell short in resolving some of the systemic weaknesses that undermine the uptake and the impact of the MHI while leaving the population vulnerable to a range of health and financial risks.
- The persistence of deficiencies in the quality, regulation, and provision of health services also impacts the public perception of the value of the MHI and perpetuates the issue of OOP payments (for example, through informal payments to health workers).

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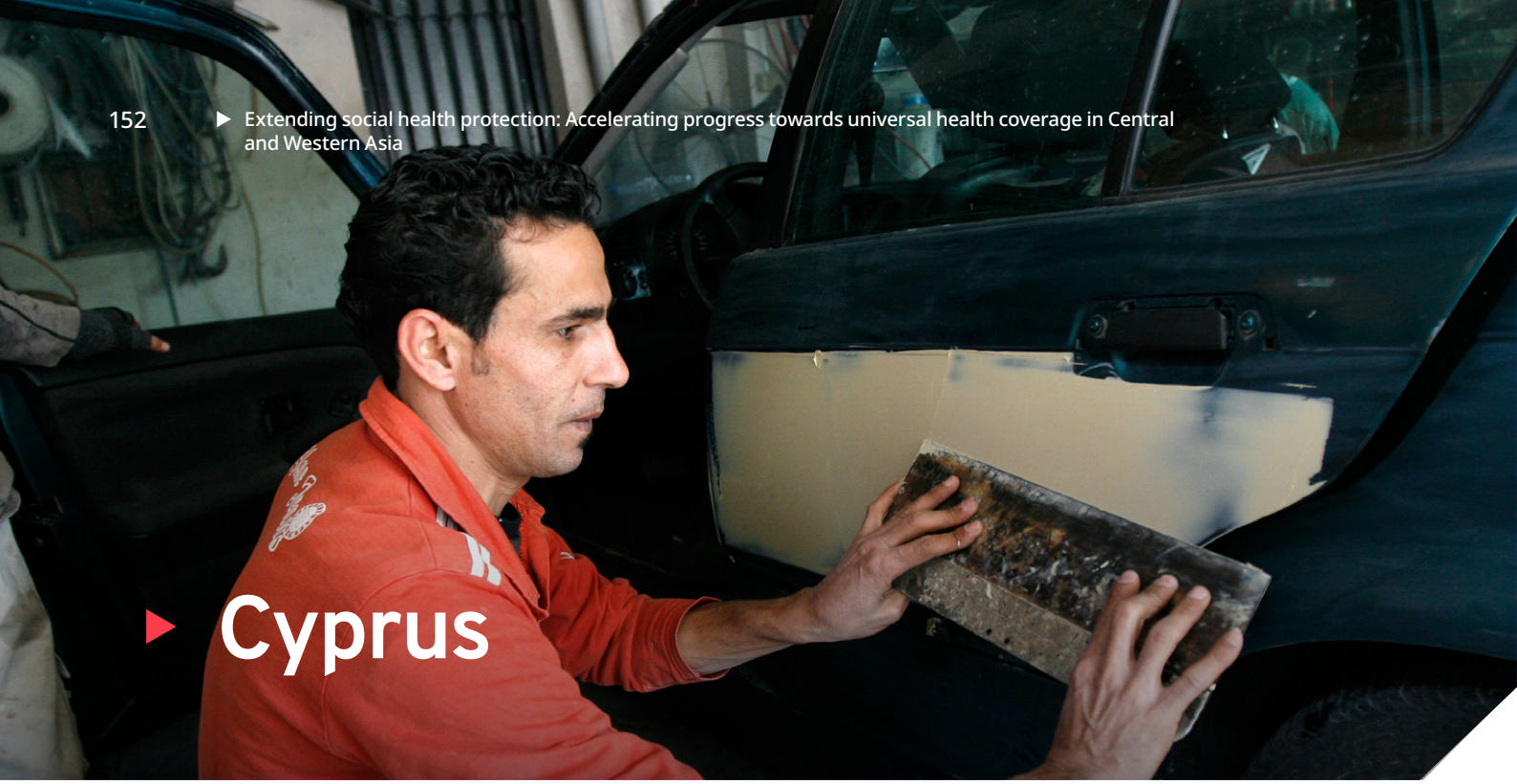

Cyprus

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1. Introduction

The Republic of Cyprus is an island state located in the eastern-most part of the Mediterranean Sea, with a population of less than a million (Eurostat 2023). In 2021, two thirds of the population lived in urban areas, with minimal demographic changes since 2011 (Press and Information Office, Ministry of Interior, Republic of Cyprus 2023). The island enjoys a strategic location that connects Europe, the Middle East, Northern Africa and Asia, situating it as a regional business centre. Cyprus has a high Human Development Index (HDI) of 0.896 in 2021 and a GDP per capita of US$32,048 in 2022, which is 2.44 times higher than the average among countries in Central and Western Asia (CWA) and slightly lower than the EU average (World Bank 2022; UNDP 2022).

Cyprus has experienced robust economic development in recent decades, fostering investment in social policies, including health care. However, the trajectory of economic growth has changed. Notably, Cyprus was heavily affected by the global economic recession which led to an economic decline from 2009-2014, during which the Government introduced austerity measures, including for the health care system. Despite experiencing a brief recovery phase from 2015-2019 with a 5.3 per cent growth increase, in 2020, as a result of the COVID-19 crisis, another decline of 5.2 per cent in real GDP occurred (ILO 2022; Kontemeniotis and Theodorou 2021).

Historically, Cyprus has allocated a small share of GDP to health, relying heavily on private spending on health through OOP payments (Kontemeniotis and Theodorou 2021). In 2019, the Government of Cyprus launched a new reform of the national health care system named the General Health Care System (GHS), which has unified a previously fragmented system consisting of two parallel and uncoordinated sectors: a for-profit private sector and a heavily regulated public sector (Petrou 2021). The new reform aims to provide equitable access and improved financial protection for all legal residents in Cyprus.

▶ 2. Context

The foundation of the current social health protection system in Cyprus began in the early 1990s, driven by the Government's initiative on the establishment of a universal health coverage system free of charge at the point of service. This effort resulted in the adoption of the General Health Insurance law [57] endorsed by parliament in 2001, outlining the GHI scheme (GHIS) reform. Despite the establishment of the Health Insurance Organization (HIO) in the same year as a public entity to manage the GHIS fund, little progress was made in terms of the operationalization of the reform. In 2012, the Cyprus Cabinet restated its commitment to the reform in accordance to the recommendations of the European Commission, emphasizing the significance of implementing SHP reforms based on a roadmap that ensures UHC delivery in a financially sustainable manner (Cylus et al. 2013).

Until 2019, the Cypriot national health service system faced numerous challenges, including limited range of services and co-payments, which increased households' reliance on the private health sector. Additionally, inadequate coordination between public and private sectors resulted in inefficient capacity for planning in terms of human resources and infrastructure. The situation was further worsened after the financial crisis in 2013, with a wave of health care professionals leaving the public sector. This led the Government to sign a memorandum for a public sector recruitment freeze until 2016 (Petrou 2021). Before the reform, health care services were provided through the public sector via a network of large district hospitals, small rural hospitals, health centres and rural subcentres. Medical services were also provided through the private sector, consisting of private hospitals, clinical units and hundreds of physicians in private practices, and a considerable share of such expenses were covered OOP by households, which significantly limited equity in access (WHO 2012; 2018).

In 2017, an amendment of the GHIS law was passed, shaping the organization of the provision of health services in the national health system. Furthermore, another structural reform took place aimed at implementing a provider-purchaser split, which led to the establishment of the State Health Service Organization (SHSO), a separate entity from the HIO. Under the new system, the Ministry of Health (MoH) assumes a regulatory function of the national health system, while the SHSO is responsible for health care provision and the HIO acts as a single purchaser managing the GHIS (Petrou 2021).

In June 2019, the Government of Cyprus began the implementation of the GHIS, building upon the foundation laid by the general health care system law of 2001 and its amendments up to 2017.[58] The 2017 amendment provisions outlined a phased approach for implementation in two phases. The implementation included the establishment of the health insurance fund, relying on contributions levied on wages, incomes, pensions and state revenues as funding sources. The first implementation phase focused on extending outpatient care coverage and improving access for the entire population, associated with small co-payments. These outpatient services included access to general practitioners, specialist medicines and laboratory services. The second phase, which started in June 2020, included extending coverage for hospital care and specialty pharmaceuticals.

Notably, after the implementation of GHIS, financing of the health system shifted from predominantly tax financing and OOP payments to a scheme whereby social contributions and government subsidies finance social health protection, with a reduced share of OOP expenditure. The reform aimed at improving access to services and financial protection through shortening waiting times, improving health service quality and reducing OOP payments, in addition to strengthening the role of the national health insurance agency (HIO) in buying services from both public and private providers (WHO 2021c). The principal objective of the GHIS was to integrate public and private medical services into one unified system under a single-payer umbrella, creating a competitive environment and enhancing efficiency and quality (Petrou 2021). Additionally, the reform efforts were supported by the establishment of an integrated information system for monitoring and evaluation purposes (OECD and WHO 2023).

[57] The General Health System Law of 2001 – 89 (I)/2001, available (in Greek) at: https://www.cylaw.org/nomoi/enop/non-ind/2001_1_89/full.html

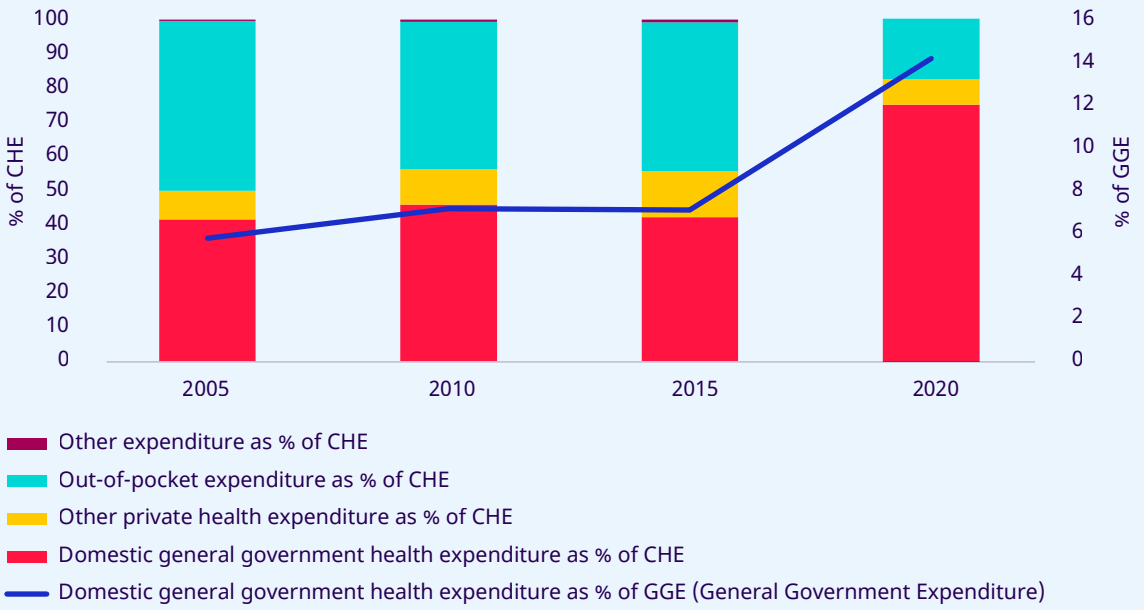
[58] The General Health Care System Law of 2001 and its amendments up to 2017, available at: https://www.gesy.org.cy/sites/Sites?d=Desktop&locale=en_US&lookuphost=/en-us/&lookuppage=hiolegislation

▶ 3. Design of the social health protection system

Financing

Current health expenditure (CHE) in Cyprus accounted for 9.4 per cent of GDP in 2021. Despite growth in health expenditure over the last few years, it is still behind the EU average (11 per cent), but above the average of Central and Western Asia countries (7.1 per cent) the same year. With the GHIS reform, CHE as percentage of GDP rose from 7.1 per cent in 2019 to 8.41 per cent in 2020, marking an increase from previous years (WHO 2023a). Public financing makes up the largest share of current health expenditure (see figure 32), increased substantially from 42.03 per cent in 2018 to 84.7 per cent in 2021 (WHO 2023b).

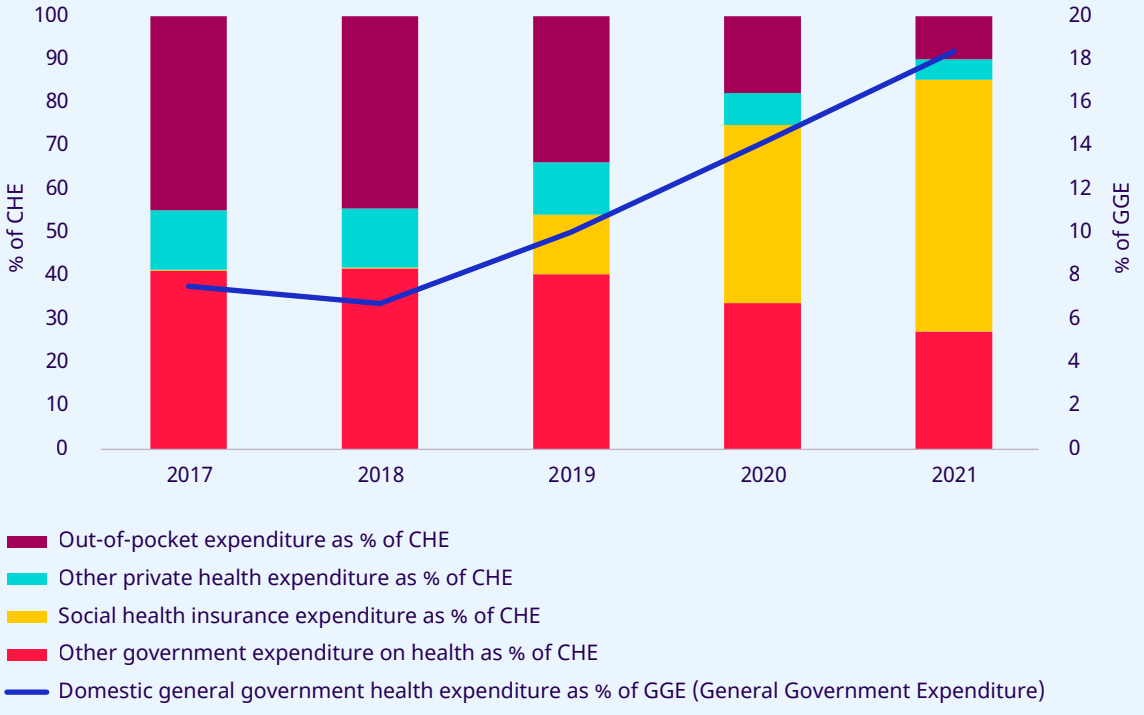
Figure 32. Composition of current health expenditure (CHE) in Cyprus, by source of financing, 2005-2020



Source: Based on data from the WHO Global Health Expenditure Database.

The introduction of social security contributions earmarked for the HIO allowed for the mobilization of additional resources for health. Since their introduction, social security contributions (which include both contributions from workers and employers and contributions from the general government budget to finance non-contributory coverage of a number of groups), have made up the majority of CHE (see figure 33). The share of OOP in CHE has decreased since the implementation of the GHIS reform. Private health insurance and external health spending play a relatively small role in CHE.

Figure 33. Relative share of social health insurance and other financing scheme as percentage of CHE, 2017-2019



Source: Based on data from the WHO Global Health Expenditure Database

In line with the reform, financing of the GHIS is mainly dependent on state revenues and social security contributions (see table 8). Contributions are collected from employees, employers, the self-employed, income-earners [59] and pensioners as a percentage of their wage or income. The responsible bodies for collecting or withholding the contributions (in the case of salaried employees) are the Social Insurance Services (SIS), the tax department and the treasury of the republic. Collected contributions and state funds are then transferred and pooled in the health care insurance fund, managed by the HIO, which in turn, purchases health services from public and private providers (Health Insurance Organisation of the General Healthcare System, n.d.-a). The contribution rates of the insurance system as of March 2020 are as follows:

- Employers – 2.9 per cent;
- workers, government officials, pensioners and income-earners – 2.65 per cent;
- the self-employed – 4 per cent;
- state/government for each employee, self-employed person, civil servant, pensioner – 4.7 per cent.

The above groups must pay contributions based on their gross income. The maximum gross annual income from which contributions are deductible is €180,000 (Health Insurance Organisation of the General Healthcare System, n.d.-a). Moreover, some vulnerable groups of the population such as the unemployed and children are exempt from paying contributions or taxes (European Commission 2023).

[59] Earnings from rent, interest or dividends.

▶ Table 8. Revenue of the Health Insurance Organization in Cyprus, 2019-2020 (in euros)

	2019	2020
Contributions	454 787 925	855 111 866
Co-payments	16 434 314	35 476 337
Discounts from pharmaceutical companies	13 272 547	35 145 924
Other income items	4 059 789	2 119 139
Other income	395 061	17 101 445
Total revenue	**488 949 637**	**944 954 711**

Note: The GHS inception was June 2019, so the financial results (contributions and expenditures) for 2019 presented do not reflect a complete calendar year result.

Source: ILO Actuarial Valuation Report to the Health Insurance Organization (2022).

Governance

The Ministry of Health of Cyprus is responsible for national health policy and ensures that health care standards and legislation are correctly applied by both private and public providers. The Ministry is also responsible for planning, organizing and managing the health care sector, including control over the provision of services in health care facilities.

As the biggest health care provider, the State Health Care Services Organization (SHSO) is responsible for the development, management, control and supervision of hospitals and health centres in the public sector, which was formerly the role of MoH (OECD and WHO 2021; State Health Services Organisation, n.d.).

The HIO serves as the single purchaser of services from both public and private providers and guarantees access to medical services for beneficiaries. Furthermore, the HIO oversees and monitors the performance of health care providers, ensuring adherence with terms and conditions of the contract, so services are provided in an efficient and cost-effective manner.

The HIO is an independent public legal entity set up under Law N.89(I)/2001 for the implementation and monitoring of the GHIS system in Cyprus. The HIO is responsible for administering the GHIS fund, pooling the collected contributions and state budget, enrolling beneficiaries, contracting health care providers, and ensuring access to quality health care services for patients (Petrou 2021). It is governed by a board of directors implementing the GHS and managing the HIO's property and resources. The board of directors consists of 13 members, including representatives from the government, employers, workers, the self-employed and patients, all of whom are appointed by the Council of Ministers (The General Healthcare System 2022b).

Legal coverage and eligibility

In Cyprus, Law (1(1)/2005) on the Entitlement and Protection of Patients' Rights [60] provides for the right to quality health care and the right to be treated unconditionally in emergency cases, in line with Article 4. Article 5 enshrines the right to be treated with dignity and Article 6 stipulates access to health care services that are available and accessible, with acceptable resources.

Law No (89(1)/2001) of 2001 on the General Health care System and its subsequent amendments up to 2017,[61] has laid the foundation for Cyprus's social health protection system. The GHS system aims to ensure universal access to health care to beneficiaries without discrimination.

[60] Law on the Entitlement and Protection of Patients' Rights of 2004 (1(1)/2005), available (in Greek) at: https://www.cylaw.org/nomoi/enop/non-ind/2005_1_1/full.html

[61] The General Health Care System Law of 2001 and its amendments up to 2017, available at: https://www.gesy.org.cy/sites/Sites?d=Desktop&locale=en_US&lookuphost=/en-us/&lookuppage=hiolegislation

According to the law, GHIS coverage is mandatory for all citizens of republic of Cyprus, EU citizens, legally residing third-country nationals and refugees. A framework of legislative acts, including laws, government regulations and other departmental regulations, provides legal protection for the health care of the population of Cyprus. The system also provides freedom of choice of provider of medical services, which can be accessed from both the private and public sectors (OECD and WHO 2021).

In contrast, asylum seekers (individuals applying for international protection), regardless of their employment status or contributions, are solely eligible for health care access through the system of pre-existing public facilities under refugee law, and they are not included into the GHIS (Council of Europe and European Union 2022). Similarly, undocumented migrants and non-EU students are solely entitled to preventative and curative care for infectious diseases (OECD and WHO 2021).

Benefits

As defined by the GHS law (article 24) and HIO regulations, a comprehensive range of health care services is included in the benefit package, covering primary, outpatient and inpatient care. Additionally, from December 2020, some preventive dental care services are included in the benefit package, but dental treatments such as fillings or extractions remain excluded (OECD and WHO 2021; Government of Cyprus 2022). The GHIS was implemented in two stages, namely Phase I and Phase II. Phase I, initiated in June 2019, includes the implementation of outpatient services (family doctors, outpatient specialists, pharmaceuticals and laboratories). Phase II, which commenced on June 2020 [62] includes all remaining services (inpatient care, accident and emergency, ambulance, allied health services, rehabilitation and palliative care and preventive dental care) (see table 9).

The benefit package includes consultations and interventions with physicians, medicines, laboratory examinations, inpatient care, emergency health care and ambulance services, palliative care and preventive dental services (such as examination and dental cleaning). In addition, assistance from nurses and midwives, clinical psychologists, clinical nutritionists, physical therapists, occupational therapists and speech therapists are included (The General Healthcare System 2022a). Although rehabilitation, long-term care and palliative care are included in the benefit package, there are challenges in ensuring effective coverage due to shortages in contracted health care professionals (OECD and WHO 2023).

▶ Table 9. Health care services covered by the GHS in Cyprus, by implementation date

Date implemented	Health care service
1 June 2019	• Personal doctors for adults and children • Specialist doctors for outpatient care • Pharmacies and pharmaceuticals for outpatient care • Laboratories for outpatient care
1 June 2020	• Inpatient care
1 September 2020	• Accident and emergency care and ambulance services
1 December 2020	• Dentists for preventive dental care • Nurses and allied health professionals (physiotherapists, clinical psychologists, clinical dieticians, speech therapists, occupational therapists) for outpatient care
1 October 2021	• Midwives
1 January 2022	• Palliative care
1 January 2023	• Institutional rehabilitation services

Source: ILO Actuarial Valuation Report to the Health Insurance Organization (2022).

[62] For more details, refer to Annex Table A1.1, Health care services covered by the GHS, by implementation date, of the 2020 Actuarial Valuation report (ILO 2022).

Cyprus applies cost-sharing arrangements consisting of low co-payments with annual limits. Physician office visits and inpatient treatment are provided free of charge. Co-payments are applied for other types of services and drugs. The objective of the co-payment, which is low and paid directly to the health care provider, is to encourage responsible behaviour from patients and health care providers and to prevent abuse of the system. For example, a consultation with a medical specialist upon referral from a general practitioner costs €6, a laboratory analysis costs €1, prescription drugs cost €1 (regardless of drug price), and a visit to a hospital due to accidents and emergencies costs €10 (see table 10). To access medicines beneficiaries pay a flat co-payment (OECD and WHO 2021). To ensure protection against catastrophic expenses, there is an annual ceiling for co-payments. For the majority of patients, this is set at €150 per year, while for the most vulnerable groups of the population such as low-income pensioners, social assistance recipients and children, it is set at €75 per year (Health Insurance Organisation of the General Healthcare System, n.d.-a).

▶ Table 10. List of co-payments applied in Cyprus, per health care service

Health care service	Applied	Co-payment amount (€)
Drugs	Per product	1
Medical devices/consumables	Per product	1
Vaccines	Per product	0
Laboratory tests (up to 10 lab tests per lab order)	Per test/test panel	1
Outpatient specialists (except radiology, pathological anatomy, cytology)	Per visit	6
Radiology	Per test	10
Pathological anatomy, cytology	N/A	0
Personal doctors	Per visit	0
Allied health professionals (occupational therapists, clinical dieticians, clinical psychologists, speech therapists, physiotherapists)	Per visit	10
Nurses and midwives	Per visit	6
Accident and emergency departments	Per visit (on triage activity)	10
Dentists	N/A	0
Inpatient services	N/A	0
Ambulance services	N/A	0

Source: Health Insurance Organisation of the General Healthcare System, n.d.-a.

Certain population groups are exempt from co-payments for outpatient visits, outpatient prescribed medicines, diagnostic tests and dental care (see box 17).

▶ Box 17. Groups exempt from co-payment for GHS in Cyprus

- People with severe mental disorders or mental disabilities;
- Children with special needs staying in institutions;
- Children under the care and supervision of social welfare services;
- Prisoners and people under arrest;
- Uninsured older Greek citizens living in Cyprus;
- Various other smaller groups of the population.

PHC serves as a gatekeeping mechanism and a referral is needed to access health care services such as outpatient specialists, laboratories, pharmacies, nurses, midwives, allied health professionals and hospitals for inpatient services. According to provisions of Part VII, Article 26 of the GHS Laws of 2001-2017, beneficiaries must register with a personal doctor of their choice. The personal doctor is responsible for guiding the beneficiary by referring the patient to the appropriate health care provider. Beneficiaries can be enrolled by a personal doctor, or self-enrolled online. In the case of children, a parent or guardian has to select a physician (paediatrician). When illness occurs, the patient must first reach their personal doctor for an initial diagnosis and provision of appropriate treatment. In more complex situations that require the involvement of specialized medical doctors, a family doctor issues a referral to a medical specialist (The General Healthcare System 2022a). Referrals are not required for dental interventions or in cases of emergency care. Usually, patients can directly approach dental surgeons for preventive dental care without a referral from a family doctor. This exemption is also applied to women above 15 years of age who need medical assistance from gynaecologists and obstetricians (The General Healthcare System 2022a).

When accessing services at a specialist level without referral or when opting for more expensive medicines, co-payments are higher. For example, there is a co-payment of €6 for outpatient visits to a specialist with a referral from a personal physician/paediatrician but it is €25 without a referral and it does not count towards the annual cap (ILO 2022).

Prescribed pharmaceuticals and vaccines are covered and the HIO fully reimburses the lowest cost pharmaceutical, with the beneficiary paying a co-payment of €1 for each prescribed item for outpatient use if dispensed from a public pharmacy. The list of prescribed medicines in the HIO catalogue mainly includes generics and, in some cases, original products when the generic option is unavailable or is still under patent. Moreover, the HIO reimburses certain over the counter products in accordance with medical need. Due to the limited availability of medicines at public pharmacies, individuals often have to pay out of pocket for medicines purchased at private pharmacies (OECD and WHO 2021; Petrou 2021; Cyprus Business News 2024; The General Healthcare System 2022a). In cases whereby beneficiaries choose a more expensive pharmaceutical product than the one reimbursed fully by the GHS, they pay the difference between the price of the pharmaceutical product covered by the GHIS and the price of the pharmaceutical product they chose (ILO 2022).

During the COVID-19 pandemic, all diagnostic and therapeutic services were free (OECD and WHO 2021).

In addition to the GHIS benefits, the Cyprus General Social Insurance Scheme provides payment of cash benefits as a replacement for income during sickness and maternity leave for employed and self-employed persons. Benefits for temporary disability associated with illness are provided to insured persons aged 16 to 63 years for 156 days. The sickness cash benefit consists of basic benefits (60 per cent of annual basic income), and supplementary benefits (50 per cent of the average weekly income). Working women are entitled to 18 weeks of maternity leave. Maternity cash benefits equal 72 per cent of the average weekly basic insurance income for the relevant year. This proportion may be increased to 80 per cent if the woman has a dependent family member, to 90 per cent in cases of two dependents, and to 100 per cent if there are three dependents. Insurance authorities make these payments from the social insurance fund (ISSA 2018).

Provision of benefits and services

The health care system in Cyprus consists of public and private health care providers. The public providers include eight public hospitals and 37 medical centres across the country (State Health Services Organisation, n.d.), with a small number of hospitals and primary health care facilities providing services in rural and mountainous areas (Lamnisos et al. 2019). Within the private sector, there are approximately 43 private hospital and 75 clinics with many more private hospitals to be issued licenses for operations (Petrou 2021; Cherries Responsible Healthcare Ecosystems 2020; Knews Khthimerini 2024). Overall, few hospitals and primary health care facilities operate in rural areas.

Primary health care services in Cyprus are provided by personal doctors in city health centres and rural health sub-centres, and can be either public or private. In principle, primary health care is provided to communities via a facility close by. Secondary care as a part of GHIS is provided by public and private hospitals, clinics and major health centres that provide specialized outpatient services. Tertiary care is delivered primarily in hospitals and specialized clinics in the capital and major cities.

To enter into a contract with the HIO, all providers are required to register as health care professionals, in accordance with the legal and regulatory frameworks applicable to the provision of each service. Following their request via a provider portal, all applicants must send a signed request form as well as supporting documents to the HIO. Once approved, the enrolment process is followed by on-site contract signing (Health Insurance Organisation of the General Healthcare System, n.d.-c).

Health care providers are reimbursed on a monthly basis, according to their professional category. Providers need to submit their claim via the provider portal to be reimbursed. PHC personal doctors are reimbursed on a capitation fee method depending on the age of each enrolled beneficiary. Most providers [63] receive reimbursement on a fee-for-service basis, but with some additional adjustments. For instance, outpatient specialists are reimbursed based on the activity list of each specialty and through a point system method. Under the point system method, the services are reimbursed based on the number of points allocated to the specific medical activity and the point value for the specific month (ILO 2022).

Hospitals providing inpatient services are paid per hospitalization case in accordance with the diagnosis-related groups (DRGs). Pharmacies dispensing pharmaceutical products to outpatients are paid per package supplied by the pharmacists to beneficiaries. The choice of fee-per-pack for pharmaceuticals aims to separate the payment method from a potential reduction in pharmaceutical prices and to encourage usage of generic medicines.

To ensure the financial sustainability of the scheme, the HIO established a pre-determined annual global budget for each category of service provided by GHS. Regardless of the volume of service provided, health care providers cannot surpass the allocated budget per service during a fiscal year. The HIO determines the annual assigned budget after consultation with respective representatives of the health care providers (Health Insurance Organisation of the General Healthcare System, n.d.-a). Reimbursement fees are subject to monthly adjustments for inpatient and outpatient services, depending on the volume of service, to align with the allocated global budget. This approach aims to ensure that the actual cost does not exceed the budget cost allocated for each category of service (Health Insurance Organisation of the General Healthcare System, n.d.-b).

The HIO is preparing to transition to a performance-based reimbursement model for primary and inpatient health services. For primary health care, this entails moving from the current capitation payment method and integrating reimbursement linked to quality indicators. As for inpatient care, the plan involves shifting from a volume-based reimbursement approach to implementing a pre-determined unit price for each hospital (Government of Cyprus 2022).

[63] Providers include: Outpatient specialists for health care services to outpatients; laboratories; nurses, midwives and allied health professionals; dentists; ambulance services; accident and emergency departments; medical rehabilitation centres (and/or per diem); and palliative care centre (and/or per diem).

▶ 4. Results

Coverage

Since the reform initiated in July 2020, over 99 per cent of the population of Cyprus, including citizens, legal residents and refugees have been covered by the scheme. The reform focused on addressing gaps in the previous system. Before the introduction of the GHS, in 2013 only 85 per cent of the population had access to the publicly financed system, with entitlement tied to citizenship and income, and individuals were subject to user fees when accessing services. Between 2013 and 2019, additional eligibility criteria were put in place (linked to tax and pension contribution payments) and coverage dropped to 75 per cent of the population during this period (Kontemeniotis and Theodorou 2021).

Adequacy of benefits/financial protection

Before 2019, the share of OOP in CHE was high due to gaps in population coverage, long waiting times, high user fees and accessing services in the private sector out of pocket. This created gaps in access and financial protection levels, particularly affecting poor and vulnerable households who faced hardship resulting from health costs, impacting their ability to meet other basic needs. Through the reform, with the extension of coverage and the integration of public and private health care providers under the same umbrella, OOP spending decreased significantly. OOP spending as percentage of CHE fell dramatically from 44.36 per cent in 2018 to 33.73 per cent in 2019, and then to 14.01 per cent in 2020, before dropping to less than 10 per cent in 2021 (WHO 2023c).

Additionally, public spending on outpatient care, inpatient care and pharmaceuticals increased. Prior to the GHS reform, outpatient treatment represented the most substantial share of OOP (10.4 per cent) alongside pharmaceuticals (7.7 per cent) (OECD and WHO 2021). Currently, the main driver of OOP spending is dental care, comprising up to one third of OOP expenditure. This is because only a few preventive dental services are included in the GHIS benefit package (OECD and WHO 2023). In addition to dental services, other gaps are long-term care, rehabilitation and palliative care. These services have been integrated into the new system, but there is insufficient capacity to meet existing needs.

Households in Cyprus spend approximately 3 per cent of their total consumption on health care. In 2015, despite relying heavily on OOP spending to cover medical costs, only 5 per cent of Cypriot households incurred catastrophic health spending (OECD and WHO 2021). The Government of Cyprus introduced various initiatives under the GHS to protect the population against catastrophic expenses, mainly by simplifying the co-payment procedure. For example, all co-payments have an annual cap set for everyone, with lower caps for children and low-income households.

Previously, outpatient medicines, diagnostic tests and emergency department visits were subject to user fees – mostly without co-financing from the state budget or exemptions (Kontemeniotis and Theodorou 2021). Patients would pay around €20-60 on average for a specialist appointment and around €100 for x-radiography and ultrasonography. Today, these services are free of charge with a low co-payment of €6-10. Moreover, the cost of vaccinations for children previously ranged from €50-100, whereas now, essential vaccinations are entirely free.

According to the latest EU-SILC survey, the level of unmet needs for health services in Cyprus is low. Only 0.1 per cent of respondents in 2022 reported an inability to access health care services due to costs, distance or waiting time, compared with 1 per cent in 2019. However, it is worth noting that there are significant discrepancies between income groups. For example, 1.9 per cent of persons in the lowest income quintile reported unmet needs, whereas only 0.2 per cent of respondents in the highest income quintile reported that their needs were not met. Prior to the implementation of the GHS, long waiting times in public facilities constituted a significant barrier to access, which was attributed as the primary reason for unmet health needs (OECD and WHO 2023).

Responsiveness to population needs

Accessibility and availability

According to WHO Global Health Observatory figures, in 2021, the UHC index in Cyprus, representing the level of coverage of essential health services, reached 80.7 points (SDG 3.8.1), surpassing that of 2010 by 11 points. In this regard, Cyprus demonstrates better results compared with the average among Central and Western Asian countries (74.6 points, 2021) and the average for the European region (77 points, in 2021) (WHO 2021d). Indicators on reproductive health, maternal, newborn, child and adolescent health reached 84 points; for infectious diseases the figure is 90 points; for non-communicable diseases, the figure is 65 points; for access to services, the figure is 86 points; and for availability of primary data for the UHC index, the figure is 56 points. Overall, these rates demonstrate significant achievements in Cyprus with regard to the provision of and access to health services.

However, some challenges remain. Despite cancer being one of the main causes of death in Cyprus, cancer screening rates have not improved in recent years. Breast cancer is the only form of cancer subject to a national screening programme for the general population, targeting women aged 50 to 69 years old. The screening service is provided free of charge within facilities located in major cities within the country. According to surveys conducted in 2019, approximately 65.8 per cent of women have accessed the service in the last two years, which is close to the EU average (59 per cent in 2019). However, there are notable disparities in access based on income levels. In 2019, only 53 per cent of women in the lowest income quintile reported having undergone screening, which is significantly lower than the rate among those in the highest income quintile (79 per cent) (OECD and WHO 2023).

In Cyprus, the density of doctors amounts to five persons per 1,000 inhabitants, slightly exceeding the average among CWA countries and the EU region (WHO 2021b). The density of nurses amounts to approximately 5 nurses per 1,000 inhabitants, well below the average in the EU, but similar to CWA countries (OECD and WHO 2023). However, these figures fail to capture the broader imbalance in workforce distribution between the public and private sectors, with physicians concentrated predominantly in private health facilities and nurses concentrated in the public health sector (see table 11). Before the introduction of the GHS, doctors were incentivized to migrate to the private health sector due to higher salaries and better working conditions, which was exacerbated by government austerity measures following the financial crisis.

▶ Table 11. Public and private medical and nursing personnel in Cyprus, 2021

	Physicians	Nursing officers
Public	797	3 375
Private	3 636	1 524
Total	**4 433**	**4 899**

Source: Statistical Service of Cyprus 2021.

Previously, the national health care system heavily relied on medical graduates who studied abroad and returned to practice in the country, mainly because Cyprus lacked medical schools prior to 2013. However, the landscape has since changed, with an estimated 10 per 100,000 inhabitants having graduated from medical school by 2021, demonstrating a consistent rise since 2019. Currently, Cyprus has four medical schools with the capacity to train more doctors per year, improving the medical workforce situation (OECD and WHO 2021; 2023).

To address the increased demand during the COVID-19 pandemic, public hospitals recruited additional medical personnel. Physicians and nurses working in the private sector were hired to work in public hospitals as a part of the standby capacity required to cope with the COVID-19 burden (OECD and WHO 2023). Before the pandemic, Cyprus had 2.2 hospital beds per 1,000 persons, which is lower than the average in CWA countries (3.9 beds on average in 2019) and significantly lower than in the EU (5.3 beds on average in 2019) (WHO 2021a). Responding to needs during the pandemic, the Ministry of Health also organized the transfer of hospital beds from private hospitals to public hospitals (OECD and WHO 2021).

Quality and acceptability

In Cyprus, life expectancy increased by around 11 per cent from 1978 to 2020 (ILO 2022). In 2022, the average life expectancy at birth was 81.7 years, and women had a longer life expectancy (83.6 years) compared to men (79.9 years). The preventable mortality rate was 112 per 100,000 inhabitants in Cyprus in 2020, while the mortality rate from treatable causes was 70 per 100,000 inhabitants (OECD and WHO 2023). The under-five mortality rate fell by more than 0.5 per 1000 live births, reaching a ratio of 2.80 in 2020 (WHO 2020b). Cyprus enjoys high levels of routine child immunization coverage (except for the case of measles) and a low infection rate of HIV/AIDS (WHO 2020a).

These figures indicate some improvements to the level of access to quality health care, yet the absence of systematic data collection on the quality-of-care indicator poses a limitation in evaluating the effectiveness and quality of the health system. For instance, between 2000 and 2020, maternal mortality worsened (from 33 to 68). The country had four maternal deaths in 2000, three maternal deaths in 2005, four maternal deaths in 2010, six maternal deaths in 2015, and nine in 2020 (WHO, 2020b). The shift of focus of health care providers towards the COVID-19 response is one of the potential explanations for the sudden doubling of the maternal mortality ratio, which is one of the highest in the world.

In the past, waiting times for accessing services in public facilities posed a significant issue that affected quality of care. This was largely caused by the imbalance of the health workforce distribution between the public and private sector, and the shortage of physicians and nurses in the public sector. The introduction of GHS has drastically improved this issue through the contracting of private providers and reduction of waiting lists of patients, especially for inpatient care (OECD and WHO 2021). Additionally, during the pandemic telehealth services rapidly expanded to compensate for lockdown conditions. This led to an increased reliance on phone and online telehealth care, which rose to 48 per cent in 2021 from 33 per cent in 2020 (OECD and WHO 2023).

Currently, Cyprus does not have an accreditation system or quality framework for hospitals, except for a basic system available in a few hospitals and laboratories. The design and development of a robust accreditation programme should aim for simplicity, minimal costs, and the involvement of all stakeholders, including patient representatives. Furthermore, there is a need to establish dedicated entities responsible for overseeing the quality of care, while involving patients in quality improvement activities (Pallari et al. 2020; OECD and WHO 2021).

As part of its National Recovery and Resilience Plan for the period 2021-2026, Cyprus set out targeted areas to improve and modernize public hospitals within the framework of the GHS. Key investments include not only the provision of support to facilitate an accreditation plan for public and private hospitals, but also the upgrading of the public health information system (Directorate General Growth, Ministry of Finance 2023). Following the introduction of the GHS, data on service quality is expected to be recorded by the integrated information system, which will be used to assess and improve the quality of services provided by either the public or private sectors (OECD and WHO 2021). This is a fundamental aspect of the new system which is fully electronic, allowing for more transparency and better control, and enhancing communication across and between providers and the HIO. All referrals, prescriptions, submissions of claims, medical audits and the implementation of protocol, along with swift communication across providers and beneficiaries, can be conducted through the information technology system (Petrou 2021).

The health technology assessment (HTA) framework in Cyprus is in its early stages and is overseen by the HTA unit of the Ministry of Health (EUnetHTA 2017). Its primary objective is decision making and reimbursement processes for integrating cost-effective new technologies and protecting against the adoption of harmful technologies in the health system. However, given its nascent stage, the current focus is predominantly on assessment rather than appraisal. This approach is internally conducted and might lack transparency, as recommendations are not publicly reported. Nevertheless, there are ongoing efforts to promote the development of a formal system with an appropriate structure and related legislation (Fontrier et at. 2022; European Commission 2017; Panayiotopoulou et al. 2019). The European Conformity marking (CE marking) tool is used to guarantee the safety and performance of medical devices. Specific health technologies such as MRI, CT scanners, gamma cameras and X-ray units are operated under the protection of Ionizing Radiation laws (N.115(I)/2002); responsibility for this legislation lies with the Department of Labour Inspection under the Ministry of Labour and Social Insurance (WHO 2012).

While migrants and refugees are included legally in the GHIS, there is some evidence of perceived discrimination in access to health care services among migrant and refugee populations, mainly due to language barriers (Gil-Salmerón et al. 2021).

▶ 5. Way forward

The development and implementation of the new ambitious GHS reform took many years to be operationalized. Through reform efforts, the previously fragmented system was consolidated and serious problems were addressed, including an imbalance of resources between public and private providers, high OOP payments, large inequalities in access and long waiting lists. The improvements were made particularly evident as a result of (and despite) the COVID-19 pandemic in 2020, during which time the new health system became operational and OOP payments were reduced considerably (OECD and WHO 2021).

Moreover, the Ministry of Health, the HIO and State Health Services Organizations have launched an ambitious programme for the digitalization of the provision of medical services and the development of a comprehensive monitoring system for electronic health care (Ministry of Health of the Republic of Cyprus 2021; G-NUIS, n.d.).

Despite universal coverage of GHIS, some groups of the populations still face barriers to access, such as language barriers for migrant and refugee populations, and equity in access to a range of services across income groups remains a concern (Gil-Salmerón et al. 2021).

▶ 6. Main lessons learned

- The implementation of reforms, including the extension of legal coverage of the population, increased public spending on health and the introduction of a provider-purchaser split, led to the successful extension of a comprehensive health system reform and, within it, expansion of a unified national health insurance scheme. This approach enabled the successful integration of previously fragmented, inefficient schemes. This led to better financial protection, with decreased OOP payments and increased coverage.
- Approaches to increase public resources for health and to improve financial sustainability include the shift from an under-financed public health system and high reliance on OOP spending, to a scheme financed by social security contributions and government subsidies; a move towards low and simplified risk-sharing mechanisms; and the establishment of a pre-determined annual global budget for health services provided by the GHS.
- Remaining challenges include inequities in access to health care services reflective of social inequalities and other forms of discrimination linked to migration status. Looking forward, the inclusion of additional services (such as rehabilitation, palliative care and long-term care) may be needed to ensure the system remains responsive to population needs.

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Georgia

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1. Introduction

Georgia is located in the western part of Transcaucasia on the eastern coast of the Black Sea. It has a medium level of development (Human Development Index – 0.802 in 2021) (UNDP 2022) and a population of 3,728 million. GDP per capita was 24,681 international dollars at purchasing power parity in 2023 (World Bank 2023). In the early 1990s, after gaining independence, the country faced economic and political crises that excessively impacted the standard of living and social protection of the population. In 1994, Georgia's real GDP fell by 72.5 per cent compared to 1990. However, since 1994, there has been almost constant economic growth, with the exception of declines in 2009 and 2020 (the latter of which was caused by COVID-19). GDP reached US$18.7 billion in 2021 (World Bank, n.d.).

Until 2010, economic growth was not accompanied by improvements in access to social health protection or to the health status of the population. This was due largely to underfinancing of the health system, a rejection of universal health coverage from 2006-2010 resulting from privatization of the social health protection system,[64] the war of 2008, as well as a high prevalence of smoking and alcohol consumption between 1994 and 2009, among other factors (Richardson and Gugeshashvili 2016). The period from 2010 to 2019 was marked by improvements, with measures aimed at improving safety on roads, ensuring universal access to health care, improving the quality of services, strengthening the financial protection of the population, and improving health care management, laying the foundations to improve the population's health. Notably, during this period, improvements were made to infant mortality, premature deaths (at the age of 30 – 69) from four major non-communicable diseases were reduced, and coverage of children with immunization against measles and rubella was increased (WHO 2017a). Unfortunately, progress was halted in 2020 by the COVID-19 pandemic.

[64] Following the implementation of mandatory health insurance in the 1990s, the Government introduced a private health insurance system in 2006. Under the system, private health insurers were responsible for purchasing health services, and the Government purchased private health insurance coverage for the poorest.

▶ 2. Context

Until 1991, the Georgian health care system was based on the Semashko model, characterized by a high level of centralization and a government owned and operated national health service (NHS) system, free at the point of service. The Semashko model in Georgia was renowned for a density of medical personnel and hospital beds exceeding the EU average. It was also known for the integration of primary health care (PHC) into municipal hospitals, medical technologies that lagged far behind Western European standards and the widespread practice of informal so-called "gratitude" payments to medical personnel.

In the early 1990s, due to economic challenges, political unrest and the transition to a market economy, the health sector was in decay:

- Public financing reduced because of economic decline and a growing informal economy, which made it a struggle to cover the cost of the relatively generous benefit package and maintain financial protection levels.
- The physical shortage of medical goods common to the Semashko system worsened because of the collapse of the former USSR market and difficulties in integrating into global markets.
- Widespread blackouts and destruction of central heating, in parallel with an almost complete lack of investment, eroded health care infrastructure.

In response to these challenges, health care providers made the following adjustments:

- "Gratitude payments" for medical personnel became the main form of income for providers. OOP payments by far surpassed government health expenditure.
- Costs were saved by reducing the number of medical personnel. The ratio of nurses to physicians reduced from 1.5 in 1996 to 1.2 in 2000 and 0.9 in 2010 (World Bank Group, n.d.).
- Many doctors and nurses sought a better income outside of the medical sector in Georgia or looked for jobs abroad. The movement of medical professionals from Georgia has features of the brain drain, and potentially brain waste as well, demonstrated by cases of Georgian certified nurses working as informal carers of senior citizens in Western Europe.
- Self-medication, as well as reliance on herbal treatments, was a way for many patients to cope with the deficit of medical goods and growing costs of medical treatment.
- Working and operating medical facilities during daylight hours only and heating medical facilities using makeshift stoves became widespread across the country.

Due to these challenges, the effectiveness of the national health system decreased significantly, leading to a decline in the quality and accessibility of medical care, and negative impacts on the population's health.

The first substantial health care reform in Georgia was initiated in 1995, which included transformations aimed at designing new legislation, strengthening the financing of health care and promoting healthy living for the country's population. A key trigger for the reform was the lack of access to free high-quality medical care services for the entire population (Rukhadze 2013). In the 1990s, a movement towards more equitable care was initiated, based on the implementation of mandatory health insurance scheme. A supervisory body – the Insurance State Supervision Service (ISSS) of Georgia – was established in 1997 to implement state objectives in the insurance sphere and to provide state regulation of insurance activities. Pooling of public resources, capitation-based remuneration of PHC, and capacity building of Mandatory Health Insurance (MHI) institutions at national and regional levels were the main features of the health financing reforms of the late 1990s. However, throughout the 1997- 2005 period, MHI did not tackle the main determinants of poor health care, namely critically low public financing, the prevalence of informal OOP payments and obsolete public health infrastructure. The privatization of the pharmaceutical sector and the emergence of private health care providers were the main features of this period. In 2004, MHI was abandoned.

In 2007, the Government introduced the Medical Assistance for the Poor (MAP) programme through which it financed vouchers for private health insurance for the poor and vulnerable. In 2011, the MAP accounted for nearly half of government spending on health. Initially, private health insurance companies won tenders according to region, resulting in each region relying on one company for the programme.

In the years following the programme's introduction, these companies were making profit margins averaging 30 to 40 per cent, and 18 per cent by 2012. As a result, in 2013, the programme in its initial form was discontinued (Richardson and Berdzuli 2017).

In 2013, the Government launched a Basic Benefit Package programme which shortly after became known as the Universal Health Coverage Programme (UHCP), implemented under the administration of the Social Service Agency (SSA) — an autonomous body under the Ministry of Labour, Health and Social Affairs in charge of administering all social protection benefits in the country. As a result, private insurance companies lost oversight over the administration of public social health protection funds. This change was reflected in the allocation of public health spending, with an initially significant drop in administrative costs. In addition to resulting in a change in institutional arrangements of social health protection, the UHCP also widened the scope of population coverage. Prior to 2013, a means-test was applied with relatively narrow targeting criteria for eligibility to the private health insurance vouchers.[65] In contrast, the UHCP scheme is near-universal, excluding only households with the highest incomes. The scheme was initially intended for those who lacked private insurance, but since there is no data sharing between private insurers and the SSA, in practice, households under the income threshold can have both UHCP and private health cover. The programme provides outpatient care, emergency inpatient and outpatient care, planned surgical interventions, cancer treatment, obstetric care and essential medicines. Like its predecessor, the UHCP scheme is financed by the general government budget from tax revenues. In addition to the UHCP, MoLHSA finances vertical programmes that are accessible to all.

New reform priorities outlined in the Georgia 2020 Strategy include:

- Improving public health care spending systems;
- Improving the quality of health care;
- Strengthening primary health care.

These transformations have increased access to health care and reduced OOP spending. Progress has also been noted on some health indicators, such as life expectancy at birth, infant mortality, tuberculosis incidence and treatment of new health regressions. For example, infant mortality decreased from 27.3 in 2000 to 9.0 in 2021 (National Statistics Office of Georgia 2021b). The incidence of tuberculosis decreased from 3,609 cases in 2015 to 1,831 in 2020, of which new cases decreased from 2,776 to 1,537 cases (National Statistics Office of Georgia 2021c).

▶ 3. Design of the social health protection system

Financing

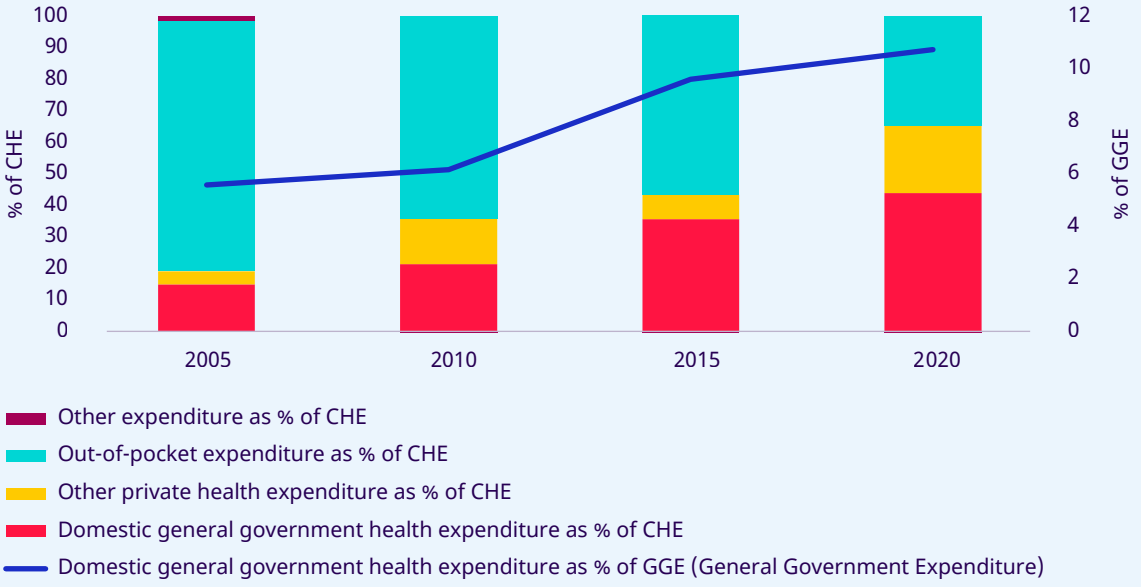
Over the last decade, Georgia has experienced a trend of increased financing on health care in terms of government spending and GDP, with a decrease in OOP payments and an increase in government funding with the introduction of the UHCP. In 2019, the share of domestic general government health expenditure was 8.1 per cent of general government expenditure and 2.8 per cent of GDP, increasing from 5 per cent of total government spending and 1.4 per cent of GDP in 2011 (WHO, n.d.). In 2020, domestic general government health expenditure comprised 47 per cent of CHE, OOP spending comprised 47 per cent and voluntary prepayments (mainly private health insurance) comprised 6 per cent. Despite improvements, Georgia continues to have high the level of OOP spending due to a low level of public funding (see figure 34).

All public health spending, like most social protection spending, is sourced from the general government budget. While there were several rounds of tax reforms in recent decades, most of the tax-financing originates from consumption taxes. Income tax on households and corporate taxes represent a much lower share of revenues and operate on a flat rate basis, which de facto limits their progressivity.

[65] Initially only the poor below the poverty line were included, and progressively additional groups were included, such as civil servants, children and pensioners.

Importantly, corporate taxes represented only 12 per cent of the fiscal revenues in 2015 and were then further reformed and reduced (Richardson and Berdzuli 2017). In a context where employers do not pay social security contributions, the fiscal basis remains skewed towards consumption and income taxes, mostly paid by households.

Figure 34. Composition of current health expenditure (CHE) in Georgia, by source of financing, 2005-2020



Source: Based on data from the WHO Global Health Expenditure Database.

Governance

The Ministry of Health, Labour and Social Affairs of Georgia [66] is in charge of policy-making and accountable for the population's health and social protection, overseeing health care policy implementation, including the adequacy of medical services, and ensuring access for all. Under the Ministry's authority are the Social Service Agency (SSA), the National Centre for Disease Control and Public Health (NCDC), the State Regulation Agency for Medical Activities (SRAMA) and the Emergency Situations Coordination and Urgent Assistance Centre (ESC & UAC).

- The Social Service Agency (SSA) is in charge of administrating and managing social protection programmes, including the UHCP, through its 68 local offices. The SSA administers insurance benefits and acts as a single purchaser of health care (ILO and UN Women 2020). Other major schemes operated by the SSA include pension, social assistance (including a child benefit programme; child disability, survivors' and disability benefits; a social package; and targeted social assistance), social services, guardianship and custody (ILO and UN Women 2020). The Agency disburses the multi-million expenses allocated to support the recipients and beneficiaries of these programmes.[67]
- Prevention and control of infectious and non-infectious diseases, health promotion, disease surveillance, immunization, laboratory work, research and response to public health emergencies are delegated to the National Centre for Disease Control and Public Health (NCDC).

[66] The full name of the Ministry is the Ministry for Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Protection.

[67] Social Service Agency's webpage, available at: https://www.sa.gov.ge/

- The State Regulation Agency for Medical Activities (SRAMA) is in charge of issuing licenses and permits for medical institutions and regulating medical professionals and the work of the pharmaceutical sector.
- The Emergency Situations Coordination and Urgent Assistance Centre (ESC & UAC) coordinates emergency medical and referral assistance which aims to improve the population's health during natural disasters and martial law; its branches are located in nearly all municipalities except for the capital.

Legal coverage and eligibility

When the UHCP was first implemented in 2013, legal coverage was truly universal in nature and covered the entire population (ILO and UN Women 2020). Access to health care services were guaranteed to all residents regardless of their social class, nationality, race, gender, language, religion, age, political or other affiliations or views.

However, since 2018, legal coverage only includes households with an annual income of up to 40,000 Georgian lari, as well as stateless persons residing permanently (legally) in Georgia, according to the Law of Georgia on Health Care (1997 and subsequent amendments).[68] The UHCP is not accessible to individuals in the highest income bracket (earning over 40,000 lari), though they are covered for emergency care and cancer treatment with co-payments.

All Georgian households are entitled to be registered in the SSA database, which is used to assess their income status, and they can re-apply the following year to have their eligibility reassessed. The SSA also carries out a review every five years (Zoidze et al. 2013).

While coverage is near-universal, two aspects are important to note:

- The process for updating the income ceiling for inclusion in the UHCP remains to be seen over the long run. Currently, only a small share of high-income households are excluded. However, if the ceiling is not periodically re-evaluated to reflect inflation and other factors, the programme may exclude an increasing share of the population, fueling OOP spending on private care and substitutive private health insurance.
- Within UHCP, the level of entitlement varies (in terms of both benefit package and financial protection) across population groups.

Benefits

The UHCP provides varying benefit packages and cost coverage depending on population groups. The SSA administers the scheme and acts as a single purchaser. The comprehensiveness of the services and the level of financial protection provided by the scheme depend primarily on a person's age and income level, with the vulnerable and the poorest receiving the most generous benefits.

The different packages are defined as follows:

1. **Universal Health care package for specific age and vulnerable groups:** Children aged 0–6, pensioners and other specified categories of the population (such as IDPs) can access a comprehensive package covering primary care, hospitalization and other services plus additional insurance.
2. **Standard State Universal Health care package:** Children above 6 years of age and people of working age subject to income tests can access a standard package which offers less financial protection than the package for specific vulnerable groups.
3. **Minimal State Universal Health care package:** This minimum package is offered to those who were previously privately insured and whose policy was discontinued. Those eligible for the minimum package include those who were insured before 2017. The package includes the services of a general practitioner, free nursing, blood and urine tests, and emergency outpatient and inpatient services for more than 450 specific listed medical conditions defined by the programme.

[68] Law on Health Care of 1997, available at: https://matsne.gov.ge/en/document/view/29980

Georgia has a uniform positive list of health services that are included in the packages for the vulnerable and the standard package, but they are subject to different co-payment levels depending on the population group (see box 18). The poor, children, pensioners and war veterans are either exempt from co-payments or pay minimal co-payments. Other groups of the population receive basic PHC services (not drugs) with no co-payment but have to cover about 30 per cent of the costs of secondary outpatient and inpatient services. The UHCP covers 70-100 per cent of the cost of outpatient services, including a range of primary and secondary health care services, namely diagnostic services (20-30 per cent of the cost is co-paid by a patient), elective surgery, oncology services, obstetric care, some essential medicines and emergency care. Scheduled surgical operations are covered by the State at 70 per cent of the cost, with an annual ceiling of 15,000 lari (or US$5,300), while non-surgical treatment of cancer patients is covered at 80 per cent, with an annual ceiling of 12,000 lari (US$4,200). Moreover, 70 per cent of the costs for the services of specialized doctors are covered.

▶ Box 18. Co-payments and exemptions under UHCP in Georgia

The SSA applies various co-payments and exemption rules for different population groups, which make the social health protection system difficult to comprehend and navigate. The following rules apply:

- Medical and sanitary services are provided for vulnerable groups, such as children under five, retirees, students, disabled children under 18, and persons with pronounced disabilities, who are fully subsidized by the Government. Such target groups benefit from 100 per cent coverage of programme services (including primary health care) with certain limitations indicated in the standard package (described above). In addition, they are eligible for 100 per cent coverage of ultrasound and x-ray examinations (fluoroscopy, radiography and mammography). Visits to specialists are free of charge for these groups upon family/village/district doctor's referral.
- Outpatient family doctor visits are provided with no official user charges for eligible beneficiaries, except for those whose income exceeds 40,000 lari.
- Emergency outpatient care is provided with no official user charges for households below the poverty line (poor), children, pensioners, veterans and those with low incomes. Those with incomes above the medium threshold are required to contribute 50 per cent of the service price.
- Outpatient specialist visits for primary care and basic laboratory tests are provided with no official user charges for the poor, children, pensioners and veterans. Other insured persons have to pay 30 per cent of the service price.
- Outpatient medicines are partially covered for the poor, children, pensioners and veterans up to the annual ceilings according to conditions.
- Dental care is not covered under the UHCP.
- Diagnostic tests, including ultrasound, ECG and X-ray, do not incur official charges for the poor and veterans. However, for children and pensioners, there is a fee ranging from 10-20 per cent of the service price for CT scans. For other individuals, a fee of 30 per cent of the service price is charged.
- Maternity care is covered without co-payments, but there are limits on the amount of public funding. For normal delivery and caesarean section procedures, there are no official charges up to 500 lari per normal delivery and 800 lari per caesarean section.
- Long-term care (nursing), with the exception of acute psychiatric treatment, is not covered by public financing.
- Regarding elective surgery, the poor and veterans are not subject to official charges. However, 10-30 per cent of the service price will be charged for other individuals, with a ceiling up to 15,000 lari per case.
- Chemotherapy, hormone therapy and radiotherapy are available without official charges for individuals classified as poor and veterans. For others, a fee ranging from 10 – 20 per cent of the service price applies, with a ceiling up to lari 15,000 per case.
- Regular patients, with the exception of vulnerable groups, purchase medicines at their own expense. The Government provides partial reimbursement (varying from 50-100 per cent) of costs for vulnerable groups, persons in particular age groups and disabled persons

Until 2020, the list of covered outpatient medicines under the UHCP was limited to around 50 essential medicines for heart disease, respiratory diseases, gastrointestinal diseases and allergies as well as antibiotics and non-steroidal anti-inflammatory medicines.

The State also finances health services for all legal residents under 23 years of age through priority public health protection programmes. These aim to provide broad geographic coverage and access to disease prevention, immunization, early detection and screening, disease management, and risk reduction counselling for designated health conditions or services, including: mental health conditions, diabetes management, paediatric leukaemia, dialysis and kidney transplantation, palliative care, certain rare diseases, ambulance services, village doctor services and referral services, tuberculosis control, malaria surveillance, viral hepatitis screening and HIV/AIDS management. A programme for the management of COVID-19 was launched in May 2020.

A highly unusual feature of the Georgian social health protection system is that specific health services are subject to a monetary ceiling, usually a typical feature of private health insurance. The ceiling is set either per episode of care or on an annual basis. For example, the State will not cover services worth more than 15,000 lari for each episode of emergency inpatient care, 15,000 lari a year for elective surgery, or 12,000 lari a year for cancer treatment. Another problematic feature of the system is that health care providers are allowed to charge patients over the price fixed by the scheme (balance billing) – that is, they are allowed to charge patients the difference between UHCP agreed tariffs and what they wish to charge for both outpatient and inpatient care (Goginashvili et al. 2021).

As a complement to the UHCP, MoLHSA finances a range of vertical disease programmes accessible to all (including those excluded from UHCP).

In addition to health care benefits, according to the Organic Law of Georgia,[69] other cash benefits related to public health include (ILO and UN Women 2020):

- Sickness benefits for all formally employed persons, amounting to 100 per cent of their previous salary and allowances for up to 30 days (which may be extended in certain circumstances).[70] However this is based on employers' liability, de facto limiting coverage, since around 30 per cent of the employed work in the informal economy.
- Maternity benefits for all formally employed women (state benefit for the private sector and employer liability for the public sector). This is a lump sum equal to the full salary for six months (183 days) or 1,000 lari (whichever is lower). However, there are no benefits for economically inactive or informally working women.

Network of service providers

As a legacy of the neoclassical policies of 2004-2012, most health care providers at the primary and secondary levels are private with low regulation, and private health insurance plays a relatively significant role in the sector since many health care providers are owned by private health insurance or pharmaceutical companies.

Since 2013, the SSA has taken on the role of purchasing the government-funded benefits package, which was previously purchased and provided by private insurance companies. Currently, the SSA procures health care services from various service providers, ensuring the involvement of both public and private health care institutions (Richardson and Berdzuli 2017).

Primary health care involves the provision of services from paramedics, family doctors or general practitioners. Primary health care services in urban areas are provided by family medicine centres, or by family doctors in rural areas, who are predominantly private.

Secondary health care services are provided in polyclinics and multidisciplinary medical institutions that offer outpatient and inpatient services and conduct laboratory diagnostic tests. They may also be served

[69] Labour Code of Georgia, No. 1393 of 27 September 2013, available at: https://matsne.gov.ge/en/document/view/1155567?publication=21

[70] According to the Labour Code of Georgia, the State provides employer liability programmes, including paid sick leave (cash sickness benefits) and mandatory employment injury insurance (not yet implemented as of 2020).

based on a referral from a family doctor. Patients are free to choose the health care providers, without being tied to a clinic near their place of residence.

Tertiary health care services are provided by specialized health care providers, such as cardiological centres, neurosurgery centres, transplantation centres and burn centres, where high-precision diagnostics and complex surgical operations are performed.

All health care facilities operate are independent entities. Private health insurance companies play a pivotal role in this landscape. The prevailing payment mechanism predominantly follows a fee-for-service structure (Richardson and Berdzuli 2017).

Health care providers can participate in the UHCP by applying to offer their services and receive reimbursement from the SSA at fixed price rates. To be eligible for reimbursement from the SSA, these facilities must agree to adhere to the agency's established reimbursement procedures. The SSA establishes a standardized list of prices for hospital services based on a list of diseases, as well as per capita rates for primary care services covered under the UHCP. However these pricing structures are generally aligned with those used by private insurance companies (Richardson and Berdzuli 2017).

Furthermore, the procedure for inpatient admission often requires the patient to request pre-authorization to SSA, after which a voucher for the procedure is delivered, upon which the patient can obtain the procedure. This process can create delays and places a heavy administrative burden on the patient (ILO and UN Women 2020; Richardson and Berdzuli 2017).

The SSA purchases services from both public and private health care providers on an equal footing. All facilities have financial autonomy and hire their own health workers. The UHCP uses capitation for primary care, and a mix of case-based payments and fee-for-service for other services. Prices tend to align with those of private insurers. The contracting model differs from the model that was implemented prior to the introduction of the UHCP; since 2017, SSA has progressively introduced more strategic purchasing methods for selected services (Richardson and Berdzuli 2017).

▶ 4. Results

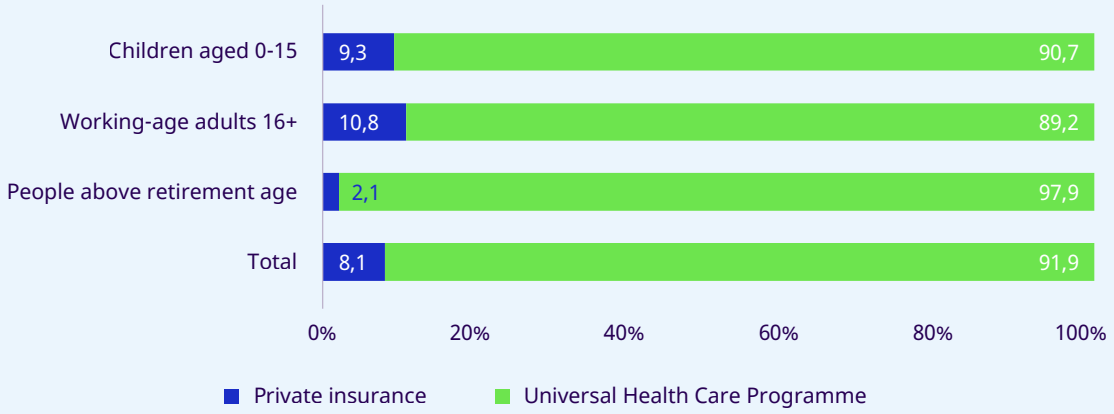
Coverage

Georgia's near-universal UHCP programme covers around 92 per cent of the total population (ILO, n.d.). Private insurance, provided either through employer-based plans or other private schemes, account for around 8 per cent of the total population. High levels of co-payments and relatively low ceilings of UHCP benefits lead to more demand for private health insurance.

According to data from 2018, among the covered population, old-age pensioners are the most likely age group to benefit from government vouchers (98 per cent), while working-age persons are the least likely (89 per cent), and a significant share (9.3 per cent) of insured children are covered under private plans (ILO and UN Women 2020). Since April 2017, the Government has implemented a policy whereby the most affluent households are no longer eligible for government-funded benefits and are instead encouraged to maintain private health insurance coverage (Richardson and Berdzuli 2017).

After a series of social health protection reforms, the proportion of the Georgian population eligible for UHCP increased from 20 per cent in 2011 to 90 per cent in 2014. This was mainly achieved through increased public health spending, which substantially improved access to health care (Thomson et al. 2019).

Figure 35. Third party payers for health care coverage in Georgia: Percentage of the population covered by health insurance, by type of insurance (broad) and age group, 2018



Source: ILO and UN Women 2020.

The highest income group (around 1 per cent of the population) is excluded from most UHCP benefits but still entitled to services offered through vertical programmes. In 2020, most of the households in the highest wealth quintile were covered by private health insurance. 0.3 per cent of population did not have any form of coverage (UHCP or private health insurance) (Thomson et al. 2019).

Adequacy of benefits

The introduction of the UHCP programme correlates with a decrease in OOP, yet OOP on health care remains high and disproportionately affects the population in the lowest income quintiles. In 2021, the incidence of catastrophic health care spending (calculated at the 10 per cent yearly income threshold) was 31.21 per cent, and 9.74 per cent at the 25 per cent of yearly income threshold (WHO 2023a). These figures are the highest in Europe and indicate that the most vulnerable groups might not be able to access health care services due to financial difficulties.

Gaps in financial protection are largely driven by design features of the UHCP that limit financial protection, such as a limited range of services, co-payments higher than 20 per cent for many items and many population groups, the application of ceilings, as well as the authorization of balance billing by providers. Indeed, health care providers are permitted to balance bill patients – that is, they are allowed to charge them more than the UHCP tariff for both outpatient and inpatient care (Goginashvili et al. 2021).

OOP spending, particularly for the lower wealth quintiles, is driven by pharmaceuticals. Indeed, most outpatient pharmaceuticals are not included in UHCP benefit packages. Moreover, Georgia has set a maximum spending amount per person that can be covered by the scheme of 50 lari (approximately US$20), which is easily exceeded in cases of severe illnesses (Thomson et al. 2019).

Around 50 medicines for outpatient treatment are covered by the UHCP. Since 2017, essential drugs for chronic diseases (such as cardiovascular diseases, including hypertension, chronic lung disease, diabetes, thyroid disease, epilepsy and Parkinson's disease) have been partly subsidized for the poor. Household budget survey data shows that the proportion of households that pay for outpatient medicines out of pocket increased from 72 per cent in 2011 to 79 per cent in 2015 (Thomson et al. 2019). Since 2018, 50 per cent of the cost of these drugs has been subsidized for pensioners and persons with disabilities.

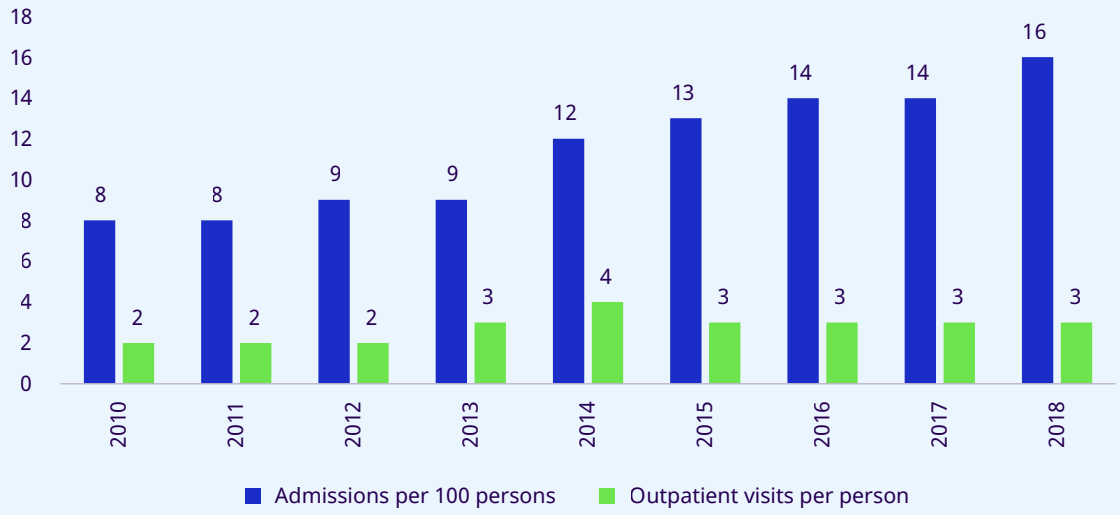
Responsiveness to population needs

Accessibility and availability

In 2019, the universal health coverage index for Georgia was 69 points which is slightly lower than it had been four years earlier (WHO 2019). This level is below the European Region average of 77 points.

Figure 36 illustrates the utilization of health services, which indicates that while the number of admissions to hospitals in Georgia is growing and currently corresponds to the EU average (around 18 per 100 persons), the number of outpatient visits is far below the EU average (about seven visits per person per year) and is stagnant. The low uptake of outpatient services in Georgia is attributed to high user charges and limited public coverage of outpatient medicines.

Figure 36. Utilization of health services in Georgia: Annual rate of outpatient visits and hospitalizations, 2010-2018



Source: Goginashvili et al. 2021.

In 2021, the number of doctors amounted to 23,000 (National Statistics Office of Georgia 2021a). The same year there were 54 medical doctors and 59 nurses and midwives per 10,000 people (WHO 2023c). However, for some time in Georgia, there was an insufficient number of nurses. This gap has been addressed by increasing the workforce by 37 per cent, from 16,400 in 2015 to 22,000 in 2021. Similarly, the lack of hospital beds recently improved, with the number of hospital beds increasing from 12,800 in 2015 to 21,000 in 2021 (National Statistics Office of Georgia 2021a).

Many private medical facilities in Georgia are well organized, equipped with high-tech facilities and staffed with qualified personnel. However, most of the private clinics are located in urban areas. In contrast, medical clinics (public and private) in rural areas lack high-quality infrastructure and, in some cases, lack essential medical equipment, which is a significant barrier to health care services in rural areas.

Local public hospitals face shortages of medical equipment and a limited number of doctors. Most of them are in critical need of logistical support and modernization, as well as the renewal of medical equipment (JICA and Nomura Research Institute, LTD 2019).

Therefore, while progress has been made on child immunization and prenatal care, access to services for HIV, tuberculosis treatment and family planning still needs to be extended. Child immunization and access to prenatal care stand out with comparatively high coverage rates at 94 per cent and 87 per cent

respectively, in contrast to HIV treatment (28 per cent), tuberculosis treatment (66 per cent), and family planning services (53 per cent) (WHO and World Bank 2017).

Due to limited availability of rural primary health care practices, patients turn towards ambulance calls or emergency care (WHO 2023b). Due to an increase in ambulance calls in recent years, improvements to emergency medical care are needed, especially during peak season times of high demand.

Since Georgia relies predominantly on OOP spending to finance primary health care, there were concerns regarding access to essential health services during the COVID-19 pandemic (WHO 2021a). Moreover, the health workforce in Georgia faced overload and burnout. As of the end of June 2021, a total of 24,345 health workers in Georgia had been diagnosed with COVID-19. Approximately 30 per cent of them were physicians and 40 per cent were nurses (about a third of all practicing physicians and over 50 per cent of employed nurses). This had significantly negative impacts on the accessibility of health services during this time (Nadareishvili et al. 2022).

Quality and acceptability

The Georgian health care system is skewed towards providing costly inpatient care rather than cost-effective primary health care. Despite reforms, the funds allocated to PHC make up only 12 per cent of total government health spending, and the share of these expenditures in GDP amounts just to 0.3 per cent (WHO 2021b). A health technology assessment has not yet been integrated into Georgia's social health protection system, but there have been discussions regarding the potential utilization of assessments developed in other countries (Richardson and Berdzuli 2017).

Public awareness of preventive medicine and health issues remains low, as indicated by the low number of outpatient visits per person, which was 3.5 in 2014. In comparison, in the European Region, this figure was 7.6 (WHO 2017b). From 2014 to 2020, the utilization rate of medical institutions providing outpatient care to the population in Georgia has not changed significantly (National Statistics Office of Georgia 2021a).

As previously noted, medical facilities at the local level face difficulties due to a lack of equipment and limited diagnostic capacities of medical centres. The public medical programme includes screening examinations and other components to improve PHC. However, some medical institutions still do not possess screening equipment (JICA and Nomura Research Institute, LTD 2019; Gokieli et al. 2021). Georgia also has an issue with regard to skills and knowledge development and the renewal of medical personnel, with many older doctors and health care workers working in difficult conditions in regional hospitals (JICA and Nomura Research Institute, LTD 2019).

According to the Law on the Issuing of Licences and Permits for Business Activities (2005), the State Regulation Agency for Medical Activities (SRAMA) handles the licensing of health providers, grants permission to health care facilities and pharmacies, and regulates medical professionals, pharmaceuticals and medical devices. However, its role is made difficult by the lack of a clear legal framework to regulate the health system and by limited resources (Richardson and Berdzuli 2017). The accreditation of hospitals was originally envisioned to be carried out by the Georgian Hospital Association, established in 2009 but it was ultimately not involved in this capacity. The scope of provider regulation extends from primary care to long-term care, including secondary care, dental care and outpatient pharmaceuticals. Notably, public health services do not fall under the purview of licensing or accreditation by SRAMA. Private health care providers operate under relatively limited regulatory oversight (Richardson and Berdzuli 2017).

This situation is reflected in the population's perceptions. According to a study conducted in 2019, despite an expansion in population coverage through the UHCP, satisfaction levels with health care services have remained low, in terms of qualifications and communication abilities of medical personnel, timely service provision, and affordability of services (Gokieli et al. 2021). Notably, the study observed that individuals with private insurance reported higher satisfaction levels (67.8 per cent) compared to UHCP beneficiaries without access to private insurance benefits (50.4 per cent). The primary factor for this low satisfaction is the cost of health care (Gokieli et al. 2021). Conversely, a study focusing on women's satisfaction with maternal care services reveals a high level of satisfaction, particularly among urban residents who are not subject to user fees for antenatal, natal and immediate postnatal care services (Sehngelia et al. 2021).

There are examples of integration and coordination between social protection cash benefits and health care benefits under the UHCP. In particular, the SSA manages a central database to identify the population and vulnerable groups for the provision of both cash benefits and the most generous UHCP package. Almost all programmes are tax-financed and means-tested, aside from a universal old age pension, which though universal is set at a very low level (ILO and UN Women 2020).

▶ 5. Way forward

Although Georgia has implemented complex health care and social protection reforms, existing barriers still hinder sustainable development and adequate protection of the entire population. The Government of Georgia is committed to tackling these challenges and taking further steps to advance the development of social health protection. The country has adopted crucial strategic documents indicating prospects for the system's development.

The National concept of the health care system lays out the vision for developing the health care system based on international and national standards. The main objectives of the public policy are to increase the population's life expectancy, reduce maternal and child mortality, and enhance health and quality of life. Ensuring universal access to health care and adequate financing of the health care sector should contribute to these national objectives (WHO 2021b).[71] Shifting national targets from objectives with little relevance for public health (for example, privatization and the development of voluntary health insurance) towards UHC is a promising development.

In 2017, a long-term Maternal and Newborn Health Strategy (2017–2030) was adopted to improve the effectiveness of maternal and child health care. The goals set by the strategy are to provide adequate protection for mothers and children and significantly enhance their health. Further strengthening of PHC is likely required in order for the strategy to be successful.

▶ 6. Main lessons learned

- The historical shift from narrowly targeted and means-tested health cover administered by private health insurers to a near-universal UHCP managed by the SSA has been successful in many respects. It illustrates the difficulties faced by the former architecture in effectively providing quality and cost-effective coverage to all, and the limitations of both narrow targeting and private health insurance administration of benefits. However, challenges remain to improve financial protection against health care costs and the efficiency of spending in a context where the private for-profit health sector dominates.
- While the wide-reaching population coverage in Georgia is an achievement, critical gaps remain in terms of adequacy of benefits. Households shoulder a significant share of health spending, and two-thirds of OOP payments are attributed to pharmaceuticals. More generous benefit packages under UHCP, starting with coverage of outpatient medicines with proven high levels of efficiency, and changes in design features that impact financial protection, such as limiting co-payments and ceilings and regulating balance billing, are needed reforms.
- Looking forward, more public funds are needed to improve the adequacy of UHCP benefits and more broadly of social protection benefits, the level of many of which remain relatively low. An extended tax base with progressive sources of revenues is required to mobilize more public funds for health and social protection in an equitable fashion.

[71] Government of Georgia, 2014 on Approval of the 2014-2020 State Concept of Health care System of Georgia for Universal Health Care and Quality Control for the Protection of Patients' Rights, available at: https://matsne.gov.ge/en/document/view/2657250

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Kazakhstan

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1. Introduction

Kazakhstan is an upper middle-income country with a population of around 19.8 million people and a GDP per capita of 36,595 current international dollars purchasing power parity (PPP) in 2022 (World Bank 2022; Qazstat, n.d.). The Human Development Index (HDI) in Kazakhstan was 0.811 in 2021, ranking the country at 56th worldwide (UNDP 2022). The poverty headcount ratio at national poverty lines was equal to 5.2 per cent of the population in 2021 (World Bank 2022). The informal economy represents a significant share of the economy, despite a decrease from 28.75 per cent in 2017 to 19.75 per cent of GDP in 2021 (QAZSTAT 2022).

Considerable improvements in health outcomes among the population have been achieved in the past couple of decades as a result of fast economic growth and continuous efforts to modernize the health system. Kazakhstan has a guaranteed volume of free medical care (GVFMC) available for all citizens and permanent residents (WHO Regional Office for Europe 2022). In addition, in 2015, Kazakhstan began taking steps towards the rollout of a mandatory social health insurance system (MSHIS) as a complement to the existing free medical care (GVFMC), with an aim to improve financing and access to health care.[72] The MSHIS was introduced in 2020 (Electronic government of the Republic of Kazakhstan 2023).

[72] Law of the Republic of Kazakhstan dated November 16, 2015 No. 405-V on Compulsory Social Medical Insurance, available (unofficial translation) at: https://adilet.zan.kz/eng/docs/Z1500000405

▶ 2. Context

Kazakhstan previously operated a non-contributory national health service system, which provided a State-Guaranteed Benefits Package free-of-charge to all citizens. This programme was progressively expanded to include permanent residents and refugees, and most of the financing burden is borne by the State.

In 1996, a first version of mandatory health insurance was introduced but its financial viability was limited and the scheme was discontinued in 1999. In the early 2000s, the financing of social health protection was further decentralised, with funding from the rayon (village) level and later with pooling of funds introduced at oblast (region) level (with oblast authorities playing the role of single purchasers) (Katsaga et al. 2012).

A range of important health system reforms have occurred since 2010, including enhancing the autonomy of public health care service providers. The most significant reforms involved the transfer of the economic management of state-owned enterprises, which was introduced by the State Health Development Programme for 2016-2019; improved regulation and centralization of health service procurement; strengthening of primary health care services; and active digitalization aimed at creating a unified medical records system and improved interoperability between different agencies and public databases (Republic of Kazakhstan 2020). These reforms facilitated the introduction of the MSHIS (Social Health Insurance Fund of Kazakhstan 2022a).

A renewed reform of social health protection in the country began in 2015-2016, through the design of a new mechanism and the establishment of the Social Health Insurance Fund (SHIF). The SHIF was tasked with managing both the GVFMC and the new MSHIS. The MSHIS was first piloted in 2019 in the Karaganda region prior to being introduced across the rest of the country in 2020 (Social Health Insurance Fund of Kazakhstan 2022a).

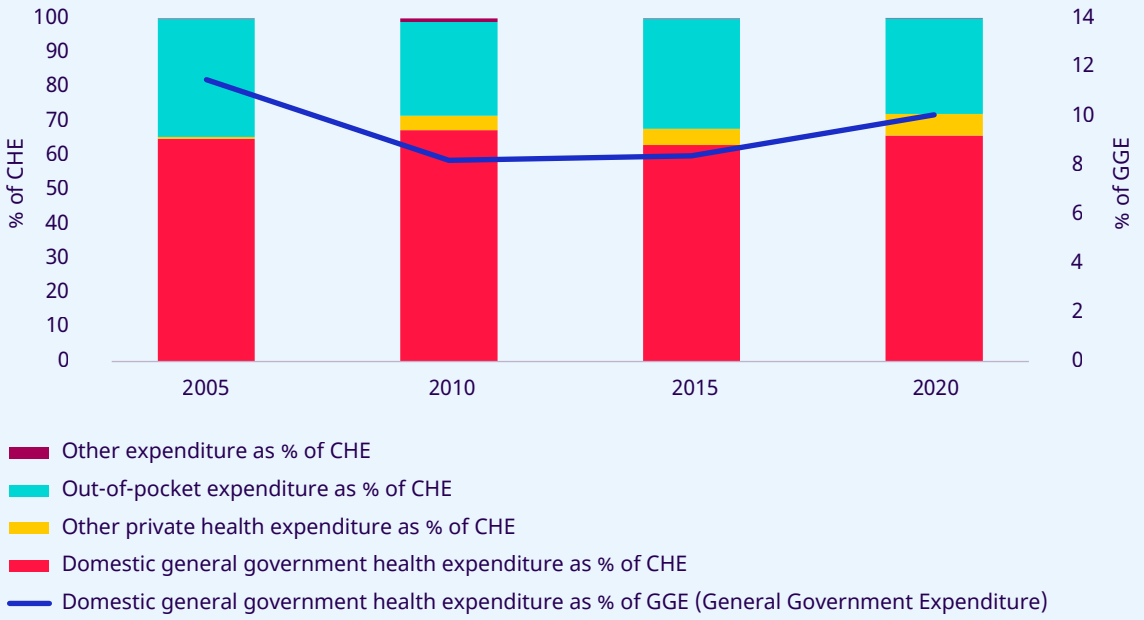
▶ 3. Design of the social health protection system

Financing

The relative level of public health financing as a share of GDP is comparatively low and stood at 2.8 per cent of GDP in 2019, which is the lowest among the Commonwealth of Independent States countries (CIS) (WHO 2020). The modest share of health expenditure has been partially offset by substantial GDP growth; although the current health expenditure (CHE) as a share of GDP has been in decline since 2000, the CHE per capita has increased (from US$51 in 2000 to US$273 in 2019) (WHO 2020). Nonetheless, there is a need to increase the level of health expenditure in the country, which remains below the average of the WHO European region (4.9 per cent of GDP) (WHO 2020).

The share of health expenditures as a proportion of the Government's budget has remained satisfactory, with Domestic General Government Health Expenditure representing between 7.6 per cent (lowest value) and 11.7 per cent (highest value) of general government expenditure between 2000 and 2020 (see figure 37). As a result, between 2000 and 2020, the share of government financing arrangements in CHE averaged almost two thirds (63.1 per cent)—one of the highest among the CIS countries (WHO 2020). OOP payments have been the second main source of health financing averaging one third or 34.3 per cent between 2000 and 2020, and dropping to 27 per cent in 2020 (WHO 2020). Additional financing came from the social health insurance scheme, representing 16 per cent of CHE in 2020 (WHO 2020).

Figure 37. Composition of current health expenditure (CHE) in Kazakhstan, by source of financing, 2005-2020



Source: Based on data from the WHO Global Health Expenditure Database.

The introduction of the MSHIS in 2020 created an additional source of funding for the system (see figure 38). For MSHIS contributors, the law mandated the following contribution requirements for 2022: [73]

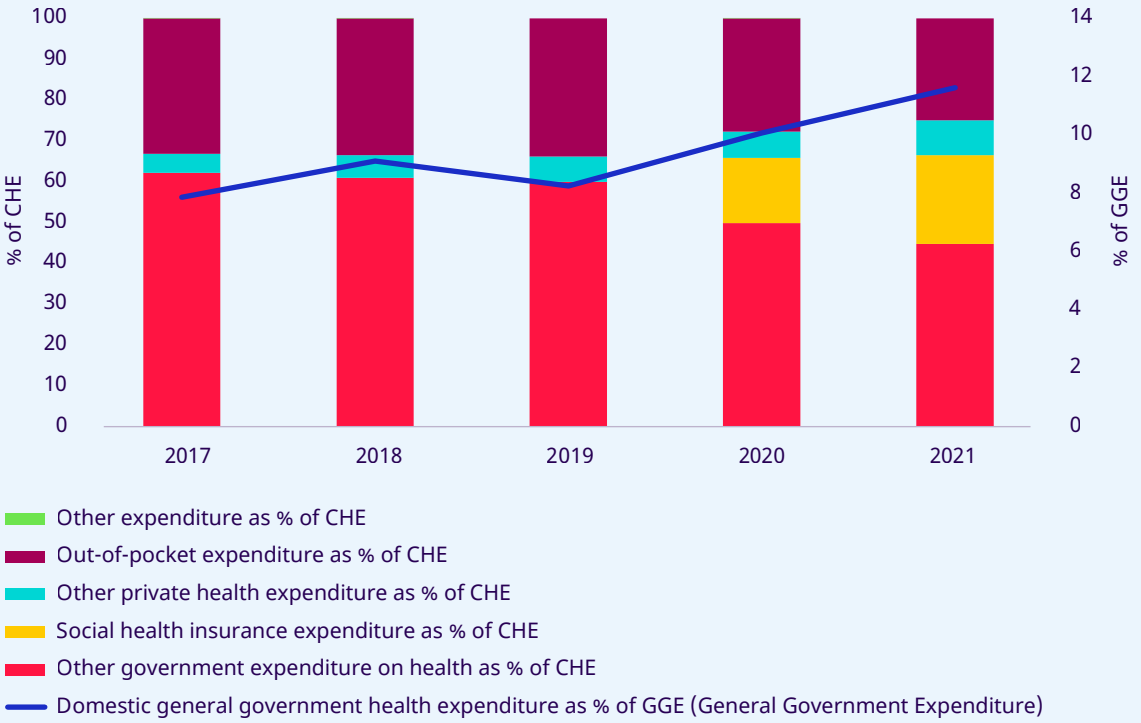
- For employed persons (labour and civil-law contracts), both employees and employers have to pay contributions (employee: 2 per cent of income; employer: 3 per cent of employee's taxable income). For income/salary-based contributions, the income is capped at the 10-fold minimum monthly salary (cumulatively for all applicable sources combined), which is around US$1,500.
- Entrepreneurs and private practitioners pay 5 per cent of the 1.4-fold minimum wage (contribution of approximately US$10). Persons remain conditionally covered for three months after contribution payments are stopped. However, they are required to eventually pay for the unpaid periods.
- Self-payers pay 5 per cent of the minimum wage each month (contribution of approximately US$7). Any person who is entitled to participate in MSHIS and is not eligible for non-contributory registration can obtain insurance by contributing as a self-payer. To be enrolled as a self-payer, a person must pay for each unpaid period in the previous 12 months or pay in advance for the upcoming 12 months. Paying for future months is a recent initiative to increase coverage.
- A presumptive tax regime which includes MSHIS contributions among other sources, was put in place to encourage formalization of the self-employed. Payers of a single aggregate payment make a unified contribution (UCP) at a privileged rate. This initiative aims to include those who have informal incomes, mainly from selling agricultural goods or services to other persons (without registering as an entrepreneur). The concerned persons pay a monthly calculation index depending on residency (Electronic government of the Republic of Kazakhstan 2023).[74] This payment counts towards income tax (10 per cent) and social insurance contributions for health (40 per cent), pension (30 per cent) and other benefits (20 per cent) (State Social Insurance

[73] Law of the Republic of Kazakhstan No. 327-VI on Compulsory Social Medical Insurance' dated May 13 2020, available (unofficial translation) at: https://adilet.zan.kz/eng/docs/Z1500000405

[74] One monthly calculation index for those residing in the capital or in cities of republican and regional significance; 0.5 monthly calculation index for other settlements.

Fund, n.d.). Unlike other mechanisms, there is a waiting period of three consecutive months of contribution payments.

Figure 38. Relative share of social health insurance and other financing scheme as percentage of CHE, 2017-2021



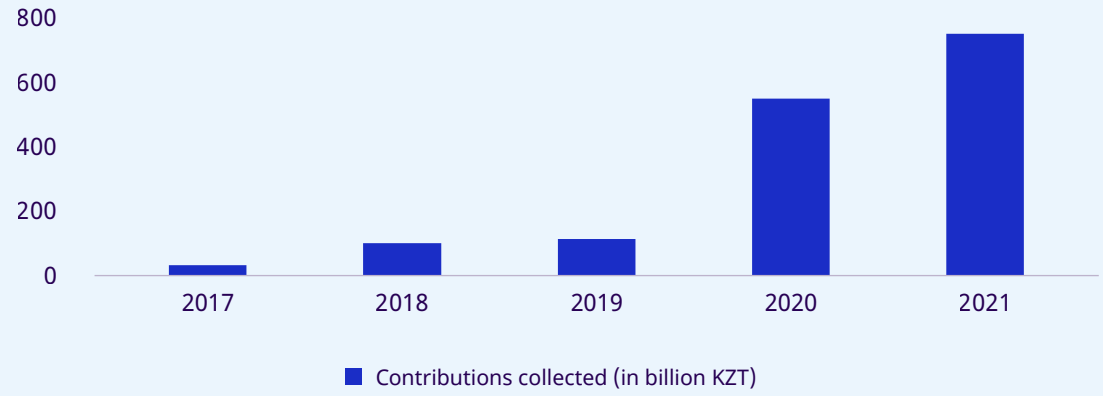
Source: Based on data from the WHO Global Health Expenditure Database.

For the population categories whose contributions are paid by the Government, the following rate applies as of 2022: 1.7 per cent of the average monthly salary for the period of two preceding years. The rate is scheduled to increase gradually to 2 per cent by 2025.

All MSHIS contributions are made to the bank account of the State Corporation "Government for Citizens", which then transfers them to the SHIF.

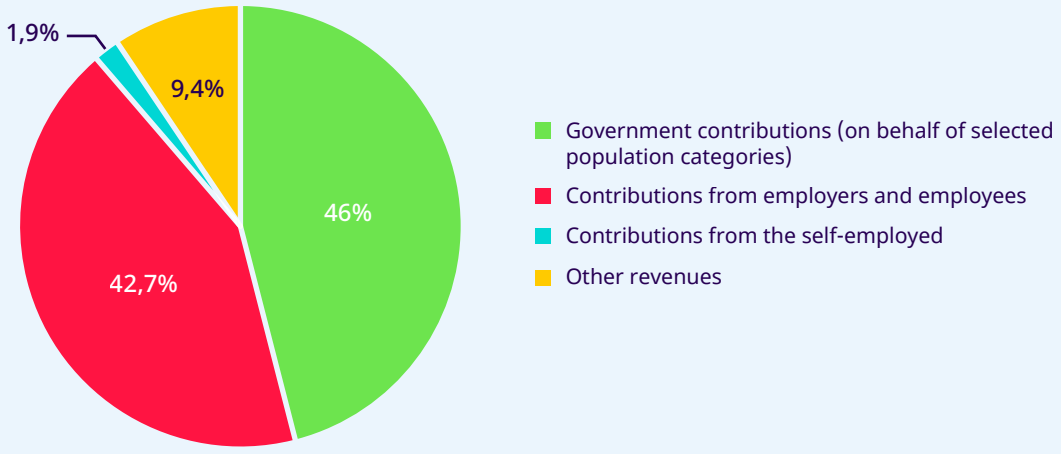
The SHIF has been collecting contributions to MSHIS since 2017, which was followed by a significant increase in contributions three years later in 2020. Figure 39 below provides further details on the funds accumulated through MSHIS, based on the data reported by the SHIF. These funds represent both revenue from contributions and state contribution subsidies (see figure 40). In 2021, these subsidies represented 346 billion Kazakhstani tenge (KZT) or 46 per cent of all funds received (see figure 40).

Figure 39. Funds collected through MSHIS, 2017-2021



Source: Social Health Insurance Fund of Kazakhstan 2022b; 2021; 2020.

Figure 40. Structure of MSHIS financing by source (2021)



Source: Social Health Insurance Fund of Kazakhstan 2022b.

The 2021 data reported by SHIF indicates that the funds accumulated through MSHIS have resulted in doubling the level of expenditure on publicly funded health services compared to 2019 (Social Health Insurance Fund of Kazakhstan 2022a).

Going forward, the transition from informal to formal employment will be an important priority to strengthen the financial sustainability of MSHIS. In this respect the Government of Kazakhstan has already achieved important milestones, including the target set by the National Development Plan of the Republic of Kazakhstan of reducing the size of informal economy to 20 per cent of GDP by 2025.[75] The Government is now planning to reduce the size of the informal economy to 15 per cent of GDP in 2050, in line with another target set by the National Development Plan (Republic of Kazakhstan 2012). This target appears to be well within reach, given that the size of the informal economy stood at 19.75 per cent of GDP in 2021 (QAZSTAT 2022). Seeking additional sources of financing for health is also an important pathway to engage in, especially since the country has raised additional excise taxes on harmful products.

Governance

Health services are governed by the following legislation:

- Code No 360-VI of the Republic of Kazakhstan on the Health of the People and the Health Care System of 7 July 2020;
- Law No. 405-V ZRK of the Republic of Kazakhstan on Mandatory Social Health Insurance of 16 November 2015;
- Decree of the Government of Kazakhstan No. 389 of 1 July 2016;
- Decree of the Government of Kazakhstan No. 421 on Approval of the List of Medical Care in the System of Mandatory Health Insurance of 20 June 2019 (as amended in 2020);
- Decree of the Government of Kazakhstan No. 672 on approval of the list of guaranteed volume of free medical care and invalidation of some prior decisions of the Government of the Republic of Kazakhstan of 16 October 2020;
- and other relevant decrees and orders regulating the provision, management and monitoring of health care services in the country.

Code No. 193-IV of 2009, Law No.405-V ZRK of 2015 and Decree No. 421 of 2019, along with other normative acts, mandate and regulate the provision of health services under MSHIS. Decree No. 389 of 2016 institutionalizes the SHIF. Together, Decree No. 389 and the Code of 2009 establish the role of the SHIF as a single purchaser of health services (Amirova and Abilkasimov 2020).

The SHIF is responsible for accumulating funds and purchasing health services under GVFMC and MSHIS, conducting an examination of the quality of provided medical services and providing support to the population in obtaining medical services. The SHIF is governed by a Board of Directors appointed by the Ministry of Health (Social Health Insurance Fund of Kazakhstan, n.d.-b). The Board includes:

- Three independent directors, one of which is the Chairman of the Board;
- Chairman of the SHIF Executive Board;
- First Vice-Minister of Health;
- Chairman of the State Property and Privatization Committee of the Ministry of Finance of the Republic of Kazakhstan.

In accordance with its governing legislation, the SHIF has an overarching mission of providing financial protection to every citizen of Kazakhstan and increasing health care accessibility and quality. As part of this mandate, the key goals of the SHIF are as follows (Social Health Insurance Fund of Kazakhstan, n.d.-a):

- To ensure universal coverage of the population under MSHIS;
- To strengthen its role as a strategic purchaser of health services;
- To protect the rights of patients;
- To ensure its sustainable functioning.

[75] National Development Plan of the Republic of Kazakhstan until 2025, dated February 2018, No. 636, available (in Kazakh) at: https://adilet.zan.kz/rus/docs/U1800000636

On the provision side, health service providers are mostly owned by local governments, though a few are also owned by the Ministry of Health. There are also many private providers that provide the GVFMC and MSHIS services (WHO 2018; WHO Regional Office for Europe 2022).

Legal coverage and eligibility

According to Kazakhstan's Constitution of 1995, article 29, "citizens of the Republic of Kazakhstan shall have the right to protection of health. Citizens of the Republic shall be entitled to free, guaranteed, extensive medical assistance established by law."

GVFMC comprises essential health services that are accessible to all citizens of Kazakhstan, permanently residing foreigners, stateless persons and refugees, while MSHIS covers an expanded package of services that is accessible to those who are registered into the scheme either on a contributory or on a non-contributory basis (Electronic government of the Republic of Kazakhstan 2023). Citizens, permanently residing foreigners and stateless persons are eligible to participate in MSHIS, but not refugees or asylum seekers (UNHCR 2021a). In 2021, 81.3 per cent of the population was insured by MSHIS (WHO Regional Office for Europe 2022).

According to Code No 360-VI of the Republic of Kazakhstan on the Health of the People and the Health Care System,[76] the GVFMC is available to all residents, including:

- All citizens of Kazakhstan;
- "Kandas" – ethnic Kazakhs who might not have Kazakh citizenship as per the regulations provided under the Law on the Introduction of Amendments and Additions to Some Legislative Acts of the Republic of Kazakhstan on the Regulation of Migration processes of 2020;
- Persons who are granted refugee status;
- Foreigners who permanently reside in Kazakhstan and have appropriate residence permits;
- Stateless persons who permanently reside in Kazakhstan and have appropriate residence permits;

Temporarily visiting foreigners, stateless persons and asylum seekers do not have the right to access the GVFMC package, unless they seek treatment for a disease or condition that poses a risk to the health of others, or unless urgent life-saving treatment is required (medical emergency) according to the terms of CIS [77] and EAEU treaties.[78]

Eligibility for the GVFMC is determined based on documentation certifying the legal status of the person seeking to access services under GVFMC.

In the case of MSHIS, there are both contributory and non-contributory affiliation mechanisms. To become insured through MSHIS, persons need to have Kazakhstani citizenship or a permanent residence permit and to make regular contributions to MSHIS as obligated by law, unless they belong to one of the population categories that are exempt from paying contributions. Contributions are paid to the fund for at least three consecutive months preceding the date of receipt of medical care.[79] Additionally, labour migrants from EAEU countries and their family members are eligible to participate in MSHIS based on the terms of the international treaty.

The main categories of MSHIS contributors, as identified by the Law of 2015 (article 14):

- Workers (both in the public and private sector);
- Individuals implementing works (services) under civil-law contracts;

[76] Code of the Republic of Kazakhstan on Public Health and Health care System No. 360-VI dated 7 July 2020, available (unofficial translation) at: https://adilet.zan.kz/eng/docs/K2000000360

[77] Resolution of the Government of Kazakhstan No. 320 on Ratification of the Protocol on the Implementation of the Agreement on the Provision of Medical Care to the Citizens of the Commonwealth of Independent States, dated 29 February 2000, available (in Kazakh) at: https://adilet.zan.kz/kaz/docs/P000000320_

[78] Treaty on the Eurasian Economic Union of 2014, available at: https://docs.eaeunion.org/docs/en-us/0017353/itia_05062014_doc.pdf

[79] Law of the Republic of Kazakhstan No. 405-V on Compulsory Social Health Insurance, dated November 16 2015 (amended and supplemented 1 July 2023), available (in Kazakh) at: https://online.zakon.kz/Document/?doc_id=32908862

- Individuals who are payers of a single aggregate payment in accordance with Article 774 of the Code of the Republic of Kazakhstan "On taxes and other obligatory payments to the budget" (Tax Code);
- Entrepreneurs;
- Self-employed and private practitioners;
- Other eligible individuals who contribute as self-payers.

Several vulnerable population categories are affiliated to MSHIS on a non-contributory basis, with the equivalent of their contributions paid by the government from the general budget on their behalf. These population categories are defined by Article 26 of the Law of 2015 and include:[80]

- Children;
- Individuals registered as unemployed;
- Pregnant women who are not engaged in any type of labour activity (this requires that they do not receive any formal income and are not registered as entrepreneurs);
- Mothers of many children awarded with pendants "Altyn alka" or "Kumis alka" previously granted the title of "Mother Heroine" or previously awarded the orders of "Maternal Glory" of I or II degree;
- Persons who take care of disabled children and are not engaged in any type of labour activity;
- Persons who are not engaged in any type of labour activity and raise children (under the age of three);
- Kandas who are not engaged in any type of labour activity;
- Prisoners and detainees;
- Students who pursue secondary special education, higher education or some other form of recognized full-time education;
- Disabled persons;
- Recipients of official social aid;
- Pensioners (including war veterans).

Benefits

Service coverage is primarily regulated by the Code of 2020, the Law of 2015, Decree No. 421 of 2019, and Decree No. 672 of 2020 as well as other normative acts setting the procedures for accessing, distributing and managing health care services. The GVFMC is regulated by Decree No. 672 of 2020, and the MSHIS package is regulated primarily by Decree No. 421 of 2019 along with the Code of 2009.

The GVFMC package aims to provide universal access to the most essential services.

The main categories of services provided under GVFMC include (but are not limited to):[81]

- Emergency medical care (including transportation);
- Primary health care, including (but not limited to):
  - Diagnostics, treatment and management of common diseases;
  - Preventive examinations of target population groups;
- Early screening activities to detect behavioural risk factors and to improve health literacy;
  - Preventive vaccinations;
  - Pregnancy monitoring and follow-up;
  - Sanitary-epidemiological and sanitary-preventive measures in foci of infectious diseases.
- Specialized outpatient medical care for:
  - Diagnosis and prevention of HIV and tuberculosis;
  - Treatment of injuries, intoxication (poisoning) and other conditions requiring urgent medical aid;
  - Diagnosis and treatment of socially significant diseases and conditions as defined by the Ministry of Health (MoH);

[80] Law on Compulsory Social Health insurance.

[81] Order of the Minister of Health No. RK HM-89 on Approval of the List of Guaranteed Volume of Free Medical Care and Invalidation of Some Prior Decisions of the Government of the Republic of Kazakhstan, dated 20 August 2021, available (unofficial translation) at: https://adilet.zan.kz/eng/docs/V2100024069

  - Diagnosis and treatment of chronic illnesses that require dynamic monitoring as defined by MoH;
- Day care for diseases and conditions defined by MoH that include socially significant diseases and chronic illnesses that require dynamic monitoring;
- Inpatient services for:
  - Quarantine and isolation of individuals who have come into contact (or suspected to have come into contact) with persons with infectious or parasitic diseases that pose risks to the health of others as defined by MoH;
  - Treatment of infectious and parasitic diseases, including those that pose risks to the health of others, defined by MoH;
  - Treatment of diseases and conditions that require urgent medical aid for persons who are not covered by MSHIS;
  - Elective treatment of diseases and conditions defined by MoH.
- Medical rehabilitation during the treatment of a disease under GVFMC and medical rehabilitation of patients with tuberculosis;
- Palliative care according to the list of diseases determined by MoH;
- Provision of blood products and their components;
- Provision of free medicines as part of emergency care, day care and inpatient care, vaccination and outpatient medicines for a list of 54 groups of diseases or conditions for certain population groups, as defined by MoH.

The MSHIS package is a complement to the GVFMC and comprises the following categories of services, in line with the law:[82]

- Specialized outpatient medical care that includes:
  - Expanded service coverage for preventive examinations of target population groups;
  - Appointment and consultations with secondary health specialists upon referral by primary health practitioners;
  - Dynamic monitoring and follow-up for persons with chronic illnesses;
  - The list of diagnostic services, including laboratory diagnostics and procedures defined by the MoH;
  - Delivery of emergency and elective dental care to selected categories of the population according to the list defined by MoH;
- Additional coverage of day care based on extended list of diseases and conditions defined by MoH;
- Additional coverage of elective inpatient treatment based on extended list of diseases and conditions defined by MoH;
- Inpatient treatment of diseases and conditions that require urgent medical aid;
- Additional coverage of medical rehabilitation based on the list of diseases and conditions defined by MoH;
- Provision of free medicines as part of day care and inpatient care, and outpatient medicines for a list of 128 groups of diseases or conditions for certain population groups as defined by MoH.

In addition, the MSHIS package currently offers access to a preventive services package on an ad hoc basis.

These benefits should be accessible without any co-payments, ceilings or deductibles (Electronic government of the Republic of Kazakhstan 2023). In 2021, a co-payment system for medicines and medical devices was established according to regulations by the Minister of health.[83] However, its implementation has been postponed until 2025 (Bukatov and Gimranova 2022).

The health care benefits presented above are complemented by some cash benefits. Cash maternity benefits are available to employed persons through social insurance supervised by the Ministry of Labour and Social Protection of Population and managed by the State Fund of Social Insurance. The

[82] Code of the Republic of Kazakhstan on Public Health and the Health Care System, dated 7 July 2020, available (unofficial translation) at: https://adilet.zan.kz/eng/docs/K2000000360

[83] Order of the Minister of Health No. ҚР ДСМ-6 on Approval of Co-payment Rules, dated July 16, 2021, available (unofficial translation) at: https://adilet.zan.kz/eng/docs/V2100023589

amount is based on the average monthly earnings in the last 12 months and it is paid for 126 days (70 days before and 56 days after childbirth). The benefit be extended for an additional 14 days for complicated childbirths and multiple births. All women, regardless of their work status, are given a lump-sum birth grant for a newborn. Cash sickness benefits are available for employed persons through employer liability, which are based on the employee's average daily earnings and conditioned by the provision of a health certificate(ISSA 2018).

The Labour Code guarantees that pregnant women, women who have given birth to a child/children, and women and men who have adopted a newborn child/children are granted the following leave in connection with the birth of a child: maternity leave, leave for employees who adopted a newborn child/children, and leave without pay for child care until the child reaches the age of three years. The duration of maternity leave is 70 days before birth and 56 days after giving birth. In cases of complicated births or the birth of two or more children, the leave is 70 days. The leave duration is independent of the longevity of employment. After the maternity leave, optional leave for child care can be granted for up to three years. Such leave can be received by the father or mother of the child, and if the child is left without parental care, then by the next of kin/caregiver.[84]

Provision of benefits and services

According to the law, the SHIF purchases and pays for the services of health care entities providing medical care in volumes and in line with the conditions stipulated by the contract for the purchase of medical services and other functions. [85] Both public and private health care providers are eligible to enter into contracts with SHIF to provide the MSHIS package. In 2020, the SHIF concluded contracts with 1,258 service providers of mandatory social health insurance, including 657 public (52 per cent) and 601 private (48 per cent) providers (Eskaliev et al. 2021).

In order to provide GVFMC or MSHIS packages, providers need to be included in the database of SHIF suppliers. This allows the provider to apply for service provision under a direct contract or provide services as a subcontractor.[86] The allocation of volumes of medical care is carried out by regional or republican commissions chaired by SHIF. An estimated 63 per cent of contracted providers in 2023 were private. The list of providers is published on the website of the SHIF (Electronic government of the Republic of Kazakhstan 2023). Purchasing mechanisms are designed to improve efficiency, cost containment and transparency. Payments are capitation-based for PHC services, while specialized inpatient and hospital care is based on diagnosis-related groups (DRGs) including more than 400 groups of inpatient cases (Mukhamedyarova et al. 2021; Chanturidze et al. 2016).

Prior to accessing health services, patients may check their insurance status through a specialized mobile application (*Qoldau 24/7*), a Telegram bot, or by visiting the national e-gov portal, or the official websites of the MoH and SHIF. SHIF also operates a hotline (1406) which can be used by patients to obtain additional information (Electronic government of the Republic of Kazakhstan 2023).

In the case of both GVFMC and MSHIS the first point of contact for beneficiaries should be at the primary health care level, where they can obtain a referral to access specialized secondary and tertiary care. The referral process can be bypassed in the case of health emergencies or elective visits to a list of specialists for certain conditions defined by the MoH (WHO Regional Office for Europe 2023).

To enable effective provision and management of services, all residents are encouraged to register with their local primary health provider. Each year, between 15 October and 15 November, a registration campaign is carried out. During this period, beneficiaries can select a clinic located close to their place of

[84] Institute of Legislation and Legal Information of the Republic of Kazakhstan, Labour Code No. 414-V ZRK of 23, dated November 2015, available at: https://natlex.ilo.org/dyn/natlex2/r/natlex/fe/details?p3_isn=102038&cs=1bzwBwsqXcZeNAWrDCxjIYoxfgxJlxLUV1KB12ezrG9dJzim0kctFMqqmntJBiTOGmBr36VCgO1YxoyBtlG7iWw

[85] Law of the Republic of Kazakhstan dated No. 405-V on Compulsory Social Health Insurance, dated 16 November 2015 (amended and supplemented on 1 July 2023), available (in Kazakh) at: https://online.zakon.kz/Document/?doc_id=32908862

[86] Order of the Minister of Health care No. 424/2020 on Approval of the Rules for the Purchase of Services from Health Care Entities Providing Medical Care within the Guaranteed Scope of Free Medical Care and (or) Within the Compulsory Social Health Insurance System, Dated 8 December 2020, available (in Kazakh) at: https://adilet.zan.kz/kaz/docs/V2000021744

residence and register with a primary health practitioner of their choice (Electronic government of the Republic of Kazakhstan 2024).

Registration is carried out through a national e-gov portal and requires a completion of an electronic form and certification though a personal electronic digital signature (EDS). The EDS requires a valid national identity document or passport to prove citizenship (Electronic government of the Republic of Kazakhstan, n.d.). Upon submission and verification of the registration application, the newly registered beneficiaries receive an electronic confirmation certified with the EDS of the health care facility of their choice.

An alternative registration procedure exists for the following categories of the population (Electronic government of the Republic of Kazakhstan, n.d.):

- Pensioners;
- Persons with disabilities;
- Caregivers;
- Prisoners;
- Students;
- Conscripts undergoing military service;
- Eligible unemployed persons who were born in foreign countries;
- Persons completing registration through the power of attorney.

Persons who fall under the above categories can register at primary health facilities without an EDS upon presentation of documents certifying their identity and their affiliation to the aforementioned categories. Registration is only possible with primary health care providers that are part of the GVFMC scheme.

4. Results

Coverage

All residents who permanently reside in Kazakhstan and whose permanent residence status is documented have access to the GVFMC. This means that, while providing coverage to the majority of the population, the GVFMC is not designed for many groups of migrants who reside in the country temporarily or whose status is undocumented, and it provides very limited benefits for these groups, primarily covering treatment for diseases or conditions that pose a danger to others (UNHCR 2021b).

Due to its geographic location and accelerated economic growth in the 2000s, Kazakhstan became a destination for many labour migrants from Central Asia. Available data suggest that Kazakhstan historically had one of the largest migrant populations in the region (relative to its population size). Modelled estimates for the 2000-2019 period suggest that the international migrant stock in Kazakhstan has been as high as 20 per cent of the population (United Nations 2020). While many of the migrants who come to the country obtain formal residency status (through work permits or otherwise), there is also a significant number of seasonal workers with temporary residence permits and many undocumented migrants. These groups are excluded from the available social security schemes, including the GVFMC, and can contract private voluntary health insurance (FIDH 2016). Some sources suggest that in 2015, between 300,000 and 1.5 million labour migrants were residing and working in Kazakhstan with an irregular status (FIDH 2016). This constitutes a notable coverage gap.

Coverage under MSHIS was estimated at 81.3 per cent of the population in 2021, which is a substantial decrease compared to an average of 85 per cent reported in 2020 (Social Health Insurance Fund of Kazakhstan 2021).

The decline in the number of insured persons between 2020 and 2021 was likely caused by failure to pay regular contributions to MSHIS (under the contributory pathway) among certain population groups.

According to the data reported by SHIF, around 2.6 million people did not make any contributions to MSHIS in 2021 and thus were excluded from the scheme.

In collaboration with other public agencies and the media, SHIF is carrying out a widescale information campaign to encourage the population to participate in MSHIS and to improve public awareness of relevant procedures and requirements (Social Health Insurance Fund of Kazakhstan 2021).

Adequacy of benefits/financial protection

Entitlements under GVFMC and MSHIS guarantee access to a broad range of health services at no cost to patients. According to the data reported by SHIF, the introduction of MSHIS resulted in a considerable increase in the utilization of many health services by the population. In particular, there has been an increase in the number of surgeries for the treatment of chronic diseases, the number of treatments for the management and prevention of disabilities, and the number of medical rehabilitation services (Social Health Insurance Fund of Kazakhstan 2021; 2020).

OOP payments dropped to 27 per cent of CHE in 2020 from 34 per cent of CHE in 2019, partly due to the expansion of MSHIS (WHO 2020). However, some of the financial risks remain unaddressed. Most notably, a large share of OOP spending in Kazakhstan is associated with the purchase of medicines (WHO Regional Office for Europe 2022). According to a 2018 Health System Review produced by OECD, households pay on average over 80 per cent of the cost of drugs out of pocket (which is two times more than in OECD countries) (OECD 2018). Although the costs of some outpatient medicines are covered by MSHIS, the number of such medicines is limited. Moreover, self-medication is an issue and some studies have observed over use of certain categories of drugs (WHO 2015; Zhussupova et al. 2020).

The practice of informal payments also threatens to undermine the level of financial protection provided through social health protection schemes. Informal payments have been commonly used by patients to circumvent certain formal procedures and/or to receive "preferential" treatment (Oka 2019). While the introduction of MSHIS will likely contribute to reducing the practice of informal payments over time, it is not yet clear what its impact will be in the short-term.

Responsiveness to population needs

Availability and accessibility

SDG target indicator 3.8.1 on UHC service coverage of essential health services increased from 39 per cent to 80 per cent over the period 2000-2020 (WHO Data 2024). Skilled birth attendance was 100 per cent in 2018 (WHO 2023).

In 2020, there were 407 physicians and 752 nurses per 100,000 inhabitants. During the same period, the number of hospital beds decreased from 719 to approximately 450 per 100,000 persons, with a slight increase to 574 in 2020 due to the COVID-19 pandemic (WHO Regional Office for Europe 2022). The average length of stay is steadily declining, having reduced from 12.3 days in 2019 to 8.6 days in 2022. The bed occupancy rate in acute care hospitals fluctuates at over 85 per cent, although it reached its lowest in 2020 (61 per cent) (WHO European Health Information Gateway 2023).

The introduction of MSHIS is believed to have facilitated access to a range of health services. The total number of providers contracted by SHIF for GVFMC and MSHIS was 1,390 organizations in 2021 (2020 –1,290; 2019 – 1,417). In particular, SHIF reports that between 2019 and 2020, there was a substantial increase in the number of contracted health care providers for the delivery of rehabilitation services under MSHIS, which increased from 64 to 539 (Social Health Insurance Fund of Kazakhstan 2021).

However, one of the major challenges faced by the health care system in Kazakhstan has been the significant gap between rural and urban regions in terms of the availability of health services (Gulis et al. 2021; Government of Kazakhstan 2019). Due to the geographic characteristics of the country, the rural population is very dispersed with some communities located in remote regions where the necessary health infrastructure remains absent or underdeveloped. Understaffing of rural health facilities and clinics has been identified as a particularly significant problem (Jobalayeva et al. 2024; Gulis et al. 2021). In response, in 2009, the Government of Kazakhstan launched an incentive scheme to motivate health care

providers to relocate to rural areas. The scheme offered a one-time allowance and housing incentives. The number of rural health care providers increased significantly from 2009 to 2020, but the increase was less substantial in per capita measures (Jobalayeva et al. 2024). Between 2000 and 2018, the number of doctors, nurses and midwives per 10,000 inhabitants was 2.5 times higher in urban areas (Shaltynov et al. 2021). Based on the data reported by SHIF, the introduction of MSHIS has allowed for an increase in resources allocated to day care and inpatient services for rural residents – from 72 billion tenge in 2019 to 92 billion tenge in 2020 (Social Health Insurance Fund of Kazakhstan 2020; 2021). However, further action is needed to strengthen the capacity of outpatient and primary care providers, particularly in rural areas (Gulis et al. 2021). Currently, the total number of medical personnel in rural areas is three times less than in urban areas – 16.1 vs 56.8 per 10,000 inhabitants, respectively. The average number of general practitioners per 1,000 persons is estimated at just 0.28 (OECD 2018).

Limited capacity and availability of primary health care providers often forces residents of remote rural communities to travel long distances to seek consultations and treatment at secondary- and tertiary-level facilities. This creates inefficiencies and translates into additional costs for patients (related to travel, accommodation, missed days of work, informal payments and co-payments to access secondary-level services without a formal referral, for example) (Gizaw et al. 2022).

The launch of central procurement of medicines and a "Single Distribution System" (thereby reducing instances of local commercial distributors playing the role of intermediaries) has allowed for significant savings while guaranteeing the availability of medical products at outpatient level (SK-Pharmacy LLP 2022; Bukatov and Gimranova 2022).

The main drivers of morbidity and mortality in the country are NCDs). It is estimated that NCDs account for 84 per cent of all deaths in the country and that the average person living in Kazakhstan has a 27 per cent risk of dying before the age of 70 from one of the four major NCDs (cardiovascular diseases, diabetes, chronic respiratory diseases and cancers) (Amirova and Abilkasimov 2020). The inclusion of preventive services in the design the GVFMC package plays an important role in adaptive responses to the change in demographics and disease burden. These services include annual health examinations as well as diagnostics and treatment for chronic and socially significant diseases, as defined by MoH.

Since 2010, Kazakhstan has seen a steady increase (by 39 per cent) in the number of persons affected by HIV (Mukhatayeva et al. 2022). This situation calls for a greater coordination with other social policies to reduce the social factors that create vulnerability to HIV transmission. As the first Central Asian country to provide citizens with free-of-charge antiretroviral therapy, preventive and curative services[87] in Kazakhstan have been strengthened in the fight against the HIV epidemic (WHO Regional Office for Europe 2022).

Quality and acceptability

A number of studies conducted in Kazakhstan found that patients are generally satisfied with the services they receive from health care providers (Seleznev et al. 2020). However, the availability of data on the quality of patient-centred care is limited (Seleznev et al. 2020). Self-reported satisfaction rates may be affected by a range of biases that can be difficult to account for. On the other hand, it can be argued that the persistence of informal payments to health care providers is indicative of patients' desire to receive services/ treatment that is of better quality than what is generally offered (Oka 2019). However, the context in which informal payments are made can vary significantly and may not necessarily be linked to a patient's perception of health care quality.

The available macro indicators suggest that health care quality in Kazakhstan has improved over time. Improvements to the delivery of health services have manifested in a significant decrease in maternal and under five mortality in the past two decades (Gulis et al. 2021; Government of Kazakhstan 2019) as well as in the reduction of mortality from diseases of the circulatory system, mortality from malignant neoplasms, and mortality from tuberculosis (Orazymbetova and Sultanbekova 2021).

87 The services range from testing and counselling; information and education work; access to condoms; and access to needles and syringes to rapid testing among key groups; and prevention of mother-to-child transmission of HIV.

Significant investments have been made in modernizing the national health system since 2000 (Gulis et al. 2021). Continuing reforms have included the optimization of inpatient care and the strengthening of primary health care services (Government of Kazakhstan 2019). Disease prevention and timely screening are currently of high importance due to the growing burden of NCDs (Farrington et al. 2019).

Nonetheless, there remains a range of challenges that complicate the provision of quality health services to the population. In particular, under-funding of primary health services and health care facilities remains a challenge (Barbazza et al. 2019). Some accounts claim that over 50 per cent of all health facilities have been in operation for more than 30 years without any major renovations, and that there is an average 30 per cent gap in the availability of medical equipment (Amirova and Abilkasimov 2020). One 2019 study that involved the collection of feedback from 198 physicians working in outpatient clinics found a range of complaints about working conditions, including insufficient amount of office equipment and supplies and inadequate workplace lighting. Around 20 per cent of physicians surveyed reported to work shifts of nine hours and longer, and around 36 per cent pointed to a lack of breaks (Aldabergenova and Turgambayeva 2021).

To improve the responsiveness of health services to patient needs, SHIF collects feedback from health care users. In 2020, nearly 720,000 requests were received and processed through the SHIF hotline, including 7,865 complaints (Social Health Insurance Fund of Kazakhstan 2021). Attention has been given to reducing waiting times for hospitalization. As reported by SHIF, the share of patients who had to wait more than 30 days before admission for inpatient treatment at hospitals decreased from 12 to 5 per cent between 2019 and 2020 (Social Health Insurance Fund of Kazakhstan 2021).

Another factor that might contribute to the improvement of health care quality in the future is the active digitalization of the national health system, which contributes to improved efficiency and can lead to substantial savings thanks to optimization, evidence-driven decision-making, and reduced coordination, monitoring and data collection costs (WHO Regional Office for Europe 2023).

▶ 5. Way forward

The national long-term development strategy “Kazakhstan-2050” identifies the following priorities in the area of health: Ensure affordable medical services with high standards of care, develop a better system of preventive medical care and introduce smart medical care, remote diagnosis and treatment and electronic medical care (Republic of Kazakhstan 2012). The rollout of MSHIS contributes to all of these priorities by mobilising additional resources for health financing and by providing a new means for structuring and regulating the provision of health care to the population.

Moving forward, retention of MSHIS contributors will likely be a priority to gradually make the scheme less reliant on government funding. This should come about through careful analysis and understanding of factors motivating drop-out rates. Among other measures, the expansion of the MSHIS benefits package to include a comprehensive list of outpatient medicines and efforts to decrease administrative barriers could increase the attractiveness of the scheme for contributors, especially given that the major share of OOP health spending is driven by medicine purchases.

Another strategic priority should be the formalization of employment and enterprises and the provision of health coverage to temporary residents and migrant workers. Given the high share of migrants in the Kazakh labour force, expanding social health protection coverage is not only a necessity to achieve UHC, but it will also contribute to social cohesion, with the potential to facilitate increased support and integration for these groups.

Further implementation and strengthening of MSHIS should be undertaken in conjunction with increased investments in primary health care capacity and quality, and improvement of public health policies, including those to close the gap in service quality and availability between rural and urban regions.

Timely screening, early treatment and prevention can strengthen the financial sustainability of MSHIS by facilitating a reduction of costs associated with high consumption of secondary- and tertiary-level

services, which will inevitably remain high if primary health and referral systems are weak. This is particularly important given the growing burden of NCDs in the country (Farrington et al. 2019)

Moreover, further digitalization of health and optimization of health data can contribute to the efficiency and sustainability of the system, and has been identified as one of the key next steps for the achievement of SDG 3 in the latest voluntary national review of SDG implementation in Kazakhstan (Government of Kazakhstan 2019).

▶ 6. Main lessons learned

- The introduction of MSHIS has yielded a range of positive effects, including increased financing and utilization of certain categories of health services. This was made possible through significant efforts to extend coverage and make the social health protection scheme available to all including informal workers and self-employed persons, through a unified contribution system for social protection benefits. However, a gap in coverage remains which disproportionately affects this group.
- In addition to reforms aiming at improving population coverage, efforts to strengthen and optimize health care delivery, including through strategic investments in primary health care development and widescale introduction of digital health services, have been ongoing. The Government is also taking steps to address availability challenges related to health workers, including through the revision of salaries of health professionals (Social Health Insurance Fund of Kazakhstan 2021).
- Improvements in financial protection can only be achieved if the scope and the coverage of the two packages offered is improved, the adequacy of benefits is addressed and the benefits are subject to regular formalized reviews and updates.
- Health financing is comparatively low in Kazakhstan. The introduction of the MSHIS allowed for the mobilization of additional earmarked resources, but additional investments are needed to improve primary health care capacity and to further optimize the health delivery system, and should come from a diversified mix of public revenues.
- One potential challenge with the use of digital health services for the extension of health care reach in rural regions is the lack of connectivity and digital infrastructure, which might impede uptake among remote rural communities. While this challenge can be resolved, additional investment might be required to ensure successful and sustainable implementation.

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Kyrgyzstan

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1. Introduction

Kyrgyzstan is a lower middle-income country with a population of around 7 million people and a GDP per capita of 6,572 of PPP current international dollars in 2022 (World Bank 2022a; 2022b). In recent decades, the main drivers of Kyrgyzstan's economic growth have been gold extraction and worker remittance-fuelled consumption (The World Bank Group 2018). Kumtor, the country's largest gold mine, accounts for 10 per cent of GDP and 20 per cent of government revenues (The World Bank Group 2018). Kyrgyzstan has a Human Development Index of 0.692, placing the country in 118th position worldwide (UNDP 2022).

Vulnerable employment represents a third of total employment while informal employment makes up for the majority of employment (ILO 2023a; 2022; Tilekeyev 2021). The Government has committed to tackling informality under its National Development Strategy for 2018-2040 (Government of Kyrgyzstan 2018).

Kyrgyzstan implements a mandatory health insurance system run by the national Mandatory Health Insurance Fund (MHIF). The MHIF provides three packages of benefits: (i) the state-guaranteed package of health services (SGBP), (ii) an enhanced SGBP package and (iii) the additional drugs package (ADP). Coverage for SGBP beneficiaries, including vulnerable groups benefiting from ADP, was estimated at 71 per cent of the population in 2022 (Mandatory Health Insurance Fund 2022a).

Amendments to the law on Medical Insurance of Citizens in the Kyrgyz Republic were enacted on 29 March 2023. These amendments aim to make enrolment in the Mandatory Health Insurance (MHI) system compulsory for all citizens of Kyrgyzstan.

2. Context

The health and social protection systems of Kyrgyzstan have undergone three major reforms since the country's independence – the first reform took place from 1996-2005 (*Manas*), the second from 2006-2010 (*Manas Taalimi*) and third from 2012-2018 (*Den Sooluk*) (OECD 2018; WHO Regional Office for Europe 2011).

- Manas, the first reform, included a structural reform of the primary health care (PHC) level and the development of family medicine, as well as the introduction of a mandatory health insurance scheme (MHI) in 1997 and outcome-based payment methods in the context of greater autonomy of health facilities. In 2001-2005, the Government introduced a single-payer system managed by the MHIF, and the State-Guaranteed Benefit Package (SGBP) was introduced. Under this package, PHC services are free at the point of service. Co-payments apply for inpatient services and for certain laboratory and diagnostic tests.
- Manas Taalimi, the second series of reforms, was predominantly a continuation of previous efforts, with emphasis on reducing geographical inequalities and sustainability of the MHI schemes (WHO Regional Office for Europe 2011; OECD 2018).
- Finally, Den Sooluk focused specifically on improving health indicators for four pathologies: cardiovascular diseases, maternal and child health and tuberculosis and HIV, through the introduction of needs-based core health services as well as the identification and removal of key barriers to access and effective coverage (OECD 2018; Government of Kyrgyzstan 2012).

Currently, the social health protection system in Kyrgyzstan consists of two main schemes administered by MHIF: (i) the State-Guaranteed Benefits Programme (SGBP) and (ii) the Additional Drug Package (ADP) (Vogler S et al. 2019).

The SGBP has two components:

- In line with the resolution of the Government of Kyrgyzstan dated 20 November 2015 [88] on the Programme of State Guarantees for medical care provision, SGBP provides free access to emergency care, a basic package of primary care services, basic outpatient specialist services, a restricted package of inpatient services, and a few medicines for chronic and socially significant diseases. This package is accessible to the entire population.
- The MHI package provides additional services, including a comprehensive list of inpatient and outpatient services either free of charge or with co-payments [89] to population groups who either contribute or are identified as particularly vulnerable.

As per the related Resolution, MHI beneficiaries can also purchase outpatient medicines at reduced prices under the ADP scheme (Vogler et al. 2019).

[88] Decree of the Government of the Kyrgyz Republic No. 790 on the State Guarantees Programme for Providing Citizens with Medical and Sanitary Care, dated 20 November 2015, available (in Kyrgyz) at: https://cbd.minjust.gov.kg/98211/edition/1288278/ru

[89] The level of copayment differs according to population categories, disease profile and level of health care organization. Population categories include: 1) Minimum level co-payment for pensioners over 70, persons receiving social benefits and persons with disabilities and others; 2) Middle level co-payment for citizens insured under MHI and military personnels; 3) Maximum level co-payment for the uninsured (Mandatory Health Insurance Fund 2023c).

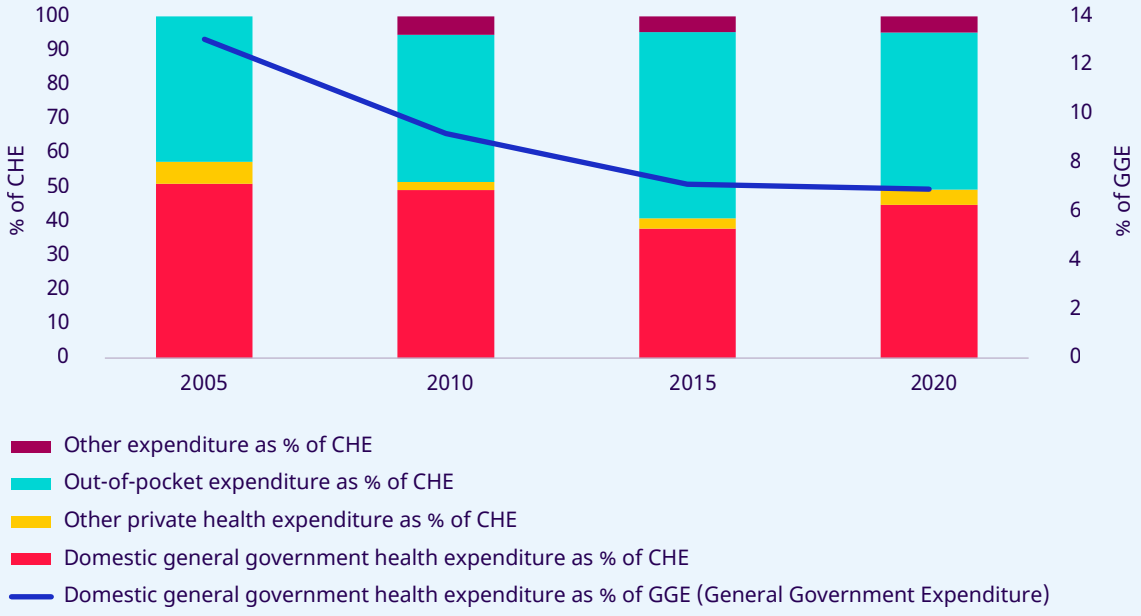
▶ 3. Design of the social health protection system

Financing

While the introduction of the SGBP, MHI and ADP schemes bolstered public financing for health, OOP spending and other private arrangements still represented 40.7 per cent of CHE in 2021 (see figure 42) (WHO 2021a).

The largest financing source, at 53.4 per cent of CHE, is domestic general government health expenditure (WHO 2021a; 2021b). Data shows that there was an increase of 8.6 per cent in 2021 compared to 2020, associated with an increase of the salaries of health workers and additional payments for purchasing medicines and hospital services during the COVID-19 pandemic (Amnesty International 2021; WHO 2021b). This increase resulted in a slight reduction in OOP spending. Social security contributions to the MHI scheme have accounted for around 10 per cent of CHE in the past decade, with a slow increase in recent years (WHO 2021a). As a relative share, the total amount of financial resources allocated to health care is comparatively low and is significantly lower than the average in the Europe and Central Asia region (WHO 2021a).

Figure 41. Composition of current health expenditure (CHE) in Kyrgyzstan, by source of financing, 2005-2020



Source: Based on data from the WHO Global Health Expenditure Database.

The MHIF serves as the main purchaser of health services in Kyrgyzstan. In line with the Budget Code of Kyrgyzstan,[90] it manages the resources allocated to the benefits provided under the SGBP, the MHI and the ADP schemes. According to article 41 of the Code, MHIF funds are comprised of the following:

- Allocations from the republican budget transferred as funds for mandatory health insurance;
- Voluntary contributions from legal entities and individuals (including foreigners) who are not covered by the mandatory health insurance system but chose to become affiliated;
- Financial penalties for improper performance of contractual obligations;
- Grants received from international organizations;
- Social security benefits;
- Other income sources that do not violate the legislation of Kyrgyzstan (including health insurance contributions accumulated and transferred from the Social Fund, as well as co-payments and special funds received by health care organizations from the population for certain types of medical services).

MHI contributions amount to 2 per cent of employees' wages paid in full by employers (WHO 2021b). According to the Law on the Rates of Social Contributions for State Social Insurance,[91] all employers pay social insurance contributions of 17.25 per cent of employee's income (divided into 15 per cent allocated for the pension fund, 2 per cent for mandatory health insurance and 0.25 per cent for the workers' health fund). Informal workers are required to make flat contributions of 1,722 Kyrgyzstani som or approximately US$19, amounting to around 1.6 per cent of the average monthly income; this has been contributed on a voluntary basis up until the recent amendment to the law which makes enrolment mandatory for all.[92] MHI contributions are collected by the Tax Inspection Office and are pooled into a Social Fund (WHO 2021b).[93] The Social Fund is responsible for pooling contributions for health insurance and transferring them to the MHIF. According to article 38 of the Budget Code of Kyrgyzstan, the budget of the Social Fund is used to finance a range of social security benefits, including health insurance. In addition, the Government contributes more than 400 million som (US$4.5 million) annually on behalf of certain categories of the population who are enrolled on a non-contributory basis (Mandatory Health Insurance Fund 2018; 2019; 2020; 2021).

The 2022 MHIF budget approved by the Parliament of Kyrgyzstan amounted to 20.2 billion som (US$ 235 million), equivalent to around 3 per cent of GDP (Mandatory Health Insurance Fund 2022b). This is more than the 2021 MHIF budget, which amounted to US$226.6 million (Mandatory Health Insurance Fund 2021). According to the MHIF 2022 report, 77 per cent of the MHIF budget came from government general budget transfers and contributions from employers accounted for around 15 per cent, while special earmarked funds, co-payments and contributions from informal workers made up an additional 8 per cent (Mandatory Health Insurance Fund 2022b).

The relatively low share of mandatory health insurance contributions in MHIF financing is linked to several factors (Jakab et al. 2018; Mandatory Health Insurance Fund 2022b):

- The SGBP, which is the main scheme administered by MHIF, is fully non-contributory and funded through general government revenues from taxes;
- Contribution collection is weakly enforced and incentives are lacking, including in the informal economy.

Voluntary health insurance is not widespread in the country. There are more than ten private insurance companies in the country, but voluntary health insurance is practiced only by large foreign companies and enterprises that provide a significantly wider range of medical services than indicated in the SGBP, including dental services. Voluntary health insurance is focused on private health care providers and dentistry (WHO 2020; WHO Regional Office for Europe 2011).

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[90] Budget Code No.59 of the Kyrgyz Republic, dated 16 May 2016, available (in Kyrgyz) at: https://cbd.minjust.gov.kg/111338?refId=1283684

[91] Law of Kyrgyz Republic on Rates of Insurance Contributions for State Social Insurance, dated 24 January 2004, available (in Kyrgyz) at: https://cbd.minjust.gov.kg/1393/edition/1241100/kg

[92] Amendments to the Law of Kyrgyz Republic No.72 on Medical Insurance of Citizens in the Kyrgyz Republic, dated 29 March 2023, available (in Kyrgyz) at: https://cbd.minjust.gov.kg/112567/edition/1244819/ru

[93] Responsibility for collection of social taxes was moved from the Social fund to Tax Inspection Services in 2019, to increase efficiency and transparency (WHO 2021b).

Governance

The existing SHP system in Kyrgyzstan is primarily governed by the following:

- The Law on Health Insurance in the Kyrgyz Republic of 1999;
- The Law on the Single Payer system in the Kyrgyz Republic of 2003;
- The Law on Health Care Organizations in the Kyrgyz Republic of 2004;
- The Law on Health Protection of 2005;
- The Decree of the Government of the Kyrgyz Republic No. 28 on Approval of the Regulations on Preferential Drug Provision of the Population at the Outpatient Level under the State Guarantee Programme and the Additional Drug Package of Mandatory Health Insurance of 2012;
- The Decree of the Government of the Kyrgyz Republic No. 790 on the Programme of State Guarantees for Providing Citizens with Health Care of 2015;
- The Resolution of Cabinet of Ministers on the Mandatory Health Insurance Fund under the Ministry of Health of the Kyrgyz Republic of 2021;
- Relevant Decrees and Orders issued by the Ministry of Health of the Republic.

Under the Law on Health Protection of 2005, the Ministry of Health is primarily responsible for national health policy, standard setting, development and implementation of health programmes, monitoring and evaluation of the health status of the population, regulation and controlling of the performance of private and public health care providers and licensing work (WHO Regional Office for Europe 2011). Notably, in addition to the MHIF, the Ministry of Health also acts as a purchaser of certain health services. Its budget is mainly formed by central government budget allocations and is used to purchase some costly (technology-intensive) services, certain pharmaceuticals and expensive medical equipment (WHO 2021b). The Ministry of Health also financially supports upgrades to health care infrastructure and finances health organizations that are paid from the republican budget (WHO 2021b).

As single payer of health care services, the MHIF is responsible for pooling health funds and purchasing health services on behalf of the population (WHO Regional Office for Europe 2011). Before 2021, the MHIF functioned as a separate entity under the Government of Kyrgyzstan. In 2021 the MHIF was subordinated to the Ministry of Health. However, it continues to run an independent budget and has a mandate to accumulate funds for the needs of the MHI system (WHO 2020; WHO Regional Office for Europe 2021).

The Resolution of 2021 [94] defines the goals, functions and obligations of the MHIF, while its budget is regulated by the Budget Code of the Kyrgyz Republic No. 59 of 2016 (section V, chapter 7). The MHIF Chairman is appointed by the Chairman of the Cabinet of Ministers at the recommendation of the Ministry of Health. MHIF has eight regional offices (territorial departments) that help with the administration of the MHIF's activities at regional levels.

According to the Resolution of 2021, the MHIF Board of Directors is a supervisory and consultative body. The Board of Directors consists of territorial department directors, heads of MHIF departments and MHIF Deputy Directors. The Chairman of the MHIF is the head of the Board of Directors, whereas the Board of Directors acts on the basis of the regulation approved by the Chairman of the MHIF. There is no tripartite representation or union involved in the Board of Directors. However, the Ministry of Health has been monitoring the Board since 2021, which was previously observed by a public council.

Legal coverage and eligibility

The SGBP package is accessible to all citizens and foreigners enrolled with family general practitioners (FGP) with either temporary or permanent residency status and identification documents (WHO Regional Office for Europe 2022). Enrolment to the MHI is mandatory for formal workers and automatic for a range of vulnerable groups. Employees in the formal sector become insured through regular contributions to the Social Fund. Contributions to the Social Fund are also made by small and medium-sized business, farmers and the self-employed as part of their usual payments to the Tax Department, which are transferred to the Social Fund, securing their affiliation to MHI and ADP. If no new payment is made during the period of one year after the last MHI payment, the insured person loses the right to

[94] Cabinet of Ministers Resolution No. 339 on the Mandatory Medical Insurance Fund under the Ministry of health, dated 24 December 2021, available (in Kyrgyz) at: https://cbd.minjust.gov.kg/158827/edition/1250723/kg

access ADP and health insurance benefits. Recently, the enrolment in the MHI became mandatory to all citizens of Kyrgyzstan, citizens of member states of the Eurasian Economic union, foreign citizens, stateless persons and refugees and asylum seekers, as stipulated by amendments of the Law on Medical Insurance of Citizens in the Kyrgyz Republic in 2023.

The following categories are covered under the MHI scheme on a non-contributory basis. They are automatically enrolled and can also access the ADP benefits (Mandatory Health Insurance Fund, n.d.-a; WHO 2021b):

- Children under 16 years of age;
- Pensioners;
- Students of public universities, higher education schools and colleges, under the age of 21;
- Persons with disabilities;
- Persons receiving social assistance payments.

Benefits

In line with the related legislation,[95] the basic SGBP includes the following services with no co-payments:

- Emergency care (including transport);
- Basic primary care (including consultation, preventive health services, 11 basic laboratory diagnostics, basic outpatient treatment and others);
- Outpatient specialist care upon referral (including consultation and diagnostic services);
- Immunization services;
- Medicines for the treatment of certain diseases (diabetes, haemophilia and tuberculosis).

Free access to a comprehensive list of outpatient and inpatient specialist services is guaranteed for certain vulnerable categories of the population, on referral and in the case of certain diseases. The list of exemptions is specified in the SGBP programme and includes 30 social categories (for example pregnant women, veterans and disabled persons) and 17 medical conditions (for example, asthma, tuberculosis and diabetes). In addition, vulnerable categories of the population (persons with disabilities, pensioners over 70 and persons living below the poverty line, among others) can receive free treatment without co-payments in state hospitals twice a year in accordance with the SGBP.

Prevention services are accessible free for all registered individuals and are covered by the SGBP as a basic package of primary care services. Prevention services include a package of antenatal clinics for pregnant women; vaccination and immunization for children up to the age 6; and a limited package for adults upon identification of risks of hypertensive disease, obesity and tuberculosis.

In addition, reduced prices apply to medicines for outpatient treatment of epilepsy, hypertension, bronchial asthma, schizophrenia, affective disorders of various origins and terminal stage cancer. Children under six years of age who are citizens of Kyrgyzstan may avail of free medical services both at hospital and the PHC level. However, registration with family doctors is required for accessing certain types of free specialized care, since a referral is required. Patients without registration have to pay the full price for such services (Abdullaeva 2022).

Co-payments vary by the level of health facility, patient beneficiary status and intervention type (Jakab et al. 2018). The minimum co-payment level is for pensioners under 70 years of age, the medium-level co-payment is for MHI beneficiaries and the maximum co-payment is for the rest of the population or patients without referrals, as per the 2015 legislation.

[95] Decree of the Government of the Kyrgyz Republic No. 790 on the State Guarantee Program for Providing Citizens with Medical and Sanitary Care, dated 20 November 2015, available (in Kyrgyz) at: https://cbd.minjust.gov.kg/98211/edition/1288278/ru

Access to other services for those who are not included in the MHI scheme is only possible upon payment of the full price. Prices for the services provided at facilities registered with MHIF are regulated through a price schedule that is set by the Ministry of Health in consultation with the Antimonopoly Regulation Service.[96]

Under the MHI, beneficiaries are entitled to necessary laboratory tests and outpatient examinations free of charge or at a discount of up to 50 per cent. The scheme also guarantees benefits for inpatient hospitalization, where beneficiaries pay a middle level co-payment of 840 som (approximately US$10), whereas other patients have to pay the maximum level of co-payment of 2,650 som (approximately US$30). The Maximum level of co-payment for inpatient hospitalization is 8,400 som (approximately US$97) following the amendment of 2023. To access MHI benefits, patients need to have a document certifying their identity, a document certifying their eligibility (such as a pensioner's ID or student card), and/or an MHI plan. For employees, MHI eligibility for benefits can be proven by the MHIF database which has close links to the Social Fund payments database.

Under the ADP, MHI beneficiaries can also obtain selected medicines at reduced prices from contracted pharmacies. The price is reduced by an equivalent of 50 per cent of the median wholesale price. To access this benefit, patients need to have a prescription from a primary health practitioner. The selected pharmaceutical products currently include 59 medicines (international non-proprietary names) (Vogler S et al. 2019). The list of eligible medicines is approved by Ministry of Health [97] and has been expanded since 2001 when it was first introduced. Initially, the list included only 34 medicines (Jakab et al. 2018). Moreover, the ADP includes all the medicines needed by pregnant women, such as folic acid, iron preparations, potassium iodide and others, at reduced prices.

Through the SGBP, health services for pregnant women who are citizens of Kyrgyzstan, including preventive and medical services, are free of charge. In all public hospitals in the country, delivery is free of charge. In addition, all pregnant women can benefit from the MHI plan benefits free of charge at the outpatient level, and are entitled to purchase medicines at reduced prices under the ADP.

Long-term care services are not included in the SGBP, while pensioners above 70 years of age benefit from free hospital care twice a year. Most long-term care is provided informally by families, or within hospitals as inpatient care due to the country's shortage of specialized long-term care facilities (WHO Regional Office for Europe 2022).

In addition to the health care schemes, some income security guarantees are in place in case of maternity. Paid maternity leave is provided during pregnancy for 70 calendar days and for 56 days after an uncomplicated childbirth. Maternity leave for women living in mountainous or remote areas that are difficult to access is up to 180 calendar days. Formally employed female employees, farm and cooperative members as well as women registered as unemployed are entitled to a maternity benefit financed from the resources of their employers for the first ten days of leave and thereafter from the general/state budget. The benefit is equal to 100 per cent of the insured person's average daily earnings for the first ten working days of the leave (which the employer is liable for paying), and then ten times the basic rate (1000 som per month) up to 126 calendar days before and after the expected date of normal childbirth, and up to 140 days in cases of complicated delivery. For unemployed women, farm and cooperative members, benefits are ten times the basic rate (1000 som per month) from the national budget. This scheme is administered by the Ministry of Labour, Social Security and Migration, and employers provide data with the calculated volume of payment to the Ministry for disbursement of the benefits. According to the Ministry of Labour, Social Security and Migration, there were 33,200 recipients of maternity benefits in 2021, which indicates low coverage (ILO 2023b).

[96] Decree of the Government of the Kyrgyz Republic No. 645 on Approval of the Regulation on Additional Payment for Medical Services provided by Health Care Organizations under the State Guarantee Programme, dated 12 September 2012, available (in Kyrgyz) at https://cbd.minjust.gov.kg/93070/edition/458521/kg

[97] List of eligible medicines approved by MoH, available at: http://foms.kg/uploads/files/lecobespechenieFebrary2022.pdf

Provision of benefits and services

Health services under the three schemes managed by the MHIF are delivered through a network of health care providers which includes both public and private entities. According to information from the MHIF, there are 145 public health facilities that provide services under SGBP, including 54 hospitals, 60 general practitioner centres, 18 family medicine centres, 13 dental clinics, and 32 private medical centres which provide only haemodialysis services (Mandatory Health Insurance Fund, n.d.-b). Other private health facilities do not provide services under the SGBP. In total, 994 pharmacies have signed contracts with the MHIF to deliver medicines under the ADP scheme (Mandatory Health Insurance Fund, n.d.-d).

Family doctors and family nurses provide prevention services at the PHC level. PHC services are provided only by public Family Medicine Centres or General Practitioners Centres (WHO Regional Office for Europe 2023). The MHIF contracts health care providers at different levels to ensure the delivery of individual health services covered under the SGBP (Mandatory Health Insurance Fund, n.d.-e). The contracts are updated each year and specify the payment amount for the expected volume of services as well as conditions for reimbursement if the real volume of services deviates from projections (consolidated budgets are used rather than line-item budgets to allow for more managerial and financial autonomy of providers (WHO Regional Office for Europe 2022). Since 2008, contracts with providers have also included some performance indicators to ensure better quality of services (WHO Regional Office for Europe 2011).

The contracts for health services provision are administered by MHIF territorial departments, which currently manage approximately 150 contracts between MHIF and health service providers. MHIF uses nine different contract forms, depending on the specificity of service and type of health care facility. Contracts are renewed annually after budget approval (Mandatory Health Insurance Fund, n.d.-e).

Purchasing mechanisms are designed to encourage the efficient operation of health care providers. Payments are usually capitation-based for PHC services and case-based for hospital services. Payment rates are harmonized but include differences by geographical location and by the level of the facility itself (WHO Regional Office for Europe 2022). National centres have payment rates that exceed the rates of city or regional hospitals by 15-20 per cent.[98]

Despite the fact that the Law on Health Protection of Citizens of the Kyrgyz Republic allows MHIF to sign contracts with private providers for the provision of medical services under the SGBP, financial constraints hinder its ability to do so. So far, contracted private providers mainly consist of pharmacies and private medical practitioners and a few facilities located mainly in the two biggest cities of Bishkek and Osh. In general, private medical services focus on obstetric/maternity services, cardio and dental services, and are predominantly located in cities. These operate under voluntary insurance companies, and are not contracted by MHIF (WHO Regional Office for Europe 2022; WHO 2020).

Among the challenges identified in relation to the existing purchasing and payment arrangements, a lack of systemic data collection and analysis of service utilization and a lack of volume control mechanisms at the level of hospital care. This often leads to excessive unplanned expenditure on hospital services, while the PHC system remains underfunded. In 2019, MHIF spending on PHC amounted to just over 35 per cent of total expenditure, while spending on hospital care amounted to more than 58 per cent (WHO Regional Office for Europe 2022; Mandatory Health Insurance Fund 2022a).

A referral is required to access specialist care and diagnostics under SGBP, which is obtained from family doctors, primary care facilities or outpatient departments of hospitals (Abdullaeva 2022).

[98] Decree of the Government of the Kyrgyz Republic No 300 on Optimizing the methods of financing health care in the single payer system' dated 13 June 2008, available (in Kyrgyz) at: https://cbd.minjust.gov.kg/7-12834/edition/374918/ru

▶ 4. Results

Coverage

The coverage of the SGBP is near-universal, while the population insured under MHI increased from 69 per cent of the population (4.1 million) in 2019, to 71.1 per cent (4.7 million) in 2022 and to 73.5 per cent (4.9 million) in 2023 (Mandatory Health Insurance Fund 2022b; WHO Regional Office for Europe 2022; Mandatory Health Insurance Fund 2023b). Children under 16 years of age, pensioners and other socially vulnerable groups whose contributions are paid by the state represented nearly half of the insured in 2019. The share of insured formal workers as a percentage of the insured decreased slightly from 19.2 per cent in 2015 to 15.4 per cent in 2019. The share of farmers among the insured also decreased during this period – from 14.2 per cent to 12.5 per cent. There has been a relative decrease in the number of people who have voluntarily purchased the MHI policy – from 0.9 per cent to 0.1 per cent (Damira and Apyshevna 2020).

In 2020 there were an estimated 199,000 migrants in Kyrgyzstan and in the same year there were 334 refugees and 343 asylum seekers (UN DESA 2020). Migrants' access depends on their possession of the required documents, as registration with the SGBP requires a temporary residence permit and basic identification documents (Gjørven 2013). In addition, foreign nationals officially working in Kyrgyzstan and paying all taxes and insurance payments become insured and have access to the basic package of primary care services and a comprehensive list of inpatient and outpatient services free of charge or with a medium-level co-payment through the SGBP, and are guaranteed the right to purchase medicines at reduced prices under the ADP. Foreign nationals who are not working in Kyrgyzstan may purchase MHI insurance policies issued for six months or one year, which grants the same access to the SGBP and ADP as insured citizens of Kyrgyzstan. Foreign citizens, even when they do not contribute, have free access to emergency medical care. Affiliation is granted within a period of five days after the purchase of the MHI plan (Mandatory Health Insurance Fund n.d.-c). Medical services provided to foreign nationals who are not insured under the MHI are subject to a fee, in accordance with the Decree on Medical Services to Foreign Nationals of 2000.[99]

Adequacy of benefits/financial protection

The introduction of both the SGBP and MHI schemes has contributed to the reduction of financial risks associated with accessing health services. However, significant gaps in financial protection remain. Despite some co-payments, the SGPB provides most services free-of-charge at PHC level and the MHI scheme provides a degree of financial protection that exceeds that of most other countries with similar levels of GDP. However, OOP spending is high, at 45.9 per cent of CHE in 2020 (WHO 2021a). More than one in ten persons face the risk of catastrophic health expenditure, which disproportionately affects the vulnerable and poor. In 2014, two thirds of households that experienced catastrophic spending on health were concentrated in the poorest quintile (Jakab et al. 2018).

Moreover, underfunding of the health care system has created obstacles to making the SGBP package more comprehensive and responsive to the population's health needs. Despite recent increases to the health budget, per capita payments for PHC have not significantly increased over the last five years. This is due to the fact that all additional funds allocated to the MHIF budget were provided for designated purposes, such as wage increases for health workers, or the payment of benefits for harm caused to health while working in emergency conditions during the COVID-19 pandemic (WHO 2021b). State contributions to health insurance for vulnerable segments of the population have remained at the level of 400 million som (US$4.5 million) annually (Mandatory Health Insurance Fund 2018; 2019; 2020; 2021).

As part of the ADP package, co-payments usually amount to more than 50 per cent of drug prices because MHIF only subsides 50 per cent of the wholesale price, which tends to be lower than the retail price (Tilekeyev 2021). The cost of medicines has consistently been the main driver of OOP spending,

[99] Decree of the Government of the Kyrgyz Republic No. 346 on Medical Care for Foreign Citizens, dated 15 June 2000, available (In Kyrgyz) at: https://cbd.minjust.gov.kg/7402/edition/1286062/kg

accounting for more than 60 per cent of total OOP spending in 2014 (Jakab et al. 2018). The list of medicines allowed for prescription and sale under the ADP programme [100] include 300 outpatient medicines, or 59 International Nonproprietary Name (INN) active ingredients, as approved by order of the Ministry of Health in 2023 (Mandatory Health Insurance Fund 2023a; USAID 2021). The population's spending on medicines remains a major expense and a leading cause of catastrophic health expenditures. Most OOP payments are related to outpatient medicines. The amount spent on outpatient medicines per person more than doubled between 2006 and 2014 (Vogler et al. 2019; Jakab et al. 2018). In 2014, OOP payments among households faced with catastrophic spending was 60 per cent for outpatient medicines, followed by outpatient care, inpatient care, diagnostic test and to a lesser extent dental care (WHO Regional Office for Europe 2019a). This could be attributed to the small share in the budget for ADP in the total MHIF budget. In 2023, the amount of funds allocated to the ADP increased by 68.2 per cent, yet its share in the MHIF budget reduced by 0.3 per cent compared to 2018 (table 12).

▶ Table 12. Kyrgyzstan's Additional Drug Programme (ADP) budget between 2018-2023

	2018	2019	2020	2021	2022	2023
MHIF budget (million soms)	14 579.4	15 234.8	17 137.2	19 544.1	24 677.5	28 770.8
MHI Additional Drug Programme budget (million soms)	**319.2**	**334.4**	**356.6**	**346.8**	**431.2**	**536.8**
MHI Additional Drug Programme budget as share of MHIF budget (%)	**2.2%**	**2.2%**	**2.1%**	**1.8%**	**1.7%**	**1.9%**

Source: Data from Mandatory Health Insurance Fund 2018; 2019; 2020; 2021; 2022a.

The list of medicines reimbursed under the ADP is significantly outdated and has not been revised since 2018. This leads to patients being prescribed modern medicines that are not in line with the ADP, meaning that they have to purchase them at full cost. This suggests that while patients are entitled to additional benefits under the ADP, they are likely to encounter many complications when claiming these benefits, due to the absence of established criteria to guide primary care physicians' decisions regarding the provision of ADP drugs, and a lack of monitoring (The World Bank Group 2021; Jakab et al. 2018).

All pharmacies and companies distributing medicines to the population are private. However, their activities are licensed by the Ministry of Health. Notably, VAT for medicines was annulled in 2001.[101] Poor price controls or the lack thereof have led to high prices of medicines which increase OOP expenses for patients (WHO Regional Office for Europe 2016). In 2019, the Ministry of Health made a systematic change to the supply management and medicines circulation and introduced a price regulation mechanism through control of the maximum mark-up for 56 pharmaceutical items of International Nonproprietary Names (INN) included in the ADP of the MHI (WHO Regional Office for Europe 2022; USAID 2021). This price control process was suspended from 2020-2022 due to the COVID-19 pandemic, but resumed in 2023.[102]

There are also issues of adequacy in relation to the available benefit packages. NCDs are increasingly becoming the main cause of death in the country. The share of mortality attributable to NCDs in

[100] Order of the Ministry of Health No. 279 on Approval of the List and the Amount of Compensation for Medicines Reimbursed under the Additional Drug Package and the State Guarantee Benefit Programme at the Outpatient Level, dated 14 March 2023, available (in Kyrgyz) at https://foms.kg/prikazy/

[101] Article 268 of Tax Code of the Kyrgyz Republic No 3, dated 18 January 2022, available at: 11-Tax-Code-of-the-Kyrgyz-Republic-unofficial-translation.pdf (invest.gov.kg)

[102] Decree of the Cabinet of Ministers of the Kyrgyz Republic No 292 on Approval of the Rules for Regulating Prices for Medicines in the Kyrgyz Republic, dated 21 May 2023, available (in Kyrgyz) at: Постановление Правила регулирования цен (1).pdf (pharm.kg)

Kyrgyzstan rose from 73.6 per cent in 2000 to 82 per cent in 2019 (World Bank 2019a). Despite this, the package of services and the corresponding allocation of resources are not updated on an annual basis to match this trend. Many priority health services (as per the current disease burden) are not included in the SGBP (WHO 2021b; WHO Regional Office for Europe 2021). In particular, this rising burden generates demand for outpatient services aimed at prevention and management of chronic diseases, including through cost-effective medication (WHO Regional Office for Europe 2017). However, most outpatient services and medicines are not covered by the SGBP. Moreover, the ADP, while offering an expanded range of benefits, requires considerable co-payments, thereby limiting access (WHO Regional Office for Europe 2021). Similarly, people over 70 years of age have free access to hospital treatment, but the number of cardiovascular diseases, including acute myocardial infarction or acute cerebrovascular accidents in people under 49 is growing every year (34 per cent in 2019, and 35.6 per 100,000 persons in 2022) (IHME 2024). Persons in this age group are not entitled to cost-free specialized medical services.

Notably, expensive and high-tech health services are usually paid out of pocket by patients. A High-Technological Fund was formed under the Ministry of Health and has mainly been used to purchase medicines, reagents and medical devices for patients with diabetes mellitus, HIV, Acute Myocardial Infarctions and Cerebrovascular Accidents, as well as chemotherapeutic agents for patients with oncology, and immunosuppressed medicines for patients who have had transplantations (WHO Regional Office for Europe 2011). Since 2023, medicines for patients with hepatitis B and C have been covered, while outpatient rehabilitation is provided free of charge for vulnerable population groups, with preferential treatment under the SGBP or with a 50 per cent discount for those who are covered by MHI (Mandatory Health Insurance Fund 2023c). The only rehabilitation centre in the country receives minimal public funding indicating a need to pay out of pocket for such services (Mandatory Health Insurance Fund 2023c).

The persistent practice of informal payments also contributes to high levels of OOP spending. According to a 2022 survey by MHIF, close to 29 per cent of surveyed patients reported making informal payments to medical personnel (Mandatory Health Insurance Fund 2022b). Patients use informal payments to bypass formal procedures and requirements and to incentivize health care workers to provide better services. Informal payments are made both to purchase medicines and to receive treatment (most commonly inpatient hospital-level care). Available data suggests that informal payments and other OOP expenditures place a greater financial burden on lower-income households compared to higher-income households, as they account for a greater share of their income (Jakab et al. 2018).

All public health care providers are located in the regional centre or in cities. Public transport services are provided only in the central cities of the country. The remaining transport services are provided by private companies. A lack of services in rural areas leads to additional expenses for transport services (World Bank 2020; OECD 2019).

Responsiveness to population needs

Availability and accessibility

In Kyrgyzstan, equal access to medical services is likely to be adversely affected by significant variations in the quality of medical services provided to the population, depending on geography of residence and socio-economic status. For example, mortality among children under five years of age is more than 50 per cent higher among the 40 per cent of the population within the lowest income groups compared to the top 60 per cent of the population— 37.4 and 24.0 deaths per 1,000 live births, respectively (NSC, MoH and IFC International 2013).

Significant progress has been made in health service coverage and utilization during the last two decades. Between 2000 and 2019, the WHO-estimated universal health service coverage index in Kyrgyzstan increased from 52 to 70 (WHO 2021c). Skilled birth attendance was estimated at 100 per cent in 2018 according to 2018 MICS data. However, significant disparities persist, including between rural and urban areas, and between regions. For example, in 2018, the proportion of children aged 12-23 months vaccinated against vaccine-preventable childhood diseases (for basic antigens) was 67 per cent in urban areas and 81 per cent in rural areas. In general, immunization coverage among urban children is lower than that for children in rural areas (NSC and UNICEF 2019).

Despite these challenges, there has been an increase in the utilization of services provided under SGBP. Between 2016 and 2022, there was a substantial increase in SGBP outpatient services, from 875,215 treated cases up to 942,997 in 2022. More than 65 per cent of patients were children up to 18 years of age (39.7 per cent), pregnant women (19.7 per cent) and other vulnerable groups. According to the SGBP, these vulnerable groups received outpatient services at no cost or at a reduced level of co-payment (Mandatory Health Insurance Fund 2022b).

However, there has been a decrease in patient visits at the PHC level from 10.7 million visits in 2016 to 8.2 million visits in 2021 (E-Health Center n.d.). During this period, the number of MHIF contracts with health care providers also decreased from 260 to 145. This was driven by optimization (the merger of small providers) and dropouts among a number of providers (Mandatory Health Insurance Fund 2022b).

Regional disparities are still significant at provision level. Kyrgyzstan has low population density and a complex geography, characterized by many mountainous regions and natural barriers, which complicates the delivery of services to many remote communities (WHO Regional Office for Europe 2011). Currently, around one-third of the Kyrgyz population live in urban areas, while the other two-thirds reside in rural zones (Mandatory Health Insurance Fund 2022b).

The distribution of health care facilities between rural and urban areas is therefore disproportionate. According to information provided by the MHIF, there are 145 health facilities in Kyrgyzstan that provide health services under SGBP; however nearly 25.5 per cent of these facilities (37) are located in the capital (Mandatory Health Insurance Fund n.d.-b). Currently, 149 villages across the country (8 per cent), all of which are located in remote regions of the country, do not have pharmacies and pharmacy points, and people have to travel to the regional centre to purchase medicines. The challenge of reducing these gaps and improving the quality of services in rural areas is expected to become increasingly pressing as the population is projected to grow while remaining predominantly rural until 2050 (Tilekeyev 2021).

Moreover, health care workers are not equally distributed between rural and urban areas, which creates imbalances in service availability. Usually, the most experienced doctors work in cities. Many qualified medical professionals leave public hospitals to join private clinics that usually operate only in urban areas. As a consequence, rural communities continue to be affected by a lack of qualified medical personnel (WHO 2019). Due to the lack of qualified specialists and the low quality of medical care in these regions, 45 per cent of hospitalizations occur in the two largest cities (Bishkek and Osh). This leads to additional transportation and accommodation expenses for patients (Mandatory Health Insurance Fund 2022b).

Furthermore, there is a general shortage of qualified health care workers. One of the consequences of underfunding of health care in Kyrgyzstan is low wages in this sector. Due to inadequate remuneration and heavy workloads, there are not enough people who are willing to work as doctors or nurses (World Bank 2019b). Many qualified professionals leave the country to seek employment abroad, which further exacerbates the issue of the health workforce shortage. Recent salary increases for medical workers during 2021-2022 have not solved the problem of the shortage of doctors, especially in rural regions. On average, a doctor's salary is 24,000 som (approximately US$280), whereas it used to be only 12,000 som (approximately US$150) (Azernews 2023; WHO Regional Office for Europe 2022).

While several measures were taken by the Government as part of health reforms implemented to upgrade medical infrastructure, health care facilities face maintenance challenges in rural areas (World Bank 2019b). To improve the availability of health services in rural regions, in 2022, the Ministry of Health purchased one CT scanner and an X-ray machine for all regions, which were previously only available in private medical centres. The population can now receive diagnostic services without leaving the capital and at a lower cost. However, these kinds of efforts should go hand in hand with enhanced training. The supply of computed tomography scanners require trained personnel to work with this equipment, the supply of which is not sufficiently available in underserved regions. In addition, given the lack of stable access to basic resources such as water or electricity, more effective and modern medical equipment cannot be installed (ILO 2020).

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Quality and acceptability

The country has a system of state licensing for medical services. All private organizations must obtain a license from the Ministry of Health for certain types of medical services. These licenses do not need to be renewed.[103]

Public health organizations carry out their activities in line with orders from the Ministry of Health. A license is not issued to them, but they need to be accredited by an independent Medical Accreditation Commission (MAC) once every three years. Accreditation is subject to a fee both for private and public health providers. If a private medical centre wishes to provide services under the SGBP and sign a contract with the MHIF, accreditation is required.

The Ministry of Health developed and approved over 700 clinical guidelines and protocols that define standards of medical care for various diseases. All clinical protocols and guidelines are evidence-based (WHO Regional Office for Europe 2018). A national Health Technologies Assessment (HTA) process has not been developed in Kyrgyzstan. A Health Development Centre exists, and has been renamed the "Health and Health Technologies Development Centre", which is obligated to implement HTA, but this process is still in the early stages (WHO Regional Office for Europe 2022).

Quality control of health care provided by private medical organizations is carried out by the Ministry of Health, as well as by organizations which protect the rights of patients in accordance with their statutory activities.[104] Control over the activities of individuals and legal entities engaged in private

[103] Order of the Ministry of Health of the Kyrgyz Republic on the Procedure for Carrying Out Licensing of Private Medical Practices in the Ministry of Health of the Kyrgyz Republic, dated 25 March 2013, available at: https://cis-legislation.com/document.fwx?rgn=61516

[104] Chapter 14 of the Health Protection in Kyrgyz Republic Law No.6 of 2005.

medical or pharmaceutical activities is carried out in accordance with national legislation in Kyrgyzstan on inspections of business entities. Quality control of medical services in public health facilities is carried out by the MHIF.

The MHIF quality control system includes the following two methods: Analyzing the medical records for inpatient treatment, twice a year; and a twice yearly Health Quality Assessment using a specially developed Balanced Scorecard (WHO Regional Office for Europe 2018).

Analysing medical records is only carried out in specialized hospitals (TB clinics, mental health facilities, Oncology facilities, for example) and national centres providing high-level medical services. From 2000 to 2018, the MHIF applied penalties to health facilities for delivering poor quality services. The MHIF has since moved towards a positive assessment of health facilities. Based on the results of the Balanced Scorecard assessment, additional financial incentives of up to 3 per cent of their available budget were provided to health providers. Since 2020, due to a lack of sufficient funds in the MHIF budget, incentive payments have not been made (Mukuria-Ashe et al. 2022; WHO Regional Office for Europe 2022; 2018). However, quality control is carried out every six months, and health care quality assessments using the Balanced Scorecard are carried out in all PHC organizations and hospitals (WHO Regional Office for Europe 2019b; 2018). Nonetheless, quality remains an issue, especially at PHC level. There are more than 690 Family Groups of Practitioners in the country, but due to the low level of PHC service quality, the population is forced to seek health services at regional and national levels (WHO Regional Office for Europe 2023; 2022). Applications for outpatient care at the regional or national level are carried out on a paid basis, which also affects the high level of OOP spending.

According to a study conducted in 2010, the population's satisfaction with health care services declined from 52 per cent to 47 per cent between 2001 and 2010 (Footman et al. 2013). Among the main issues are inequalities between urban and rural areas and a lack of financial protection. People from rural communities find it challenging to pay for their medical expenses, which often forces them to use savings or borrow money from relatives.

In addition, awareness is an issue. Patient surveys suggest that many patients remain unaware of some of the benefits they are entitled to under MHI (Mandatory Health Insurance Fund 2022b). To address this, the MHIF has initiated large-scale work to improve the insurance literacy of both the population and medical workers, with video clips broadcast through the media on TV and radio. Each health care organization now has high quality boards with accessible information. This work is carried out under the direct supervision of the Government and the Minister of Health.

▶ 5. Way forward

In 2021, the country's leadership launched a large-scale revision of laws and regulations, including for those related to health care. This process revealed a critical need to review the SGBP and payment regulation decrees to ensure financial sustainability, good value for money, enhanced financial protection and equity. The most recent amendments of the law, which have mandated the inclusion of the entire population in the MHI scheme could be a step in this direction. Improving compliance to ensure employers effectively pay social fund contributions, as well as efforts to identify additional public sources of financing may be required (Damira and Apyshevna 2020).

Moreover, there is a need for more systematic or evidence-based procedures for reviewing and revising the lists of medical services and medicines that should be included in the SGBP. It is also crucial to consolidate the gains of MHI and effectively expand the scheme universally, with additional to coverage for non-nationals.

The Government recognizes the challenges that the health system is facing and has made a strategic commitment to take steps to further reorganize and strengthen health care. The 12-year health strategy

"Healthy Person – Prosperous Country 2019-2030"[105] sets the objectives of improving the accessibility of essential health services, enhancing PHC and expanding the coverage of financial protection mechanisms. Due to the COVID-19 pandemic, the implementation of this programme was suspended, but since 2022, the Ministry of Health, under the initiative of the WHO, has resumed its implementation.

To achieve the objectives identified by the 12-year health strategy and to strengthen health protection for the population, several measures can be enacted:

- Further strengthen health service delivery and optimize the distribution of resources, while continuing to increase the number of active MHI contributors. The integration of better system monitoring and data collection mechanisms can further facilitate the modernization of the mandatory health insurance system to the benefit of the population.
- Improve the financing of priority health services and of health care in general. As part of this effort, it will be important to increase the share of MHI contributions (MHI plan payments and payments to the Social Fund) in the overall MHIF budget. Better enforcement and incentives for MHI participation are required. In addition, the financing of primary and outpatient services at community level should be strengthened.
- Strengthen the resourcing and capacity of the health system through improvement of service availability and infrastructure, particularly in rural areas.
- Improve the accessibility of medicines through the expansion of the list of discounted medicines and better regulate medicine prescriptions and prices.

▶ 6. Main lessons learned

- The country managed to secure near-universal coverage for a basic package of health care benefits through the SGBP scheme, managed by a central institution in charge of pooling funding and paying providers, namely MHIF. Despite this progress, challenges remain when it comes to expanding higher levels of benefits under the MHI and ADP schemes to the entire population.
- Through the reforms that accompanied the introduction of these schemes, Kyrgyzstan achieved some notable improvements in health outcomes, with expanded scope, coverage, and utilization of health care services, alongside the diversification and growth of health financing sources. Average life expectancy increased by three years between 2000 and 2019, and there has been a substantial reduction in the incidence of tuberculosis and the risk of child mortality (WHO 2021a).
- However, the SGBP, as described in various legal documents, is complicated and can be confusing to the general population. Even within primary care, some services are free to the whole population, while others require payments from certain groups. For inpatient care, some groups have unlimited benefits, while others are subject to a cap. Additional rules govern the MHI and ADP schemes, respectively, adding further layers of complexity for beneficiaries.
- It is necessary to reinforce PHC and align resource allocation with this priority, otherwise weak infrastructure and low capacity of family doctors may force patients to seek care at outpatient departments of hospitals, thereby creating duplication of structures and increasing patient expenses.
- The provision of a number of high-priority services (such as primary care and medicines) remains underfunded, while many hospital-level services are being overutilized. Among the key remaining challenges include high OOP spending on priority services, the underdevelopment of PHC, and significant gaps in service availability in rural areas.

[105] Resolution of the Government of the Kyrgyz Republic No. 600 on the Program for 2019-2030 on Population Health Care and Development of the Health Care System "Healthy Person – Prosperous Country", dated 20 December 2018, available (in Kyrgyz) at: https://www.gov.kg/ky/npa/s/222

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Tajikistan

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1. Introduction

The Republic of Tajikistan is a lower middle-income country located in Central Asia with a growing population and a developing economy. Since 1991, the population has increased by 73.2 per cent reaching 9.506 million in 2021 (ILO 2023). GDP per capita at purchasing power parity (PPP) was 4,885 international dollars in 2022 (World Bank 2022a). The Human Development Index for Tajikistan was 0.685 in 2021, which exceeds that of Afghanistan (0.478) and Pakistan (0.544) but is the lowest among Western and Central Asian countries (UNDP 2022). While there have been indications of some reduction in informality in the past two decades (ILO 2019a), the informal economy in Tajikistan remains very large, with estimates ranging from 22 per cent to 43 per cent of GDP (Bekzhanova and Temirova 2019; Medina and Sheinder 2018). Research suggests that around 32 per cent of men and around 15 per cent of women are employed informally (Staneva and Arabsheibani 2014). Since the early 2000s, the country has been experiencing economic growth, with GDP per capita at PPP increasing threefold between 2000 and 2022 (World Bank 2022a). Alongside economic growth, the quality of health and social protection services has gradually improved, and over 16.1 billion Tajik somoni was allocated to these sectors from 2018-2020 (Ministry of Finance of the Republic of Tajikistan and PEFA 2022).

In 2016, the Government of Tajikistan adopted the long-term National Development Strategy (NDS) 2030, embarking on a new path towards economic development. The social implications of this shift in strategy and policy have been significant. In particular, the NDS has set the wheels in motion to halve poverty and eliminate extreme poverty, double GDP, improve the country's ranking in the UN's Human Development Index and the World Bank's Doing Business ranking, significantly increase social protection and health spending, and improve health care indicators (ILO Social Protection, n.d.).

The Government of Tajikistan is committed to ensuring the population's access to affordable health care and quality nutrition, cultivating a healthy lifestyle and introducing high-tech medical services (ILO 2019b). Currently the main programme providing financial protection in Tajikistan is the Guaranteed Medical Services programme (GMSP), regulated by Decree No. 90 of 2017. The procedure for health

service provision in public health facilities is regulated by Decree No. 600 of 2008 and subsequent amendments (for example, Decree No. 485 of 2018). Both mechanisms are publicly funded with co-payments for the main population (with exemptions).

▶ 2. Context

Since Tajikistan gained independence in 1991, a lack of resources has posed major barriers to improving accessibility of services and social health protection coverage. Underfunding, combined with poor management of the health sector, has limited the health system's ability to respond to population needs, with reported workforce, facilities and equipment shortages. The first years of independence were accompanied by a significant deterioration of the population's health due to a rise in a number of communicable-and non-communicable diseases, the effects of the civil war and limited access to health services, particularly for poorer groups of the population (The Borgen Project 2021; WHO 2020).

Reforms attempting to address the issue of prevalent informal co-payments to health care workers were initiated in the early 2000s, which involved developing and approving the primary benefits packages in 2005. This did not occur quickly as the system was not prepared for drastic and progressive reforms, mainly due to low capacity, poor inter-ministerial coordination, economic recession caused by the civil war, and a lack of standardization of co-payment categories and rates (Jacobs 2019).

The basic benefits package and co-payment rates were defined and introduced in four pilot districts from 2004-2005 (Jacobs 2019). In 2008, two milestone legal acts were adopted: (1) Government Decree No. 600 on the Procedure of Health Service Provision in Public Health Facilities to the Citizens of the Republic of Tajikistan, which introduced the regulation of health care fees outside of the regions where the basic benefits package was piloted; and (2) Law No. 408 on Health Care Insurance in the Republic of Tajikistan of 2008, which provided for the introduction of a mandatory health insurance (MHI) scheme and the establishment of the Mandatory Health Insurance Fund (MHIF). Decree No. 600 determined beneficiaries and a benefit package and level of protection (services to be provided for free, and co-payments for other services). The pilot was extended to the entire country in 2010 (Khodjamurodov et al. 2016).

In support of these measures, the Government implemented important structural and administrative reforms, including capitation-based payments at the primary health care level, investing in health care resources to improve service availability, and expanding the institutional capacity of public health providers (Khodjamurodov et al. 2016). These initiatives had to be integrated by the MHI scheme mandated in 2008. However, through a series of amendments (in 2010, 2014, 2018 and 2022), the introduction MHI was postponed several times (Jacobs 2019; Khodjamurodov et al. 2016).

In 2017, the Government introduced the Guaranteed Medical Services Programme (GMSP), which was built upon the basic benefits package designed in 2008. The GMSP is a state guarantee for a basic package of health care services, provided free of charge to some vulnerable groups of the population, and on the basis of co-payments for others in pilot regions. The expansion of GMSP was gradual. In 2018, it reached 31 districts out of 79 in 19 regions, eventually expanding to nationwide coverage in 2021 (WHO 2020; 2022).

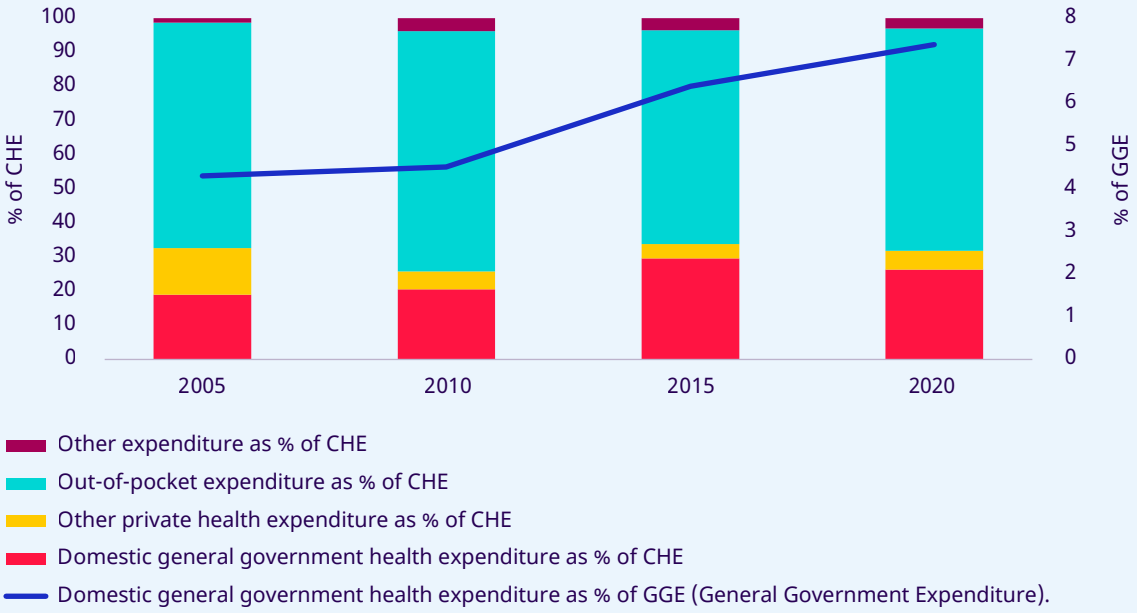
▶ 3. Design of the social health protection system

Financing

Today, health expenditure in Tajikistan is financed predominantly by general taxes. Government spending on health increased significantly during the past two decades, from less than 0.9 per cent of GDP in 2000 to 1.9 per cent of GDP in 2021 (WHO 2021c). Similarly, health expenditure has been increasingly prioritised

in the national budget, growing from 4.6 per cent of general government spending in 2000, to 6 per cent in 2017, and reaching 7.4 per cent in 2020. The growth of public expenditure resulted in an increase of general government health expenditure as a percentage of CHE from 21 per cent in 2000 to 29 per cent in 2017, which then decreased to 26 per cent in 2020, which is still comparatively low by international standards. Private health financing is prevalent, which obstructs accessibility of care for the less well off.

Figure 42. Composition of current health expenditure (CHE) in Tajikistan, by source of financing, 2017-2021



Source: Based on data from the WHO Global Health Expenditure Database.

In 2021, CHE per capita was estimated at just US$73, and US$351 per purchasing power (PPP) according to the exchange rate at the time (WHO 2021b; World Bank 2024). The level of health expenditure measured according to the exchange rate is at a similar level to that of neighbouring Kyrgyzstan (US$64) but falls short in comparison to Uzbekistan (US$121) (WHO, n.d.). However, a significant portion of funding comes from OOP payments. While the publicly-funded system aims to ensure free access to services provided at health facilities, co-payments and informal payments are widespread (Khodjamurodov et al. 2016). The share of OOP payments in total health spending accounted for as much as 63.2 per cent in 2017 (WHO 2021d). In 2021, OOP expenditure still accounted for almost two thirds (64 per cent) of health spending (see figure 43). Decree No. 90 makes provisions for additional financing whenever possible from local executive bodies, international donors and other sources in line with national legislation (ILO 2019b).

Governance

Tajikistan's social protection and health systems are centralized and run publicly, and the Ministry of Health and Social Protection (MoHSP) plays a central role in policy making, tasked with identifying priorities in the health care sector and developing a national health policy (Khodjamurodov et al. 2016).

MoHSP coordinates activities within the health system, sets health care standards and monitors the quality of services and medical goods such as pharmaceuticals. The Ministry is also mandated with tasks such as building the capacity of health care professionals and licensing specialists and institutions

employed within the health care system (Khodjamurodov et al. 2016). The Health Code [106] outlines the roles of relevant public institutions in managing, regulating, and supervising health services. It sets the general structure of the health system, identifies the main sources of financing and defines the rights and responsibilities of both patients and health care workers, as well as the different types of medical services.

MoHSP is also tasked with managing medical institutions (secondary and tertiary) at the republican level (Khodjamurodov et al. 2016), and sets rules and procedures for providing all types of medical care in the country. The Ministry of Finance oversees public health expenditures as an integral part of the national budget (WHO 2022).

Health care at regional (viloyat or oblast) and district/city (rayon) level is managed by local health departments and administrations. Local-level health authorities are tasked with running and financing local health facilities. They report to both local governments and MoHSP (Khodjamurodov et al. 2016).

As per the provisions of the Health Code, the Government of Tajikistan is responsible for carrying out public policies on health as well as setting up and supervising state bodies responsible for managing the health system. The Government approves relevant national programmes, initiatives and some health-related regulations that have implications for the budget or the structure of the system. The Government is also responsible for improving and defining the scope of international cooperation in the area of social health protection and health.

Legal coverage and eligibility

Article 38 of the Constitution of the Republic of Tajikistan [107] guarantees the universal right to health care. It stipulates that "everyone shall enjoy free medical assistance provided by public medical institutions." The right to protection of health is rearticulated in article 36 and article 41 of the Health Code. For example, article 41 guarantees the right to medical, orthopedic and prosthetic care.

All citizens of Tajikistan, without exception, are eligible to receive health services under either GMSP (as per Decree No. 90 of 2017) or in line with the procedure of health service provision in public health facilities (Decree No. 600 of 2008 [108] and subsequent amendments, such as Decree No. 485 of 2018), depending on their place (district) of residence. Both GMSP and the procedure of health service provision in public health facilities define categories of individuals who are eligible for exemption from co-payments for health services that are not free.

The lists of such categories are similar for both Decrees and predominantly include groups categorized as vulnerable (WHO 2022a; Khodjamurodov et al. 2016). These groups include the following: War veterans; people affected by the Chornobyl nuclear disaster; children with disabilities and adults with certain forms of disabilities; [109] children under one year of age; orphans living in state orphanages and children left without parental care; the elderly over 80 years of age; and citizens living in nursing homes or similar institutions. These population groups are exempt from co-payments for health services. In addition to the above categories, patients suffering from a pre-defined list of the following conditions (as defined by MoHSP) are also eligible for free public health services related to these conditions (WHO 2022a; Khodjamurodov et al. 2016):

- Leprosy;
- Tuberculosis;
- HIV/AIDS;
- Haemophilia;
- Cholera;

[106] Health Code of the Republic of Tajikistan, dated 15 March 2017, available (in Tajik) at https://mmk.tj/system/files/Legislation/1413%D1%82%D1%87.pdf

[107] Constitution of the Republic of Tajikistan, available at: https://www.wipo.int/wipolex/en/legislation/details/10268

[108] Government of Tajikistan Decree No. 600 on the Procedure for Providing Medical and Sanitary Services to Citizens of the Republic of Tajikistan, dated 2 December 2008, available (in Tajik) at: http://mti.tj/tartibi-hizmatrasonii-tibbiyu-sanitar-ba-sha-rvandoni-um-urii-to-ikiston-dar-muassisa-oi-sistemai-davlatii-tandurust/

[109] Adults suffering from disabilities since childhood and adults with disabilities of groups I and II as a result of work-related injuries or diseases.

- Diphtheria;
- Diabetes (insulin-dependent form).

In addition, according to Decree No. 600, patients with acute myocardial infarction and terminal cancer are also exempt from user fees (Khodjamurodov et al. 2016).

Benefits

Under GMSP and procedures for public health provision as per Decree 600, public health facilities provide health care services both free of charge and on a fee basis.[110] Free health services include emergency care; preventive health services (such as the promotion of healthy lifestyles); immunization; basic diagnostic tests and consultation at the primary level; and initial patient consultation and prescription at primary and secondary levels, upon referral (Khodjamurodov et al. 2016). Other health services (including specialty outpatient consultations and planned hospital services) require co-payments, which are regulated by Decree No. 600 of 2008 and Decree No. 90 of 2017.

For outpatient services, patients with referral must pay a 50 per cent (*under GMSP*) or 80 per cent (*under the Decree 600 procedure*) co-payment and patients with no referral must pay a 70 per cent (*under GMSP*) co-payment or the full amount (*under the Decree 600 procedure*) (O'Dougherty et al. 2014)

Children and pregnant women also have free access to a range of services, including health monitoring, delivery services and preventive check-ups (including periodic dental check-ups) (Khodjamurodov et al. 2016).

Additional services are provided for free under a number of targeted public and international programmes run in the country (WHO 2021a). However, these services typically vary depending on the type of programme and are not formally institutionalized. Consequently, their coverage is neither wide nor uniform.

Sickness and maternity benefits are available respectively through social insurance for employed persons and social assistance for all women in Tajikistan. They are supervised by the Ministry of Labour, Migration and Employment of the Population and administered by the State Social Insurance and Pensions Agency and its regional bodies (ISSA 2022).

Entitlement to the maternity benefit depends on the following conditions: a) a woman must be insured; b) a contingency should occur during the period of work; and c) an application for the benefit should be made no later than six months after the end of the maternity leave. The amount of benefits is also influenced by the specifics of the maternity leave (multiple birth, complicated childbirth, adoption of a child), whereas health services are provided to all with no exceptions (ILO 2019b).

Provision of benefits and services

Tajikistan operates a publicly-run centralized health care system, with the exception of an almost completely private pharmaceutical sector (WHO 2022). In 2020, 525 hospitals, 1,731 community health centres, and 2,891 outpatient clinics were operating in the country (Tajstat 2021). Private health facilities constitute the minority of these facilities, although the number of such facilities has been growing in recent years. Most private providers are concentrated in urban areas and therefore are not accessible to a large share of the population (WHO 2022). Currently, there are close to 2,500 pharmacies in Tajikistan, most of which are also located in urban areas (WHO 2020).

In order for individuals to access benefits provided under Decree No. 600 of 2008 and Decree No. 90 of 2017, they are required to provide an identity document (with indication of their place of residence) and a referral (in the case of accessing specialized services).

Primary health care workers (including family doctors, local therapists, paediatricians, obstetrician-gynaecologists, staff of territorial offices of health care, and medical-control commissions) are the first

[110] Health Code of the Republic of Tajikistan, dated 15 March 2017, available (in Tajik) at: https://mmk.tj/system/files/Legislation/1413%D1%82%D1%87.pdf

point of contact for patients (WHO 2020). There is currently no purchaser-provider split in the Republic of Tajikistan, as all public health facilities (which serve as the main providers of health care in the country) are both financed and run by local or national administration (Jacobs and Camargo 2020).

Payment models for PHC providers are reported to be mixed. In some districts, a results-based model is applied as part of a pilot conducted in collaboration with the World Bank. In most other districts, a capitation approach is used with different reimbursement rates for urban and rural facilities. For hospitals, reimbursement is usually provided using an input-based model with line-item budgets for facilities (WHO 2021a).

▶ 4. Results

Coverage

In 2016, Tajikistan began piloting the implementation of the GMSP to expand social health protection coverage with the support of the national government and international development partners (WHO 2022). However, population coverage reached only 20.7 per cent in 2019 (WHO 2020). This supplements health care services provided on a paid basis, including those provided in accordance with Government Decree No. 600.

Access to health care for the remaining 79 per cent of the population is legally governed by the provisions of Decree No. 600 of 2008 (WHO 2020). The number of people who are entitled to full exemption from co-payments under the two decrees is relatively small, estimated at just 4 per cent of the population in some regions, which makes OOP payments significantly high in comparison to government spending on health care (Khodjamurodov et al. 2016).

Adequacy of benefits/financial protection

Financial protection through Decree No. 600 of 2008 and the GSMP is limited. Unfortunately, data indicates that the limited financial protection far from guarantees equitable coverage and accessibility of care. Furthermore, the coexistence of two mechanisms perpetuates fragmentation of social health protection schemes.

While the introduction of co-payments has led to a reduction of informal payments, the move has not substantially reduced OOP spending, which remains very high, posing a significant financial risk and a barrier to accessing health services. Between 2009 and 2013, informal OOP expenses decreased from around 54 per cent to less than 47 per cent of CHE (WHO 2020). Catastrophic health care payments also declined from 31 per cent in 2003 to 19 per cent of CHE in 2011. However, progress has slowed since then, with catastrophic health care payments reported at 18 per cent of CHE in 2015, and a risk of impoverishing expenditure for surgical care at 68 per cent of the population in 2022 (WHO 2020; World Bank 2022c).

High co-payment rates are contributing to increased OOP spending, and it is likely that a considerable number of people are forced to pay for extra charges for health care services under current provisions. The practice of informal payments is still reported at all levels in Tajikistan, which is fundamentally linked to underfunding of the health system and low salaries among health workers (WHO 2020).

Notably, the population is highly dependent on remittances, which constitute an important means of paying OOP expenses. Personal remittances received by households from Tajik labour migrants were estimated to account for nearly 27 per cent of GDP in 2020 (World Bank 2022b). Research has shown that remittances have positively contributed to health services utilization in Tajikistan (Kan 2021), and tend to be particularly important for lower-income households, where they also supplement food consumption. However, remittances do not constitute a stable, progressive way to finance social health protection, providing merely a backup solution to address low public funding and large gaps in financial protection.

In addition to limited availability and unequal distribution of services and infrastructure, the population also has limited access to pharmaceuticals, which are largely excluded from the list of services that are

provided free of charge under the GMSP and Decree No. 600 of 2008 (WHO 2021a). Weak regulation of prices of medicines means that they are often unaffordable, and poor and vulnerable people cannot purchase the medicines they need (ILO 2019b). Some sources report that spending on medicines accounts for 37 per cent of OOP payments (WHO 2020).

Looking ahead, Tajikistan faces a rising burden of NCDs. It is estimated that NCDs accounted for 69 per cent of all deaths in the country in 2016 (WHO 2022). Cardiovascular diseases are the main cause of mortality, followed by cancers, chronic respiratory diseases and diabetes (WHO 2023). However, the GMSP predominantly exempts patients suffering from Communicable Diseases from payments, as opposed to those suffering from NCDs, impacting access to NCD care.

Responsiveness to population needs

Availability and accessibility

In Tajikistan, the UHC service coverage index on coverage of essential health services increased from 41 in 2000 to 66 in 2019. Excess mortality is estimated to have increased during the COVID-19 pandemic, which also disrupted access to essential health services (WHO 2022).

On the other hand, immunization coverage in Tajikistan is high. For example, childhood vaccination reached 97 per cent of coverage of Diphtheria tetanus toxoid and pertussis (DTP3) in 2020. Rates for some communicable diseases have also improved in recent years, but challenges remain for others such as tuberculosis (TB) (WHO 2022).

In terms of availability, Tajikistan has one of the smallest ratios of health workers to the population in the Europe and Central Asia region as well as among Central and Western Asia countries. In 2021 there were only 215 practicing physicians per 100,000 persons in Tajikistan (a slight increase from 167 in 2000), compared with an average of 372 in the Europe and Central Asia Region and 269 in Central and Western Asia countries. There are also far fewer nurses than in most other neighboring countries, with only 537 practicing nurses per 100,000 persons in 2021 compared with 818 in the Europe and Central Asia Region and 468 in Central and Western Asia (WHO 2022). In short, Tajikistan has fewer practicing doctors and nurses per population than most countries in Europe.

There are also major regional inequalities in the geographical distribution of health care staff. Health workers are primarily concentrated in the capital, Dushanbe, and staffing rural areas has historically been a challenge. For example, according to recent estimates, in Dushanbe there were 8.25 doctors per 1000 people, whereas in Khatlon district (a district neighboring Dushanbe) there were only 1.15 doctors per 1000 people (WHO 2020). In addition, Tajikistan struggles with migration of health workers to other countries, in particular to the Russian Federation, where salaries are higher (WHO 2022). Physical access to specialized services can be a challenge in rural areas too, particularly in mountainous and remote areas of Tajikistan (WHO 2022).

In response, the Government has started tackling the growing demand for health care workers by increasing the number of medical training institutions. The number of medical universities increased from one to three, and the number of medical colleges increased from ten to 28 from 1991-2020. Increased training capacity contributed to a growth in the density of medical professionals from 19.2 to 21.3 for doctors and 42.2 to 61.7 for nurses per 10,000 people from 2005- 2020 (Tajstat 2021).

On the other hand, the health care system has a relatively high number of hospital beds and significant over capacity in this regard. However, the ratio of hospital beds per 1,000 persons decreased from around 6.5 in the year 2000 to 4.7 in 2014 (World Bank 2014). Bed occupancy rates are 66.4 per cent with an average length of stay of nine days (WHO 2020).

Availability of services is affected by a lack of equipment and infrastructure. For example, reports indicate that there is a shortage of emergency vehicles. Neonatal transport often needs to be organized and paid for privately by families, as the number of emergency vehicles is insufficient. Notably, more than 70 per cent of transport is organized privately (WHO 2021a). Less than 20 per cent of the country is covered by ambulance services (WHO 2021a). The vehicles that do exist and are used for neonatal transport are limited in number and are often not equipped properly, and no helicopters are available for emergency

transport. This may cause isolation, especially in rural areas where, due to weather conditions, there are few connections to cities (Peyrouse 2021). A lack of equipment, devices and aids has been reported at the level of primary health care, where family doctors and district physicians report being insufficiently equipped or lacking the necessary laboratory and radiography facilities (Khodjamurodov et al. 2016).

Tajikistan has around 2,450 pharmacies, only 30 per cent of which are in rural areas. Since three quarters of the population live in rural areas, a large proportion of the population does not have easy access to medicines (WHO 2020). Median availability of the lowest priced generic medicines in the public sector increased from 70 per cent in 2005 to 96.6 per cent in 2012 (Perehudoff et al. 2019). There have also been issues with a prevalence of low-quality medicines and new drugs unknown to the majority of health professionals in the country. The widespread trafficking and availability of counterfeit pharmaceuticals is a major area of concern (Khodjamurodov et al. 2016).

Large inequalities exist in access to antenatal care as well as immunization, according to income, with a difference of 36.6 percentage between the wealthiest and poorest quintile among women who had at least four antenatal care visits during pregnancy. There are also significant variations between rural and urban areas in relation to skilled birth attendance (WHO 2017).

Quality and acceptability

Quality of care remains a major concern, given the historic underinvestment in facilities and equipment, and outdated clinical guidelines. The country adopted regional development programmes in line with a strategic focus on improving access to quality health care and social health protection. However, economic pressures – due to the COVID-19 pandemic, inflation and the energy crisis – have limited some of the work originally planned. This level of quality of care results in low utilization of health care facilities. Notably, factors contributing to poor health outcomes for maternal and child health include poor quality of maternal and emergency obstetric care, and reluctance to seek medical assistance due to high OOP costs (WHO 2022).

The quality of health services is further impacted by the brain drain, which is predominantly driven by low salaries, with some PHC physicians earning less than bus drivers (WHO 2021a). Moreover, unfavourable working conditions, including poor infrastructure, make the health profession unattractive to many professionals (WHO 2020).

Limited availability and quality of services is caused by limited funding, as more than 80 per cent of the (limited) public health spending goes towards salaries (World Bank 2021). Funds for the renovation of existing facilities or the construction of new facilities have been lacking, and available equipment tends to be obsolete and/or dysfunctional. In most health facilities, heating, water and electricity supply are unsatisfactory (Khodjamurodov et al. 2016). This lack of technical infrastructure impedes the provision of care. Most health facilities (especially regional and district hospitals) were constructed during the Soviet period and have deteriorated since the 1990s mainly due to underinvestment. The Government and external donors have started to address this but it will take time to see substantial changes (Khodjamurodov et al. 2016). Medical facilities in rural areas are in a worse condition than those in urban areas. Most rural hospitals are staffed with only one doctor and other medical facilities are staffed with young, inexperienced nurses and lack basic medicines (Peyrouse 2021).

In addition, poor training of staff and the absence of modern information technologies are obstacles to reliable data collection. A study conducted in 2012 found that 90 per cent of family doctors and 82 per cent of district physicians did not use a computer in their practice (Boerma et al. 2014). Furthermore, urban areas are better informed about available services than rural areas, with rural patients more limited in their choice compared to urban patients, who can more easily change their practitioner, specialist or hospital physician (Khodjamurodov et al. 2016).

Private medical facilities also report facing constraints in purchasing medical equipment. In particular, since 2007, private providers have been required to pay value-added tax on imported medical equipment, which has been noted as an obstacle (Khodjamurodov et al. 2016).

Low quality of infrastructure and services affect the uptake of care and could potentially complicate the rollout of a mandatory health insurance scheme. Available data indicates that the utilization of PHC

services has not been on the rise. On the contrary, between 2010 and 2016, the average number of visits to PHC facilities per person decreased from 4.8 to 4.1 (WHO 2020).

In addition, data on patient satisfaction is contradictory. According to a survey among 2000 respondents conducted in 2011, only 16 per cent of respondents were satisfied with ambulatory care and only 19 per cent were satisfied with inpatient hospital services (Azevedo et al. 2014). However, according to another survey conducted in 2010, 57 per cent of respondents were satisfied with the quality and efficiency of the publicly run health system (Diagne et al. 2012). Surveys conducted in the region where the Tajik–Swiss Health Sector Reform and Family Medicine Support Project (Project Sino) was implemented between 2005 and 2014 indicated very high levels of patient satisfaction. This paradoxical finding may be due to low patient expectations (Khodjamurodov et al. 2016).

According to a more recent study conducted in the Isfara district, women interviewees reported that they were satisfied with the PHC they received in village-level health centres. However, when referring to secondary, tertiary or specialized services in Isfara town, women reported issues related to time and cost. Traveling to towns and queuing may impact women's decisions to see a doctor, and services in towns cost more compared with village health care facilities. Consequently, some women choose not to follow referrals if their case is not perceived as severe. Moreover, prescribed follow-up visits after treatment are often perceived as unnecessary (Nabieva and Souares 2019).

Polypharmacy [111] and the use of antibiotics with no prescription are practices that are widespread in Tajikistan (WHO 2021a). A prescription is not mandatory for antibiotics and people often go directly to a pharmacy because it saves time and money compared with an appointment with a doctor. Limited trust in PHC also plays a role in self-medication. Instead of consulting a doctor, people tend to consult with friends, colleagues or family members before going to the pharmacy (Kaae et al. 2020). According to a study, during hospitalization, children and pregnant women are commonly prescribed medications when it is not indicated, or with no evidence of benefits, suggesting that people may purchase drugs that are not be beneficial, thereby creating an unnecessary financial burden (WHO 2022).

5. Way forward

There is a need to ensure financial protection for all residents across the country and for all diseases. In 2021, the Government of Tajikistan adopted the Strategy for Population Health Protection until 2030 (Decree No. 414 of 2021) (Aiypkhanova 2022; Government of the Republic of Tajikistan 2024). The strategy reiterates the universal right to access medical services, and emphasizes the need to improve financing of the health system and improve the availability and quality of health services nationwide.

Specific actions should include the following:

- An extension of social health protection coverage to the entire population of Tajikistan, including the development of an appropriate feasibility study for the rollout of a Mandatory Health Insurance scheme in the country.
- An expansion of the benefit package, including the list of medicines (including those for NCDs), followed by the reduction of co-payments.
- An improvement of the availability and quality of health services nationwide through further investment into personnel, equipment and PHC facilities. All hospitals should have proper energy and water supply, functioning heating/cooling and sewage management systems, and basic medical and laboratory equipment should be available across the country.
- Training of health care staff and equitable regional allocation of graduates of medical schools as well as retainment of medical professionals in the health sector.
- Efforts to improve the availability of emergency care across the country, with a stronger emphasis on emergency care for patients suffering from stroke and heart attack in the mid-term.

[111] This term refers to the practice of using multiple -five or more- medications especially concurrently for the treatment of a single disorder (Masnoon et al. 2017).

- An increase in health care efficiency through digitalization of the system. Widespread usage of cell phones in Tajikistan may be used to the advantage of population health.
- An investigation of ways to mobilize fiscal resources and expand fiscal space in the context of financial constraints which limit the scope of services available to the population. Given the urgent need to mobilize financial resources to extend financial protection, mobilizing domestic revenue, including through progressive taxation mechanisms or through introducing contributory mechanisms, should be favored. Introducing taxes on health-harming products has been proposed as a potential solution. Currently, tobacco tax rates in Tajikistan are below the WHO-recommended levels (WHO 2021e). However, before introducing tobacco taxes, the Government should carefully analyse the potential regressive nature of such measures.
- A focus should be placed on transitions from informal and formal sectors and extending coverage to the informal economy. This will contribute to enhancing public resources available for social spending.

In light of the postponement of the national rollout of MHI, which was decided in December 2022 on the grounds of limited financial resources, the priority should be raising resources for social health protection. Slow improvements to public financing are impeding Tajikistan's progress towards UHC in line with Sustainable Development Goal 3 and the National Programme 2021-2030 (WHO 2020).

6. Main lessons learned

- Recent efforts to extend coverage should be commended. The gradual expansion of the GMSP in pilot districts means that Tajikistan has opted for a step-by-step expansion of coverage. This approach provides an opportunity sustain the financial viability of the new programme.
- However, the prolonged existence of parallel systems may create confusion in entitlements, administrative inefficiencies and the maintenance of a two speed-system.
- A number of challenges impede the achievement of adequate financial protection and equitable access to quality health services under the existing system. The current co-payment regulations do not provide the necessary level of financial protection, which is compounded by the persistence of informal payments. Moreover, most outpatient medicines are not covered by public financing. Despite the recent increase in health care expenditure, underfunding remains a major barrier, which affects the health care workforce and the availability of equipment and infrastructure in the country.
- Dependence on remittances among a large number of households is a widespread ad hoc mechanism used to pay for health care, providing a source of funds to cover relatively high co-payments in Tajikistan. This practice is not rights-based or progressive, nor is it sustainable or predictable in the long run. As such, remittances are not a valid or reliable source for funding health care on the country's path towards UHC.
- Access to pharmaceuticals remains limited to a large share of the population residing in rural areas, and a disparity in the availability of services exists within and outside cities. Lack of accessibility affects uptake of services, with a significant share of the population forced to seek alternative means of care, which manifests in a prevalence of self-medication.

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Türkiye

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1. Introduction

Türkiye is an upper-middle-income country with a population of 84,680,273 in 2021 (TURKSTAT 2022). With a GDP of US$906 billion, and US$10,616.1 per capita, Türkiye is the 19th-largest economy in the world. The country's Human Development Index (HDI) was 0.838 in 2021, ranking Türkiye as the 48th country worldwide (UNDP 2022). The share of people below the US$5.50 per day poverty line fell by three-quarters to 8.5 per cent between 2002 and 2018. High inflation and high unemployment have been exacerbated by macro-financial instability since August 2018. In addition, the COVID-19 crisis has deepened gender gaps, exacerbated youth unemployment and increased the poverty rate (World Bank 2022). The total informality rate declined between 2004 to 2018 from 50.1 per cent to 33.4 per cent, and the informal employment rate among salaried workers reached 13.7 per cent in 2021 (Bank for International Settlements 2023; Bağır et al. 2021).

Türkiye launched a series of reforms under the Health Transformation Programme (HTP) between 2003 and 2013. Its main goal was to provide universal health coverage and ensure equitable access, strengthening primary care services and expanding the capacity of hospitals. The HTP undertook several measures to achieve these goals. First, all public health facilities were merged under the Ministry of Health to consolidate the provision of public health care services under one authority. The second major reform was realized through the financing of health care service use via the establishment of the *Genel Saglik Sigortasi* General Health Insurance Scheme (GHIS), which covers the whole population. The third area of reform was in primary care: A pilot family practitioner scheme was introduced and this scheme was later extended to cover the whole population at the end of 2010 (European Observatory on Health Systems and Policies 2011).

Overall, the HTP has positively impacted all aspects of the national social health protection system, resulting in the substantial extension of population coverage, which reached 98.8 per cent of the population by 2021 (from 69.8 per cent in 2002), as well as improved access to and financing of health care services (OECD n.d.-c).

▶ 2. Context

The foundations of the current public health system for Türkiye were established during the period 1923-46. The focus was on preventive public health programmes and programmes to control communicable diseases such as tuberculosis, malaria and leprosy. In 1961, the Law on Socialization of Health Services (Law 224) was adopted. The law provided the basis for the establishment of national health services in Türkiye and stated that health services should be delivered in an equitable manner, continuously and in accordance with the needs of the population. The law aimed at providing free (or partly free) health care to all citizens, and financing came from co-payments and allocations from the government budget (OECD 2009).

In 1963, for the first time, health was included in the five-year development plan. The objectives of the first five-year development plan for the health sector were to: i) Give priority to preventive health care; ii) provide public health services through the Ministry of Health; iii) distribute health personnel evenly throughout the country; iv) promote community health services; v) encourage the domestic pharmaceutical industry; vi) support the establishment of private hospitals; vii) establish Universal Health Insurance; and viii) set up revolving funds in government hospitals. A general Health Insurance Law promoting the idea of Universal Health Insurance was subsequently drafted, but it was not until 1971 that this was forwarded to the Turkish Grand National Assembly, and ultimately it was not adopted (OECD 2009).

The series of reforms initiated under the HTP in 2003 have led to the achievement of UHC and improvements to the current health care system (Bump et al. 2014). The GHIS — a universal health insurance scheme placed under the social security institution) — is one of the main pillars of the programme, which was introduced in 2008 and extended to all in 2012 (Adaman et al. 2018). The GHIS is compulsory for all and includes both contributory and non-contributory pathways for enrolment (SGK 2021).

Before the reform, the social health protection system was characterized by fragmentation into separate schemes, each of which had different benefit packages and requirements: The *Emekli Sandigi* Government Employees Retirement Fund (GERF) for retired civil servants; The *Sosyal Sigortalar Kurumu* (SSK) Social Insurance Organization for white and blue collar public and private workers and their dependents; *Bag-Kur* for the self-employed; and the Green Card scheme to provide health benefits to the poor and vulnerable who were incapable of paying for health services. The Green Card programme was considered a transitional solution until universal health insurance was introduced (OECD 2009). It was expanded from 2003–2006 and provided citizens with extended benefits which helped to reduce OOP spending and catastrophic health expenditures for those in the upper end of health spending distribution (Tirgil et al. 2019). Active civil servants were not included in GERF, and their expenses were directly financed from the state budget. Service delivery was similarly fragmented, since many public health facilities were implemented under SSK, and the others were overseen by the Ministry of Health (Menon et al. 2013). By October 2008, the health care schemes were harmonized entirely, and all service users were covered by GHIS under a single umbrella (Burcu 2013).

Türkiye undertook extensive reforms in order to merge different insurance schemes and achieve integration and cross-subsidization. In 2006, the GHIS was established under the Ministry of Labour and Social Security to merge all existing health schemes (social insurance for merchants, artisans and the self-employed, the Green Card scheme and the GERF) under one umbrella, namely the social security institution known as SGK. In addition, various health care users were granted access to additional health care services. For example, Green Card holders were given access to outpatient care and pharmaceuticals, whereas SGK beneficiaries were given access to all public hospitals and pharmacies. Moreover, in 2006, the pharmaceutical list was integrated across all health insurance schemes, including that of Green Card holders. In 2007, legislative measures mandated that all Turkish citizens have access to free primary care, even if not covered under the social security system. Subsequently, under the Health Implementation

Decree of 2007,[112] benefits across the health insurance schemes were further harmonized and finalized in 2008 (Bazyar et al. 2020).

According to the new Social Insurance and General Health Insurance Act No. 5510 of 31 May 2006,[113] the same benefit package is provided to all. All individuals registered with the GHIS can benefit from public health facilities without or with very limited co-payments. Although private health insurance is also available on a complementary or supplementary basis, it is relatively expensive, and only 7.6 per cent of the population were members in 2020 (OECD n.d.-d). Moreover, individuals with private health insurance cannot opt out of compulsory public health insurance; they have to pay premiums and contributions to both schemes separately (Dorlach and Yeğen 2023).

The Ministry of Health developed a new Strategic Plan for 2019-2023. It aims to strengthen primary health care services and increase their efficiency, ensuring improved access, greater efficiency and higher quality of health care services by focusing on service users and medical personnel satisfaction with the use and provision of health care.

▶ 3. Design of the social health protection system

Financing

Türkiye's public health care spending as a share of GDP was among the lowest of the OECD countries in 2020. In 2020, Türkiye spent 4.6 per cent of its GDP on health, while the average value for OECD was 8.8 per cent. In the first three years following the introduction of the HTP in 2003, although health expenditures rose rapidly, increases in both total and public spending on health care seem to have remained affordable because economic growth in Türkiye was also rapid. However, Türkiye's current health spending represents a decline since 2009 when it reached 5.5 per cent (WHO 2020; OECD 2009).

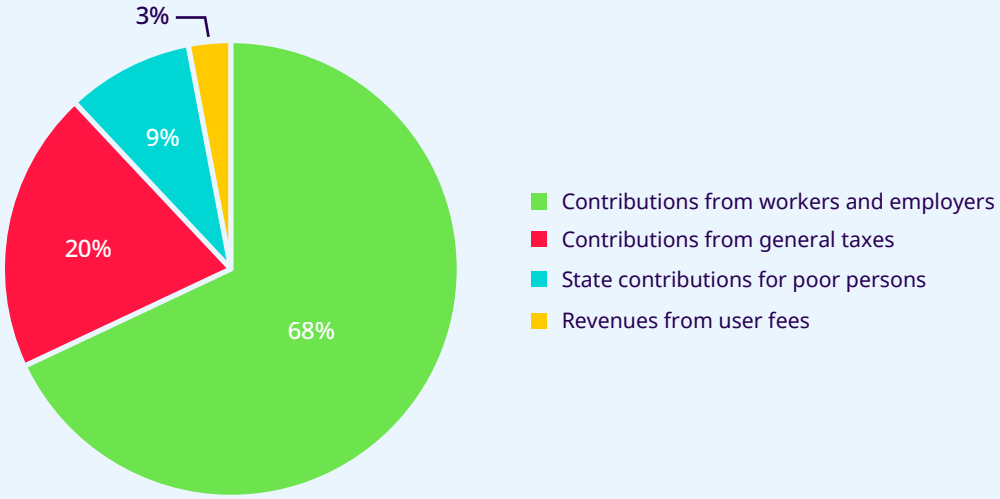
Türkiye's GHIS is a compulsory universal health insurance scheme, which both employers and workers contribute to. According to Law No.5510, the total contribution rate for the scheme is 12.5 per cent, whereby employers pay 7.5 per cent and employees pay 5 per cent. Contributions for employees, civil servants, the self-employed and foreigners are defined as a share of their wage. The Unemployment Fund pays the contributions of persons who are eligible for unemployment benefits. Contributions of pensioners are paid either by SGK or the State depending on their status. Unemployed persons who are not eligible for unemployment benefits and informal workers pay contributions for themselves, based on a means-test assessment.

Contributions are collected and pooled through the account of the SGK and operated by the General Department of Universal Health Insurance (see below). The Government contributes to the revenues of the SGK by financing the groups that are included on a non-contributory basis. Furthermore, through the Ministry of Finance, the state subsidizes the SGK by compensating the institution's deficits from general government funds and transferring funds amounting to 25 per cent of the collected contributions in monthly instalments as per the Law of 5510 (Tuncer et al. 2017) (Venkateswaran and Singh 2022).

[112] Social Security Institution Health Implementation Notification No. 26532 dated 25 May 2007, available (in Turkish) at: https://www.mevzuat.gov.tr/File/GeneratePdf?mevzuatNo=17229&mevzuatTur=Teblig&mevzuatTertip=5

[113] Social Insurance and General Health Insurance Law No. 5510 dated 31 May 2006, available (in Turkish) at: https://www.mevzuat.gov.tr/mevzuat?MevzuatNo=5510&MevzuatTur=1&MevzuatTertip=5

Figure 43. Revenue source distribution of Universal Health Insurance Fund of Türkiye, 2019



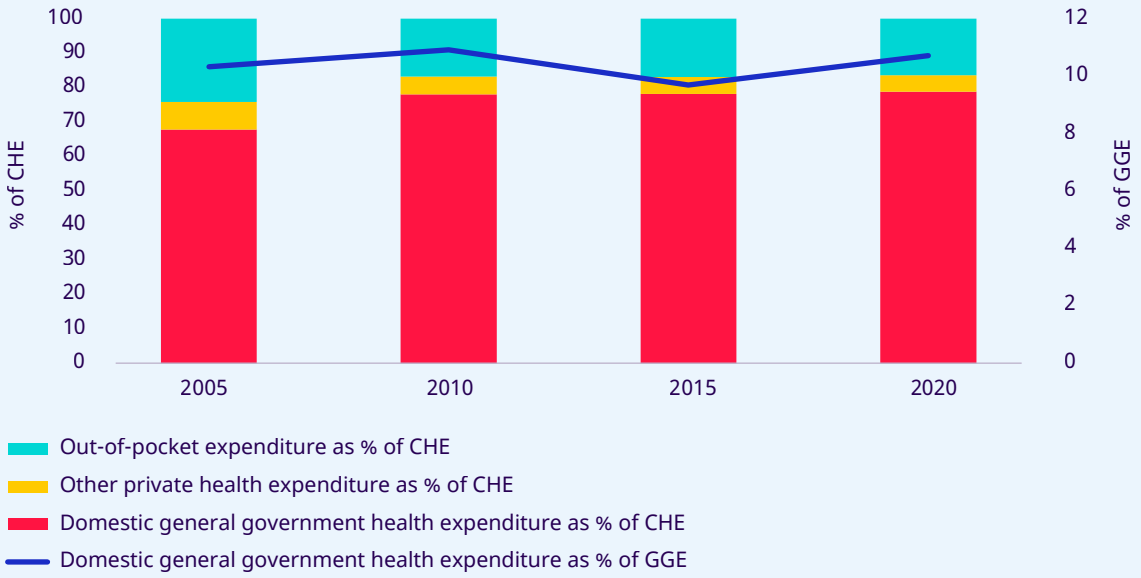
Source: SGK 2021.

For the period 2013-2022, there has been an upward trend in revenue collection from SGK, with a slight decrease following COVID-19. Contributions make up the majority of the total revenues, followed by State contributions (see figure 45). A challenge was first posed to SGK related to the collection of contributions for persons who pay for themselves—those who have a per capita income exceeding the threshold for contribution exemption as per means-testing. In 2017, there were 1.9 million individuals (2.3 per cent of the population) in this category, most of whom were informal workers. SGK therefore experienced difficulties in collecting regular contributions from this population group. As a solution, contribution amnesties were issued every few years. However, since 1 April 2017 (in line with Law No. 6824),[114] contributions are now fixed at 3 per cent of the monthly gross minimum wage for all persons in this group (Yenimahalleli 2019).

There has been a decline in OOP payments since GHIS became compulsory. The ratio of household OOP expenditure as a share of total health expenditure was 16.0 per cent in 2020 (TURKSTAT 2021).

[114] Law on Restructuring some Receivables No 6824, issued in Official Gazette No. 30001, dated 8 March 2017, available (in Turkish) at: https://www.mevzuat.gov.tr/MevzuatMetin/1.5.6824.pdf

Figure 44. Composition of current health expenditure (CHE) in Türkiye, by source of financing, 2005-2020



Source: Based on data from the WHO Global Health Expenditure Database.

Governance

The SGK is an autonomous public authority with administrative and financial functions and the only government institution that has a mandate for social protection in relation to health in Türkiye. Its legal structure is based on the Law No. 5510 on Social Security and General Health Insurance.[115] According to this law, SGK is responsible for implementing and managing the social security system in Türkiye, including collecting social security contributions and providing various social security benefits to eligible individuals. The institution is overseen by an Administrative Board, composed of 12 members (SGK 2020). Six members are appointed by the State: One member from the Ministry of Family, Labour and Social Services, two members from the Ministry of Treasury and Finance, and three members representing the SGK (the SGK president and two of the vice presidents). The other six members are elected for a three-year period by social partners in the General Assembly, and represent employees, employers, civil servants, pensioners, self-employed persons in the agricultural sector and self-employed persons outside the agricultural sector. The Administrative Board is chaired by the President of SGK and meets at least once a week (SGK 2020).

At central level, the SGK General Directorate for Universal Health Insurance administers the GHIS scheme, including reimbursements, benefits, pricing for health care services and purchasing services from health care service providers. Social contributions are collected through the account of the Institution and operated by the Directorate (SGK 2021).

Legal coverage and eligibility

The right to health is enshrined in the Constitution of Türkiye, according to which "everyone has the right to live in a healthy and balanced environment." Articles 60 and 61 refer to social security rights. Article 60 states that: "Everyone has the right to social security. The State shall take the necessary measures and

[115] Social Insurance and General Health Insurance Law No. 5510 dated 31 May 2006, available (in Turkish) at: https://www.mevzuat.gov.tr/mevzuat?MevzuatNo=5510&MevzuatTur=1&MevzuatTertip=5

establish the organization for the provision of social security." Article 61 emphasizes the State's duties to protect children, widows, orphans, disabled persons and older persons.

The Social Insurance and General Health Insurance Act No. 5510 of 31 May 2006 entered into force on 1 October 2008 alongside the social security reform. The national law guarantees health insurance for all based on mandatory enrolment.

The GHIS applies different eligibility criteria based on vulnerability and income level. The GHIS consists of a contributory scheme and a non-contributory means-tested scheme that provides health coverage to all citizens and residents of Türkiye. In addition, nationals and foreigners residing in Türkiye for more than one year, who do not have health insurance coverage from another country, qualify. Registration is made on a family basis, whereby family members, including spouses, children under the age of 18, high school students under the age of 20, higher education students under the age of 25, disabled children, and parents determined by SGK as indigent are covered as dependants. This applies only if these family members are not insured or are not receiving any pension or benefit from SGK. Children continue to be considered dependants within two years of their high school or university graduation, provided they are no older than 25 and are not already included as contributors. During this period, they are not obliged to pay contributions, without an income test (Ezer 2023).

In order to be covered under GHIS as a self-registered contributor, a minimum contribution payment period of 30 days is required within one year prior the date of accessing health care. Self-employed persons should have no more than 60 days of contribution debt (SGK 2021). Exemptions are applied to all persons below the age of 18, pregnant women, those employed by SGK, stateless persons, refugees, those with incomes below one-third of the minimum wage in Türkiye, and those in receipt of social assistance benefits (ESCAP 2019). Coverage of vulnerable groups is subsidized by the State. Diplomats, short-term visitors, temporary residents who are residing in the country less than a year, convicts, detainees, prisoners and illegal immigrants are not eligible as per the Social Insurance and General Health Insurance Law of 2006.

In addition, the following groups are not covered by the GHIS because their own institutions pay their health care costs (SGK 2021).

- Members of the cabinet appointed from the Grand National Assembly of Türkiye whose appointments are terminated, and deputies and their dependents.
- Presidents and members of higher judicial bodies including retirees and their dependents.
- Chiefs of General Staff and Force Commanders and those who are in the ranks of General/Admiral, including retirees and their dependents.
- Participants of funds established for banks, insurance and reinsurance companies, chambers of commerce, chambers of industry, stock exchanges or their associations and their dependants.

Benefits

Under the GHIS, free access to health care is the right of affiliates and their dependents. There is a rigid rule against establishing any relationship between contribution levels and health care benefits level and duration under the system. Therefore, everyone is entitled to receive equal benefits on the same basis, with the system broadly applying the principle of solidarity (SGK 2016).

Primary health care facilities of the Ministry of Health, as well as workplace doctors within the public administration, provide services for free. The GHIS benefit package is an addition to these services and provides a comprehensive package and entitlements for a range of preventative, diagnostic and curative services, providing both inpatient and outpatient care services. GHIS benefits include the following (SGK 2021):

- Medical treatment, preventive health care services and emergency health care services;
- Pregnancy and maternity care;
- Laboratory tests, analysis and other diagnostic methods;
- Surgery;
- Vision, hearing and dental care;
- Prescribed medicines, medical and optical devices, vaccinations, orthosis and prosthesis, vaccines, and blood and bone marrow treatments;

- Reproductive care;
- Transplantation of organs;
- Rehabilitation services;
- Orthodontic treatment for those under the age of 18;
- Travel expenses, daily allowance and companion expenses in cases whereby treatment takes place outside of the patient's place of residence.

Other specialized services such as cancer treatment; emergency care; intensive care; burn treatment; assistance to newborns; organ, tissue and cell transplantation; surgery for congenital anomalies; dialysis and cardiovascular surgery are also provided free-of-charge. Moreover, emergency care is provided for free in private hospitals, even those that have no contract with the SGK (Adaman et al. 2018).

While most of the free health care services are provided by national and local health care providers, some cases that require highly specialized medical interventions offered only by international medical providers might also be financed by the GHIS scheme (SGK 2016).

Cost sharing through formal co-payment is applied broadly in the general health insurance scheme. Co-payment, co-insurance and additional payment are three types of OOP payments provided for by the law (Law no 5510/2006). The Turkish health care system involves varying levels of co-payments from patients for outpatient visits and 20 per cent co-insurance for prescription drugs (Kaymaz 2020). Co-payments are made at varying rates based on the level of the health care provider, the service type and the insured person's socio-demographic characteristics. Co-payments are not reimbursable through private health insurance (SGK 2021).

A co-payment is required for physical examinations, orthotics and prostheses, healing materials, medicines and fertility treatments (ESCAP 2019). No co-payment is required for primary care visits or hospitalizations. Health services provided in cases of work accidents, occupational injuries, military maneuvers, disasters or war and pandemics, as well as medicines for chronic illnesses, are exempt from co-payment obligations. Furthermore, certain segments of the population are exempt from co-payments (See box 19). Beneficiaries pay 6 lira (US$1.23) for outpatient specialist care in public hospitals, 8 lira (US$1.65) in university hospitals and 15 lira (US$3.09) in private hospitals (Social Security Administration 2018). Balance-billing is authorized for private providers. Private health care providers are allowed to charge insured persons for the standard services they provide, up to twice as much as the standard prices established by the Health care Services Pricing Commission (HSPC), the SGK price-setting organisation (SGK 2021).

▶ Box 19. Population groups exempt from co-payments in Türkiye

- Honorary pensioners and persons who receive a pension according to provisions of the Law on Military Service Planning, and their spouses
- Pensioners and their dependants
- Disabled veteran pensioners and their dependants and persons who receive a pension under the Law on Fight Against Terrorism
- Persons and children under age of 18 who benefit from free rehabilitation services
- Persons who receive a duty invalidity pension that is granted due to a public mission
- Cadets who receive education in military academies, police academies, or staff colleges of the armed forces or the general directorate of security
- Persons who are victims of terrorist attacks, until the end of their treatment
- Soldiers serving compulsory military service and candidate cadets (students) of the military schools
- Foreign soldiers, who are receiving training and education under the International Training Cooperation Agreement in Türkiye, and their dependants.

Source: SGK 2021.

In addition to health care benefits, SGK also guarantees cash benefits for accidents at work, occupational diseases and sickness and maternity for employed and self-employed insured persons as part of the broader social security system. Civil servants are covered by a special scheme. Contributions are calculated for all short-term benefits and the rate is 2 per cent of the earnings of the insured person, paid by the employer (there is no employee payment) (SGK 2020). Insured women are entitled to maternity cash benefits for each day of maternity leave, for up to 16 weeks (eight weeks before and eight after the expected date of childbirth). This can be extended by two weeks for multiple births. The benefit amount is the same as that applied for all short-term benefits: Two thirds (66.7 per cent) of average daily earnings in cases of outpatient care and half of average daily earnings in cases of inpatient care. There is also a nursing benefit for mothers that equals a lump sum of 133 lira (ISSA 2018).

Provision of benefits and services

On the health service provision side, centralization is a key attribute of the Turkish governance model for health care, both geographically (limited local autonomy) and functionally (keeping control of duties within the Ministry of Health). The Ministry of Health leads on governance, planning and supervision, and the system provides primary, secondary and tertiary care throughout the country. The Ministry of Health coordinates all health care services, including the running of hospitals, monitoring of private hospitals and pharmacies, accreditation, and Health Technology Assessments (OECD 2014).

Türkiye has attempted to decentralize the health care system; although some transformations have been accomplished, decentralization was not successful due to coordination challenges. All hospitals were intended to be administratively and financially autonomous, and some functions have been transferred to newly created agencies affiliated with the Ministry of Health, covering medicines and devices, public health, public hospitals, borders and costal agencies (Nurşen 2022; Yildiz et al. 2018).

The majority of health facilities in Türkiye are public. In 2020, out of a total of 1,534 hospitals there were 900 Ministry of Health hospitals, 68 university hospitals and 566 private hospitals (WHO 2022).

Primary care comprises general practitioners (family physicians) settled in family health centres under the Family Medicine Programme. Primary care and preventive services are financed by general taxes through the central government budget allocated to the Ministry of Health. Medicines prescribed in primary health centres (Family Health Centres) are financed by GHIS (Venkateswaran and Singh 2022; SGK 2021). In 2019, general practitioners (family physicians) accounted for 33 per cent of all physicians (OECD, n.d.-a).

Secondary care is provided by hospitals in the private and public sectors, while at the tertiary level services are provided by research and education hospitals under the Ministry of Health and university hospitals (Tuncer et al. 2017). Although the GHIS finances secondary care, insured persons must make co-payments for outpatient clinic services (both public and private), drugs, and services at secondary and tertiary health care facilities. An exception applies to family physician visits (SGK 2021).

SGK purchases health care services from health care providers in the public and private sectors. For public sector providers of secondary care, there are no contractual agreements where facilities are owned by the Ministry of Health; the SGK transfers funds on a global budget basis to the Ministry of Health for services provided to its beneficiaries (European Observatory on Health Systems and Policies 2011).

The following private providers have signed agreements with the SGK: Private university hospitals, private hospitals/medical centres, pharmacies, medical device sales centres and opticians. An exception applies in emergency cases, whereby health care services can be delivered by a non-contracted health care provider. For private providers, payments are made per capita per unit utilized (fee-for-service) (Venkateswaran and Singh 2022).

The Directorate General for GHIS undertakes the following duties: Determines public prices of health care services provided by the SGK; updates the Health Implementation Communiqué (HIC), which includes terms regarding reimbursement of treatment services, medicines, medical devices and materials; and concludes contracts with health care service providers for health services, making payments to them in return for their services (SGK 2021).

A claims and utilization management system called MEDULA has been in place since before the creation of the GHIS to process claims for all the health insurance funds including the Green Card scheme. Under the 2007 Health Budget Law (SUT), all public and private health facilities contracted by SGK are required to submit claims through the MEDULA system. The establishment of a unified claims management system has standardized the submission of claims and contributed to the establishment of a virtual single-payer system, which was unified across all the health insurance funds even prior to the establishment of GHIS (SGK 2024).

Currently, no formal care coordination or referral process between primary and secondary care and primary care structures have been defined for GHIS beneficiaries (Sumer et. al. 2019; Bener et al. 2019). Co-payment exemptions for primary care are in place to incentivize people to obtain a referral before accessing secondary and tertiary care (WHO 2022).

▶ 4. Results

Coverage

In 2021, 98.8 per cent of the population in Türkiye was covered by GHIS, up from 69.8 per cent in 2002 (OECD, n.d.-c). In addition, 9 per cent of the population had voluntary private health insurance, primarily to cover care in private hospitals not under (or under a limited) contract with the SGK, or as complementary health insurance to cover services outside the basic benefits package (WHO 2022).

In the past, people who did not make their contributions on time were excluded from the scheme. In 2016, around 7 million people (about 9 per cent of the population) failed to make contributions, and 5 million people (approximately 6 per cent of the population) did not undergo a means-testing assessment which would allow them to benefit from the scheme without making contributions (Adaman et al. 2018; Bülbül 2015). As such, informal workers, low-income self-employed persons, the unemployed, and their dependents are at risk of exclusion from coverage (Adaman et al. 2018; Bağır et al. 2021).

▶ Table 13. Number of persons covered by GHIS in Türkiye in 2020

Year	2020
Total Population	83 614 362
Active Insured Persons	23 344 547
Passive Insured Persons (Pensioners)	13 264 220
Dependents	35 556 141
Social Insurance Holders	72 593 383
Registered only as GHIS Holders	9 767 789
Total Coverage of GHIS (Proportion to the total population)	98.5 %

Source: SGK 2021.

Türkiye hosts the world's largest refugee population, with 3.6 million refugees and asylum seekers (majority of whom are Syrians 3.5 million) recorded in 2022 (UNHCR 2023). According to the Law on Foreigners and International Protection, refugees and asylum-seekers may benefit from one year of health care insurance services. With Turkish identification documents, refugees are included in the scheme on an equal footing with Turkish citizens under GHIS. This means that refugees have access to all medical services provided by Turkish health institutions, including family care centres, state hospitals and university hospitals. They can also benefit from primary health services free of charge in their place of residence. If refugees are not registered with the Turkish authorities, only emergency services at

hospitals are available and accessible to them free of charge. Therefore, millions of unregistered refugees and migrants still face challenges in accessing health care (UNHCR, n.d.; Barış et al. 2023).

Adequacy of benefits/financial protection

The social health protection system in Türkiye guarantees substantial financial protection for the population. Generally, private health insurance remains limited in Türkiye, due to adequate social insurance coverage (Ozsari and Güdük 2020). Through GHIS, free-of-charge services are provided for primary and emergency care, while co-payments are required for physical examinations, outpatient medicines, orthotics and prostheses, healing material and fertility treatment services. Co-payments for physical examinations are generally low at a fixed nominal amount, while the rest represent a percentage of the cost (10-20 per cent) (SGK 2021). Before the 2003 reform, Türkiye's health care sector experienced a high rate of informal payments. Although public funding for health care increased after the introduction of GHIS, data suggest that some informal payments persist, potentially impacting financial protection (Yilmaz 2021; Adaman et al. 2018).

After introducing GHIS in 2008, OOP spending as share of total health expenditure decreased from 23.89 per cent in 2007 to 16.43 per cent in 2020 (OECD, n.d.-b), which remains low compared to other countries in Central and Western Asia. Although the co-payment rate appears low, OOP spending places an unbearable burden on the poor and vulnerable in Türkiye. Households in the bottom socio-economic decile allocate nearly 70 per cent of their budget to food and housing (Baez et al. 2021) and the poor in Türkiye often face financial hardship due to payments for health care services. This limits access to health care, undermines health conditions, deepens poverty rates and increases inequalities. In 2016, 3.19 per cent of the population or over 2.5 million people in Türkiye, primarily the poor and vulnerable, spent at least 10 per cent of their household budget on health care (WHO 2023a). It is noteworthy that while OOP expenditure has decreased since the early 2000s, the share of households experiencing catastrophic expenditures increased marginally between 2012 and 2019 (Venkateswaran and Singh 2022).

One study drawing on national Income and Living Conditions surveys data revealed a high level of unmet needs due to a lack of availability of services reported by the rural population. This was attributed to insufficient rural health services in the family practice-centred system, that was established in 2010 to replace Türkiye's traditional district-oriented health service model dating back to the 1960s. The same study concluded that access to health care has improved with the reform process in Türkiye, but that disparities in access to care between income groups have grown, disadvantaging the poorest. These results suggest that high informal employment and unemployment pose a challenge to ensuring equal access to care in middle-income countries with unstable economies such as Türkiye (Yardim and Uner 2018).

Responsiveness to population needs

Availability and accessibility

The Government has focused on reducing regional disparities in the distribution of the health workforce across the country by implementing the Family Medicine Programme, which encourages doctors and other health workers to serve rural populations. Appointment and transfer of doctors to rural areas ensures a more balanced distribution of health care personnel across all regions. Under this initiative, family doctors are contracted by the GSK to provide primary health care for those living in rural areas, including the provision of mobile health services for those unable to travel to clinics. Additionally, since 2009 Türkiye introduced mobile pharmacy service to improve access to medication in rural areas (Atun et al. 2013). Furthermore, the Government has taken steps to prohibit the practice of dual work (combining public and private practice) and raised salaries for public sector health workers. These measures have helped to increase the recruitment and retention of health workers in the public health sector (Venkateswaran and Singh 2022).

While there has been a continuous increase in the numbers of nurses, health officers, physicians and health care providers in the last ten years, Türkiye still lags behind many OECD countries in this regard (Gürsoy 2015). Despite a substantial increase in physicians by 46 per cent in 2020, the current number of doctors (205 per 100,000) is the lowest among OECD countries, slightly lower than the average in CWA

countries (269 per 100,000) and lower than the Europe and Central Asia average (372 per 100,000) (OECD, n.d.-a). This predominantly impacts on the health of marginalized populations. The shortage of doctors and irregular distribution in all regions of the country leads to gaps in availability and accessibility. The estimated number of in-person consultations per doctor was 5,033 in 2019, which is the highest among OECD countries. An increased workload seriously burdens physicians and substantially impacts the quality of care, especially in regions experiencing staff shortages. Data from the Ministry of Health shows that due to COVID-19 restrictions, the number of visits to a physician per capita declined by 26 per cent in 2020 (from 9.8 in 2019 to 7.2 in 2020) (OECD 2021; Dierks 2024).

In rural areas, health care service availability remains more limited than in urban areas, with rural residents incurring transportation costs when attempting to utilize available services in neighboring districts (UNHCR 2021). Moreover, in 2019, 9 per cent of the lowest income quintile had no access to medical care, compared to 0.4 per cent of people in the highest income quintile (OECD 2021).

The number of hospitals has grown in line with the increase in health care spending, with the number health care providers almost tripling from 2002 to 2012, reaching nearly 30,000 hospitals. The increase in the number of private hospitals is especially noteworthy when compared with a smaller change in the number of Ministry of Health-operated hospitals. The increase in private hospitals stems from the increase in GHIS coverage and contracting of private providers, and the extensive benefit package; the private sector has taken advantage of this transformation, investing in health services (Gürsoy 2015).

The HTP has improved health care utilization rates as a result of increased accessibility. For example, an increase was observed in doctor's consultations per capita between 2013 and 2018 (from 100 visits to 117 visits). A significant upward trend was also observed with regard to the "Diagnostic Examinations" indicator (including both CT and PET scans), which increased from around 140 to 250-300 diagnostic examinations in the same period (Torun and Aslan 2022).

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Quality and accessibility

Life expectancy in Türkiye increased from 71.9 in 2002 to 77.7 years in 2014. The under-five mortality rate fell sharply from 61 per 1,000 live births in 1993 to 37 per 1,000 live births in 2013. Similarly, infant mortality fell from 53 per 1,000 live births in 1993 to 15 per 1,000 live births in 2013. Between 2000 and 2020, the maternal mortality rate fell by 46 per cent from 32 to 17 per 100,000 live births. Between 2002 and 2012, the overall health workforce increased by 36 per cent, growing from 295,000 to 460,000. Moreover, Türkiye's health expenditures increased from 5.4 per cent of GDP in 2000 to 6.7 per cent in 2011, which led to substantial reductions in OOP spending for health services (World Bank 2018; WHO 2023b).

Since the implementation of the HTP, which radically changed the Turkish health system, trust in the health system has been persistently high and satisfaction with health care services has steadily increased. According to Life Satisfaction Statistics in 2016, 75.4 per cent of respondents indicated that they were either satisfied or very satisfied with public health care services (Ertong 2018). Notably, the Ministry of Health has established Migrant Health Centres in 29 provinces, where Syrian doctors provide primary health care services to Syrians under temporary protection. This measure has helped to improve access to health care by reducing language barriers and increasing human resource capacity.

▶ 5. Way forward

Over the last 20 years, with the introduction of the HTP reform, the provision of comprehensive benefits and improved service delivery, health care coverage in Türkiye has substantially expanded, reaching near-universal coverage through GHIS. Overall, Türkiye achieved great success in health care delivery and equity, with decreased health costs and high levels of satisfaction with the health system among the population. However, there is a need to increase the primary health care medical workforce and build capacity in this area (Bener et al. 2019). Despite advancements, further efforts are needed to protect and improve citizens' health and provide equal access to health care for all.

Currently in Türkiye, the share of health expenditure in GDP remains below the average rate of OECD countries (OECD 2023). However, health expenditure in Türkiye is expected to increase in parallel with the National Development Plan (2019-2023).Unless the demographic window of opportunity is thoroughly utilized and necessary measures related to retirement and the broader social security system are put in place, increasing health expenditures will squeeze the social security system and public finances in the upcoming period (Presidency of the Republic of Türkiye, Directorate of Strategy and Budget, n.d.). In this respect, it is essential to consider elements that impact the financial sustainability of the health system, namely the organizational structure of the health care sector, including university hospitals, the persistence of unnecessary medical interventions and examinations, an inefficient reimbursement system and performance-based supplementary payment system, the breadth of the SGK benefit package, and outdated medicine prices (Balci and Gümüş 2021).

High-quality primary care plays a critical role in the population's health protection. National policies should aim at increasing per capita primary care utilization by shifting citizens' negative perceptions of primary care. The Turkish Government has proposed restructuring primary care for efficient functioning, capacity building of primary care personnel, and redesigning the performance system for staff with a focus on labour productivity and health outcomes. This requires developing family medicine referrals, increasing family medical units and raising awareness about family medicine services. Currently, the referral system is not mandatory; patients are free to enter the system at whichever point they prefer, and the primary care level is not working as effectively as it should. The main reason underlying the lack of a compulsory referral system is related to the general undersupply of doctors nationwide and, in particular, the low number of doctors working at the primary care level who can act as gatekeepers. Currently, outpatient care, either primary or specialist, is provided by family practitioners, hospital outpatient departments (public and private) and private practitioners (European Observatory on Health Systems and Policies 2011).

In the context of a continuous rise in the number of migrants and refugees in Türkiye, there is a need to abolish administrative barriers and facilitate enrolment in the national system. In addition, the effectiveness of migration health services should be strengthened by improved targeting mechanisms and raising awareness of health care services. The involvement of health professionals from the countries of origin of refugees could potentially tackle the communication barriers between health care providers and service users. Moreover, enhancing access to health care for migrants and refugees by expanding the number of migration health centres and extending the duration of health insurance coverage would significantly improve financial protection and equity for this population.

OOP payments in Türkiye are relatively low; however, they disproportionately impact the poor population and more efforts need to be made to improve equity in effective access to health care between rural and urban populations. Continued development and implementation of policy measures to reduce OOP expenditure on health is recommended, ensuring more efficient contribution collection mechanisms, an increase in government spending, investments in the health care sector, the consolidation of primary care, and improved awareness among the population on health care services (Jalali et al. 2021).

▶ 6. Main lessons learned

- Substantial progress towards Universal Health Coverage has been made during the last 15 years in Türkiye. Reforms to extend both legal and effective population coverage and increase health expenditure have reduced OOP spending on health, increased financial protection and improved access to health services, positively impacting on health outcomes.
- Merging the different health insurance schemes into a single GHIS scheme accelerated the extension of coverage while consolidating the social health protection system's financial sustainability, by facilitating the combination of contributions and tax-based revenues. The previously fragmented nature of the system, which caused complexities in terms of the flow of funds to providers, causing unnecessary inefficiencies, has been addressed.
- Raising awareness among the population about social heath protection is vital for an operational and efficient health care system. Lack of knowledge and negative perceptions among the population negatively affects primary care, thus increasing OOP payments for secondary and tertiary care.
- Ensuring long-term financial sustainability of the GHIS scheme, while maintaining its comprehensive scope, is crucial. This is particularly important in the context of rising health care expenditures and changing demographics, disease burdens and economic factors. There is a need to increase fiscal space for health, improve contribution compliance, achieve efficiency gains and enhance cost containment measures.

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Uzbekistan

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1. Introduction

Uzbekistan is a lower middle-income country with a population of more than 35.3 million people. It is the third largest country by population size in the Commonwealth of Independent States (CIS) and the most populated country in Central Asia (UZ Statistics Agency 2022d). In 2020, close to 50 per cent of the population lived in rural areas (UZ Statistics Agency 2022c). The population is in large part young, and there has been continuous population growth over the past decades (UZ Statistics Agency 2022e). Life expectancy was estimated at around 75 years in 2019 (pre-COVID-19) (UZ Statistics Agency 2022b).

Since the 2000s, Uzbekistan's economy has grown rapidly, at an average rate of more than 6 per cent of GDP between 2000 and 2021 (UZ Statistics Agency 2022a). In 2022, GDP per capita by purchasing power parity (PPP) was equal to 9,042.3 international dollars (World Bank 2022). In parallel, the share of the low-income population in the country decreased by more than 2.5 times between 2001 and 2019 – from around 28 per cent to 11 per cent (UZ Statistics Agency 2022f).

Since 1996, Uzbekistan has been operating a state-run health care system with a publicly financed package of benefits (Ahmedov et al. 2014). The package guarantees free access to a list of essential health services to Uzbek citizens, foreign citizens and stateless persons permanently residing in the Republic of Uzbekistan, funded by the state budget. It also offers a list of complementary services to specified vulnerable population groups at different levels of care (Ahmedov et al. 2014). In 2020, a Social Health Insurance (SHI) scheme was launched, currently being progressively extended with the aim of reaching full population coverage by 2025 (Aiypkhanova 2021).

▶ 2. Context

Following independence in 1991, Uzbekistan inherited a centralized publicly run health system. While the legacy system performed well in tackling the main communicable diseases in the country, major improvements were necessary to respond to the shift in the burden of disease as well as changing socio-economic conditions while ensuring financial protection for all (Ahmedov et al. 2014).

In the late 1990s, Uzbekistan embarked on gradual reforms to make its health system more efficient and responsive to the evolving needs of the population. While the system remained state run, significant efforts were made to strengthen PHC, improve the distribution of resources, and strengthen medical training, management and monitoring. In this context, one of the focus areas of the reforms has been shifting emphasis from secondary to primary health to increase accessibility of services to the population and to improve health system efficiency. This was achieved through primary health capacity building (including investment in infrastructure and the workforce), consolidation of the secondary health system (including through the merging of facilities), and implementation and enforcement of patient referral procedures (Ahmedov et al. 2014).

In 1996, the Government of Uzbekistan institutionalized a state-guaranteed package of basic health benefits (SGBP) by adopting Law No. 265-I on Health Protection.[116] The Law re-affirmed the right of all citizens to health protection and the responsibility of the Government to ensure that this right is fulfilled. By introducing a defined list of available benefits, the Government sought to limit the scope of services provided while shifting some of the health costs to patients (specifically for secondary care and medicines) (Ahmedov et al. 2014; European Observatory on Health Systems and Policies and WHO 2022).

In 2018, a new set of reforms was initiated by Presidential Decree No. 5590 on Comprehensive Measures to Improve the Health care System of the Republic of Uzbekistan of 2018.[117] The Decree approved a new strategic plan for the development of the national health sector, namely the Concept on Health Development of the Republic of Uzbekistan 2019-2025 (European Observatory on Health Systems and Policies and WHO 2022). One of the overarching goals of the Concept [118] is to improve health financing and the organization of health care to achieve equal access to medical care, financial security and a fair distribution of resources. The Concept further sets an objective to gradually introduce a compulsory medical insurance scheme and to create a State Health Insurance Fund to pool and distribute financial resources for the needs of health care (WHO Regional Office for Europe 2021).

Accordingly, in 2020, the Government established a State Health Insurance Fund (SHIF) to serve as a single-payer mechanism for the purchase of health services for the entire population.[119] It is envisaged that the SHIF will accumulate, manage and distribute the funds allocated from the State budget to finance the state-guaranteed health benefits provided under the compulsory health insurance scheme. The scheme will remain funded through taxes but there will be a purchaser-provider split. In addition, health care institutions will start receiving payments on the basis of work performed (capitation for PHC facilities and case-based payment for hospitals), rather than on the basis of projected budgets as was the case in the legacy system (WHO Regional Office for Europe 2023).

In 2021, the Government launched a pilot project in the Syrdarya region to test the new scheme. The Syrdarya region is the smallest region of the country in terms of population size, accounting for

[116] Law of the Republic of Uzbekistan No. 265-I on Protecting the Health of Citizens, dated 29 August 1996, available (in Uzbek) at: https://www.lex.uz/en/docs/41329

[117] Presidential decree of the Republic of Uzbekistan No UP-5590 on Comprehensive Measures for improvement of the health care system, dated 7 December 2018, available (in Uzbek) at: https://lex.uz/docs/4096199#4099852

[118] The Concept sets out the following three overarching goals:
1. Increase population life expectancy by improving treatment and prevention of diseases that cause the most premature mortality and disability;
2. Improve health financing and organization of health care to achieve equal access to medical care, financial security and fair distribution of resources;
3. Enhance the capacity of health authorities, strengthening the role and responsibility of health managers to achieve the objectives set by the Concept.

[119] Presidential Decree No. 4890 on Measures to Integrate a New Model of Health System Organization and Mechanisms of State Health Insurance in Syrdarya Region, dated 13 November 2020, available (in Uzbek) at: https://lex.uz/docs/5100701

around 2.5 per cent of the total population (Aiypkhanova 2021). An updated package of benefits has been institutionalized by Presidential Decree No. 4890 of 2020 as part of the pilot which is broader than the previous package, supplemented by an outpatient drug package. The SHIF also covers the cost of treatment for specified vulnerable population groups in pre-specified secondary and tertiary level medical facilities as well as private clinics throughout the country (State Health Insurance Fund 2024) (WHO Regional Office for Europe 2023).

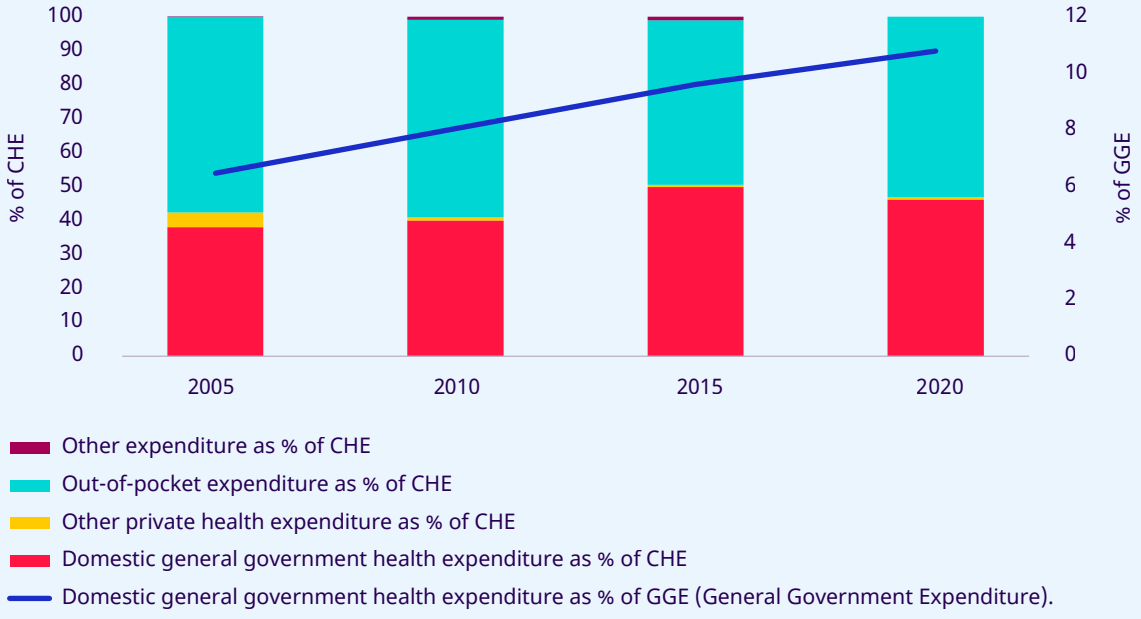
Starting from 2023, the new scheme has been expanded to other regions of the country. While a nationwide transition to the compulsory health insurance scheme (managed by the SHIF) is expected by 2025, the state-guaranteed basic benefit package (SGBP) remains, for now, the main social health protection scheme in Uzbekistan (WHO Regional Office for Europe 2023).

▶ 3. Design of the social health protection system

Financing

The composition of national health spending in Uzbekistan is characterized by a comparatively low share of public spending. Public health expenditure amounted to 39.3 per cent of CHE in 2021 (WHO, n.d.). While this is above the average among lower middle-income countries and is similar to the levels in other Central Asian countries, the current level of health funding results in exceptionally high levels of OOP spending, which amounted to 60.3 per cent of CHE in 2021 (WHO, n.d.) (see figure 46).

Figure 45. Composition of current health expenditure (CHE) in Uzbekistan, by source of financing, 2005-2020



Source: Based on data from the WHO Health Expenditure Database.

In 2021, the Government of Uzbekistan increased spending on health as part of the effort to respond to the COVID-19 pandemic (UNDP 2021). Most of the public funding originates from general tax revenues. As such, financing follow pre-set health care budgets that are determined based on past expenditures, expected input requirements and relevant policy and administrative guidelines (Ahmedov et al. 2014).

In recent years, further efforts have been made to increase public funding. In accordance with the Decree of the President of the Republic of Uzbekistan No. PP-5124 [120] dated 25 May 2021, since 15 June 2021, the amount of funds allocated per capita to primary health care institutions for obtaining medicines and medical products has on average tripled. In line with this resolution, in 2022, an additional 400 billion Uzbekistani som (US$36.3 million) was allocated from the state budget to expand the provision of medicines and medical products to primary health care institutions. This had a positive effect on reducing the level of OOP payments. The details of public funding for health are presented below:

▶ Table 14. Public health funding in Uzbekistan between 2018 and 2022

	2018	2019	2020	2021	2022
Public Health Expenditures (million US$)	1 161	1 354	1 487	2 333	2 537
Population (million US$)	32.7	33.2	33.9	34.6	35.3
Per capita (US$)	35.5	40.7	43.8	67.4	71.9

Source: Ministry of Economy and Finance of the Republic of Uzbekistan 2024.

As part of ongoing reforms, the existing model is to be replaced with a single-payer health insurance scheme by 2025 (Robinson 2021). The scheme will remain primarily non-contributory (therefore tax-funded) (WHO Regional Office for Europe 2023).

The Government plans to fund the SHIF from the following sources (Norma 2019):

- Funds received from the state budget for the needs of the compulsory health insurance scheme: For this purpose, the SHIF estimates the necessary funds for providing the state-guaranteed benefit package and, together with the Ministry of Health, sends a request to the Ministry of Finance.
- Excise taxes on tobacco products, alcohol, foods high in sugar, trans fats and other unhealthy products: While the Government has recently raised the rates of these taxes to earmark funds for other health purposes, they have not yet been used to replenish the budget of SHIF.
- Funds received from the state budget to pay compensation for the execution of court decisions: Currently this is not yet implemented.
- Voluntary contributions and receipts under donor agreements: So far, the SHIF has not received any contributions or receipts from donors.
- Grants from international organizations: The SHIF is currently partnering with the WHO and the UN Multi-Partner Human Security Trust Fund for the Aral Sea Region;
- Funds received from charitable foundations, international organizations and foreign citizens;
- Other sources that do not violate national laws and regulations: In practice, this constitutes income from the placement of free funds of SHIF in financial instruments (deposits of banks, and so on).

According to comments from government officials, no additional social contributions are envisaged to help fund the SHIF.

[120] Resolution of of the President of the Republic of Uzbekistan No. PP-5124 on Additional Measures for Complex Development of Health Sector, available at: https://cis-legislation.com/document.fwx?rgn=132527

Governance

Law No. 265-I on Health Protection of 1996 is the principle legal instrument governing the health system of Uzbekistan (Ahmedov et al. 2014; Robinson 2021). The Law defines the roles and responsibilities of the key actors involved in the management of health services and sets a legal framework for the overall health system in the country (Ahmedov et al. 2014).

The health system in Uzbekistan is governed by the Ministry of Health, which plays the leading role in organizing, planning, and managing the health system (Robinson 2021). The system is dominated by the public sector and has three administrative levels, namely national, regional (oblast) and district (tuman) (Ahmedov et al. 2014):

- The national level is comprised of the Ministry of Health and republican-level facilities and institutions, including research institutions and universities and specialized centres. The Ministry of Health has the responsibility of setting and monitoring budget expenditure for national-level hospitals, specialized medical centres, emergency care centres and research institutions.
- Regional-level institutions consist of regional health facilities and regional branches of republican-level institutions and centres. They are managed by the respective health departments of regional (or city) administrations. Regional administrations are responsible for financing local and regional-level hospitals, primary health centres, sanitary-epidemiological units and other local-level facilities. A large share of funding comes from local tax revenues collected by the finance departments of local governments.
- The district level is formed of central district hospitals, district multidisciplinary outpatient clinics (polyclinics) and a network of rural physician centres, dispensaries, family health centres and obstetric centres. District institutions are directly supervised by district or city medical unions. The unions are responsible for administering funds for social assistance and for managing health and social services.

When it comes to private health care providers, both the Ministry of Health and regional health administrations have the right and the obligation to monitor and control the services provided by the private sector (Ahmedov et al. 2014).

After the nationwide rollout of the compulsory health insurance scheme, the financing function of district, regional and national-level administrations will be overtaken by the SHIF (WHO Regional Office for Europe 2023). However, currently these administrations remain in charge of setting and managing the budgets of public health care providers at their respective levels.

The Supervisory Board of the SHIF is chaired by the First Deputy State Counsellor, and its members include vice ministers of the Ministry of Health and the Ministry of Finance, heads of the Antimonopoly Committee, the National Association of NGOs of Uzbekistan (NANNOUz), regional health departments and regional governors.[121]

Legal coverage and eligibility

According to article 48 of the (new) Constitution of the Republic of Uzbekistan (dated 30 April 2023): "Everyone has the right to health protection and qualified medical care", institutionalizing the universal right to access qualified medical care. Accordingly, the 1996 Law on Health Protection institutionalizes a basic benefit package that is accessible to all citizens free of charge. Article 13 of the Law stipulates that the State provides citizens with health care regardless of their age, gender, race, nationality, language, religious relations, associations, beliefs, or personal and social status; and that the State should protect citizens from discrimination.[122]

According to article 14 of the Law, foreign citizens within the territory of the Republic of Uzbekistan are guaranteed the right to health care in accordance with international treaties of the Republic of Uzbekistan. Furthermore, stateless persons permanently residing in the Republic of Uzbekistan enjoy

[121] Presidential decree of the Republic of Uzbekistan No UP-5590 on Comprehensive Measures for improvement of the health care system, dated 7 December 2018, available (in Uzbek) at: https://lex.uz/docs/4096199#4099852

[122] Law of the Republic of Uzbekistan No. 265-I on Protecting the Health of Citizens, dated 19 August 1996, available (in Uzbek) at: https://www.lex.uz/en/docs/41329

the right to health protection on an equal footing with citizens of the Republic of Uzbekistan. This is also endorsed in article 48 of the new Constitution of the Republic of Uzbekistan.[123]

Benefits

Benefits included in the SGBP are outlined in Chapter III of the Law on Health Protection.[124] The Resolution of the Cabinet of Ministers of the Republic of Uzbekistan No. 832 of 30 September 2019 [125] approved the regulations on the procedure for the formation of the list of guaranteed volumes of cost-free medical care covered by the state budget. Decrees issued by the Ministry of Health provide further guidelines on different types of services and health care delivery.

As a result, the following categories of services are included in the SGBP:

1. Primary care:
    - Management of prevalent and emergency conditions;
    - Preventive and sanitary-epidemiological activities;
    - Initiatives in family, maternal and child health;
    - Health promotion and education.
2. Emergency care
3. Care for "socially significant and hazardous conditions" (the list is monitored and updated by the Ministry of Health), including:
    - Selected intestinal, respiratory, skin and blood-borne infectious diseases (HIV/AIDs, tuberculosis, leprosy, syphilis and poliomyelitis, among others);
    - Selected chronic conditions, including but not limited to mental health disorders and cancers.

No payments are required from the population for medical services included in the guaranteed benefit package. Services not included in the guaranteed benefit package (mainly for secondary and tertiary care) are provided on a paid basis, except for vulnerable groups (as determined by the Government).

The state-guaranteed package approved in 2021 included more than 40 medicines and more than 20 medical products provided at PHC facilities. This list was expanded in 2022 to 70 medicines and 50 medical products and consumables (Ministry of Health of the Republic of Uzbekistan 2023). Additionally, a list of medicines for inpatient and emergency care is provided for vulnerable categories of the population (Ahmedov et al. 2014). As per article 35 of the Law on Health Protection, the list of vulnerable categories of the population eligible for free outpatient medicines is defined and approved by the Cabinet of Ministers of the Republic of Uzbekistan.

Sickness and maternity benefits are available through employer liability and social insurance for persons in covered employment, persons on leave from employment while pursuing secondary, technical or advanced education, and registered unemployed persons. These benefits are managed by the Ministry of Labour and Social Protection and paid for by enterprises and local Departments of Social Protection. Those who are entitled to sickness cash benefits with less than eight years of uninterrupted employment are provided with 60 per cent of their monthly income, and those with more than eight years of uninterrupted employment are entitled to 80 per cent of their monthly income. As for maternity cash benefits, employers bear a portion of the financial responsibility under the current system. According to new regulations, employers are required to supplement the tax-financed maternity cash benefit to reach either 75 or 100 per cent of the woman's prior monthly earnings. Employers' liability does not apply when the benefits are equal to or less than the minimum consumer expenditure, or when the woman has worked for less than six months. In such cases, the cash benefit is fully covered by the state budget. The benefit is equal to the last full month of income, provided for 56 days prior to and 56 days after childbirth and can be extended for 70 days in cases of complicated or multiple births. Additionally, a lump sum of

[123] The Constitution of the Republic of Uzbekistan was adopted by nationwide vote at the referendum of the Republic of Uzbekistan held on 30 April 2023, available at: https://constitution.uz/en

[124] Law of the Republic of Uzbekistan No. 265-I on Protecting the Health of Citizens.

[125] Resolution of the cabinet of ministers of the Republic of Uzbekistan No. 832 on Approval of the Regulation on Forming the List of the Guaranteed Amounts of Medical Care covered at the expense of the Government Budget, dated 30 September 2019, available (in Uzbek) at: https://lex.uz/docs/-4535086?ONDATE=05.04.2022%2000#

405,460 som (200 per cent of the monthly minimum wage) is paid to working mothers caring for children younger than two years of age (ISSA 2019; ILO 2023)

Provision of benefits and services

Health services provided under the SGBP are delivered through a network of public health facilities, which include family doctor points (in rural areas), family polyclinics, district (city) central polyclinics, district (city) hospitals and emergency care centres.

The national State Committee on Statistics (UZSTAT) reports that, in 2022, there were 1,328 hospitals and 7,010 outpatient clinics in Uzbekistan (UZ Statistics Agency 2023a; 2023b). The vast majority of these facilities are publicly owned and operated. Health workers are salaried and paid according to state guidelines (Ahmedov et al. 2014).

To access SGBP, patients need to visit their family doctor at local physician points, family polyclinics or central multi-profile polyclinics in their registered area of residence. Upon initial contact with qualified health professionals, patients can be referred for specialized treatment in district, regional or national level institutions (Ahmedov et al. 2014).

Public district (city) inpatient facilities provide secondary services included in the SGBP; however, patients are responsible for covering the cost of food and accommodation (Ahmedov et al. 2014). Certain vulnerable population groups are exempt from these expenses, which the State covers on their behalf (Ahmedov et al. 2014).

Portability of benefits is limited. Public health care institutions are allowed to charge patients in cases when patients seek services outside their registered area of residence (Ahmedov et al. 2014). The price-setting process for such services is regulated, and user charges have ceilings defined by the regional health department, in accordance with the order of the Ministry of Health (order No. 293 of 3 December 2023). However, emergency care can be accessed free of charge from any provider regardless of registered place of residence.

According to statistics from the Ministry of Health, there is a trend towards the rationalization of health facilities (Open Data Portal of the Republic of Uzbekistan, n.d.-c). This translates into a decrease in the number of hospitals and an increase in the number of hospital beds. The table below shows the dynamics of changes in the number of medical institutions providing inpatient care, indicating the number of beds during the period from 2016 to 2021. The number of hospitals during this period decreased by 18 (3 per cent), while absolute number of beds between 2016 and 2021 increased by 6,281 (5 per cent) (Open Data Portal of the Republic of Uzbekistan, n.d.-b).

▶ Table 15. Number of hospital beds in Uzbekistan (absolute and relative) between 2016 and 2021

	2016	2017	2018	2019	2020	2021
Number of hospitals	582	581	574	566	570	564
Absolute number of beds	115 936	116 391	117 169	117 366	120 977	122 217
Provision of hospital beds per 10,000 population	36.7	35.9	35.6	35.3	35.0	34.7

Source: Open Data of the Ministry of Health of the Republic of Uzbekistan.

The number of medical institutions providing medical outpatient care also decreased during the period from 2016 to 2021 (Open Data Portal of the Republic of Uzbekistan, n.d.-a). The reduction in PHC facilities (by 34 per cent between 2016 and 2021) occurred due to a decrease in the number of rural medical posts

(SVPs). This decision was made in order to optimize the SVP network, in accordance with the Decree of the President No. PP-2857 dated 18 March 2017.[126]

▶ Table 16. Number of PHC facilities in Uzbekistan between 2016 and 2021

	2016	2017	2018	2019	2020	2021
PHC facilities	3 758	2 377	2 374	2 368	2 374	2 478

Source: Open Data of the Ministry of Health of the Republic of Uzbekistan.

The private sector plays a minor but gradually expanding role in the country's health system. While the number of private providers grew from around 3,500 in 2017 to more than 6,000 in 2020, most of them constitute small practices (Robinson 2021). Furthermore, existing regulations require certain services to be delivered by the public sector (such as HIV/AIDS and tuberculosis) (Robinson 2021). However, it should be noted that the private sector has been contributing to an increasing share of hospital bed capacity (estimated at 23.4 per cent in 2018) (Robinson 2021). If patients choose to access services from private providers, they are usually responsible for paying the entire cost, although reimbursement mechanisms exist for vulnerable population groups (veterans, persons with disabilities, orphans and so on) (Ahmedov et al. 2014).

The new SHIF contracts different types of legal entities: Regional hospitals; district (city) medical unions, which consist of family doctor points (in rural areas); family polyclinics; district (city) central polyclinics; and district (city) hospitals for purchasing medical services included in the SGBP. SHIF pays PHC facilities per capita and via case-based payment of 10 per cent of the hospital's budget (WHO Regional Office for Europe 2023).

▶ 4. Results

Coverage

Under the Law on Health Protection and other legislative documents, the SGBP is accessible to all citizens of Uzbekistan, as well as foreigners and stateless persons who have permanent residence status in the country. In this context, legal population coverage of the existing scheme can be assessed as close to universal.

However, some groups of residents are not covered by the programme, most notably foreigners without permanent residence status and persons with irregular residence status. According to UN estimates, in 2015 there were close to 1.8 million immigrants in Uzbekistan (UN 2020b). A significant number of these immigrants likely had informal status and therefore were not eligible to access the SGBP (unless there was a bilateral agreement with their country of origin). Based on data sourced by the Vatican's Migrants and Refugees Section, there are approximately 100,000 people in Uzbekistan who are considered stateless, but only 50,000 of them will be granted Uzbek citizenship (Integral Human Development 2020).

In addition, some internal labour migrants and internally displaced households face challenges when accessing the SGBP because they are seeking care outside their registered area of residence (UNDP and Gender Programme of Swiss Embassy 2008). It is estimated that in Uzbekistan, there are more than 70,000 persons internally displaced by adverse climate events and disasters and around 3,500 persons displaced by conflict and violence (OCHA 2022). In addition, there is continuous internal migration from rural to urban areas linked to employment (Integral Human Development 2020).

[126] Decree of the Republic of Uzbekistan No. PP-2857 on Measures to Improve the Organization of Activities of Primary Health care Institutions, dated 29 March 2017, available (in Uzbek) at: https://old.lex.uz/docs/3177802

Adequacy of benefits/financial protection

Entitlement to SGBP provides access to a range of health services at no cost to patients, including preventive services. For instance, vaccination and immunization programmes are included in the benefit package and provided according to the approved vaccination schedule.[127] The prevention of the spread of infectious diseases is also included, with a number of programmes implemented to combat HIV/AIDS, tuberculosis, hepatitis B, C, D and others. Each of these programmes is supported at the government level and financed from public funds.

However, the current composition of the package largely excludes secondary and tertiary care as well as some outpatient pharmaceuticals for most of the population (Robinson 2021). As a result, there are substantial shortfalls in financial protection as patients are forced to pay out of pocket for the services that are not covered under the existing arrangement. Notably, while NCDs are the main cause of death in the country,[128] the basic benefits package only includes some NCDs, such as cancer, cardiovascular disease and diabetes, while other common NCDs (asthma, Chronic obstructive pulmonary disease and others) remain uncovered by preventive and screening programmes.

In general, the SGBP does not cover rehabilitation services. In family polyclinics there are exercise therapy rooms (the office of physiotherapy exercises),[129] but the level of equipment and the attendance of patients is low, with many turning to private clinics providing rehabilitation services (Ahmedov et al. 2014). Overall, the volume of medical services provided by private providers is estimated at 30 per cent of the total volume of medical services provided (The Government Portal of the Republic of Uzbekistan 2023).

While existing guidelines and regulations provide for referral procedures, in practice, they are loosely followed by both patients and health care providers (Ahmedov et al. 2014). Therefore, it is not uncommon for patients to access health care directly from secondary-level institutions, many of which have outpatient units, which limits financial protection. Furthermore, beneficiaries have the option to seek medical services outside of the provider network, as they can access health care at private clinics that require patients to cover their health care costs. Moreover, the SGBP does not cover compensation for transportation costs, meaning that patients are forced to pay these costs at their own expense, which reduces the level of financial protection and adversely affects well-being, especially among vulnerable people.

Persons who are not included in vulnerable groups of the population are forced to buy medicines and pay for medical devices and consumables for surgical operations (stents, endoprostheses and so on) (WHO Regional Office for Europe 2023; ILO, UNICEF and World Bank 2020). Moreover, a shortage of medicines is being reported.

Another challenge to financial protection is presented by informal payments (Ahmedov et al. 2014). Some reforms have been introduced to tackle this, but they have proven to be ineffective. Informal payments are common at secondary and tertiary care levels, representing an obstacle for all, primarily the most vulnerable, to access these levels of care. Despite an increase in public expenditure on health, OOP payments, informal payments and the limits of the benefit package led to large gaps in terms of financial protection (Jung Cho and Haverkort 2023; European Observatory on Health Systems and Policies and WHO 2022).

For all of these reasons, OOP spending amounted to 57.7 per cent of CHE in 2019 (WHO n.d.). WHO estimates suggest that in 2018 almost one in five households incurred catastrophic health expenditures (Robinson 2021). It is estimated that 36 per cent of CHE was spent on medical goods (mostly medicines) in 2019, and this cost was solely borne by private household spending. Similarly, domestic private expenditure on curative care represented 18 per cent of CHE, which means that households still have to pay for a major share when it comes to access to curative services (European Observatory on Health

[127] Resolution of the Sanitary and Epidemiological Welfare and Public Health Service of the Republic of Uzbekistan No. 02, dated 19 July 2021, available (in Uzbek) at: https://lex.uz/docs/5520052

[128] The share of mortality attributable to NCDs in Uzbekistan has risen from 73 per cent in 2000 to 85 per cent in 2019 (World Bank 2020).

[129] Ministry of Health of the Republic of Uzbekistan Order No.594, dated 29 December 2007, available (in Uzbek) at https://www.med.uz/documentation/detail.php?ID=9128

Systems and Policies and WHO 2022). In 2020, 18 per cent of households reported that at least one household member had not sought medical care because they could not afford it (World Bank 2021).

Representative surveys of Uzbekistan residents conducted in 2006 and 2010 found that among the most common challenges experienced by people when accessing health care were the need to make informal payments (27 per cent), the lack of required medicines in facilities (25 per cent) and long waiting times (21 per cent) (Habibov et al. 2019). Despite the incomplete provision of the necessary medical care within the framework of the SGBP, the demand for voluntary medical insurance is not particularly high (European Observatory on Health Systems and Policies and WHO 2022). The main reason for this is the limited services included in insurance products and the high levels of insurance premiums for obtaining this type of insurance.

Responsiveness to population needs

Availability and accessibility

Despite improved access to certain types of services (such as maternal, child and reproductive health services, which have been prioritised by the Government in recent years), a very large portion of the population continues to face major barriers when seeking health care. In 2019, the health service coverage index (health service indicator 3.8.1) was equal to 71, which is below the value of Kazakhstan and Turkmenistan but above that of Tajikistan and Kyrgyzstan. The sub index on reproductive, maternal, newborn and child health was indicated at 83.61 (WHO 2021).

Several factors affect service availability in Uzbekistan:

- Geographic remoteness of some rural settlements poses a challenge to health care accessibility. Even when medical facilities are present, staffing remains low (Ahmedov et al. 2014). To access some villages located on the territory of Kyrgyzstan, it is necessary to cross the State border, which creates obstacles in the provision of doctors and medical equipment (Baizakova 2017).
- One of the main challenges to tackle is the brain drain and migration of health professionals to neighbouring countries where there are better financial conditions (Dronina and Nam 2019). This has led the country to face a shortage of physicians. However, the number of nurses per 100,000 persons continued to remain stable at between 1,000 and 1,200 and remained the highest in Central Asia during the period 1990-2012 (Ahmedov et al. 2014). According to the national Statistics Agency, in 2020, the number of nurses was estimated to be 3,656 per 100,000 persons (UZ Statistics Agency 2022g).
- The distribution of the health workforce in the country remains unequal, with the majority of health professionals located in urban areas, leading to shortages in rural areas. Since half of the population lives in rural areas, this phenomenon affects a large share of citizens (Robinson 2021). Health workers are salaried and paid according to state guidelines, yet the salaries are low and insufficient to cover the cost of living. This explains why many professionals tend to emigrate to neighboring countries (Ahmedov et al. 2014).
- Differences in competencies between rural and urban areas and low enrolment in higher education contributes to shortages of highly qualified personnel (UN 2020a).
- Water services and sanitation infrastructure require extensive rehabilitation and renewal, since they were built predominantly under the Soviet Union (Robinson 2021).

On 11 December 2020, in an effort to bring medical care closer to the population, Presidential Decree No. UP-6110 was adopted to promote the additional creation of family doctor points and family polyclinics. This Decree determined that between 2021-2023, the following additional facilities should be created:[130] 315 family doctor points (100 in 2021, 105 in 2022, 110 in 2023); 52 family polyclinics in rural areas (17 in 2021, 18 in 2022, 17 in 2023); and 33 family polyclinics in cities (seven in 2021, 13 in 2022, 13 in 2023). Moreover, in selected areas, laboratory and diagnostic services, hemodialysis services (PPP project), and treatment services for the certain categories of the population [131] are being purchased from private providers. In addition, there has been a gradual adoption of telemedicine and eHealth solutions to increase the efficiency and reach of health services, with several major projects piloted in 2020 and 2021 (Robinson 2021; WHO Regional Office for Europe 2023).

Quality and acceptability

In recent years, much attention has been paid to improving the quality of medical care, especially in the field of maternal and child health (European Observatory on Health Systems and Policies and WHO 2022). As a result of consistent health resource commitment to maternal and child health, 100 per cent of births were attended by skilled health personnel in 2020, and maternal and child mortality have decreased significantly (WHO Data 2024). However, these rates are higher than the average for the Europe and Central Asia region, highlighting the need for further progress in this area (World Bank 2023; UNDP 2022). National standards have been developed for the management and provision of medical care to pregnant women, which are based on evidence-based medicine and approved by orders of the Ministry of Health (Republican Specialized Scientific and Practical and Medical Center for Maternal and Child Health, n.d.).

According to studies conducted by the National Committee for the Confidential Study of Maternal Deaths during the period from 2018 to 2020, over the past 25 years, the maternal mortality ratio (MMR) in Uzbekistan has decreased by more than 3 times: In 1990, it was 65.5 per 100,000 live births, and in 2015, this figure was -18.9. The studies revealed that the main cause of maternal mortality in Uzbekistan are direct obstetric causes, which accounted for 77.3 per cent of cases. In most cases, these causes are preventable, which indicates that there is still room for reducing maternal mortality (National Committee on Confidential Maternal Mortality Research 2022). For example, analysis of maternal mortality indicators shows that most cases of maternal mortality occur in district level facilities (RMO) due to risk factors that should have been the basis for referral or transfer to a higher level of perinatal care (National Committee on Confidential Maternal Mortality Research 2022).

The organization and management of the health system is not sufficiently optimized, which leads to congestion in certain areas, which can affect the quality of medical services. In addition, there are significant regional disparities both in terms of specific indicators and in assessing the quality of medical institutions. In order to monitor the activities of medical institutions and the quality of medical care provided, regular monitoring visits are carried out, problems are identified and measures are taken to eliminate them. Licensing of the activities of medical organizations is carried out by the Ministry of Health,[132] and state medical organizations are often issued a license by default, while non-governmental medical organizations must meet the established requirements for obtaining a license.

[130] Decree of President the Republic of Uzbekistan No. UP-6110 on Measures to Introduce Fundamentally New Mechanisms into the Activities of Primary Health care Institutions and Further Increase the Effectiveness of Reforms in the Health care System, dated 11 December 2020, available (in Uzbek) at https://lex.uz/ru/docs/5100679

[131] Resolution of President the Republic of Uzbekistan No. 5199 on Measures to Improve the System of Specialized Medical care in the Health care Sector, dated 19 July 2021, available (in Uzbek) at: https://lex.uz/docs/5534908

[132] Resolution of the Cabinet of Ministers in the Republic of Uzbekistan No. 92 on Enhancement of Procedure for Licensing of Medical Activities dated 29 March 2012, available at https://cis-legislation.com/document.fwx?rgn=50991

However, a range of significant issues persist that affect the quality of health care and the willingness of the population to access services offered by the public health system. Despite the orders approved by the Ministry of Health indicating measures for prevention and the timing of their implementation, prevention activities [133] are not carried out regularly or efficiently. As such, the level of preventive measures taken can be assessed as unsatisfactory (European Observatory on Health Systems and Policies and WHO 2022; WHO Regional Office for Europe 2023).

It should also be noted that the prevalence of self-medication in Uzbekistan is high. One 2014 study observed that close to 80 per cent of schoolteachers in cities used non-prescribed antibiotics for self-treatment (Belkina et al. 2014). The frequent use of self-medication is often indicative of challenges with accessibility and acceptability of health services, but can also be linked to cultural beliefs. It also highlights the need for stronger regulation and monitoring to avoid the negative effects of excessive antibiotics usage and health-harming use of medicines.

Information on the satisfaction of patients is scarce and seems to be conflicting. Available surveys suggest that patients are usually satisfied with the services provided by health care workers at polyclinics and hospitals (Akhmedov et al. 2022; Madrakhimov and Karimov 2021). However, these results are difficult to extrapolate to the overall health system, since the surveys in question were conducted in specific locations (facilities) and concern specific procedures. Furthermore, anecdotal evidence suggests that, when their financial situation allows, many patients prefer to seek treatment overseas or in private health facilities (Ahmedov et al. 2014).

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[133] This includes activities such as screening for oncohematology among children aged 3-18 years; cervical cancer among women aged 35-55 years; breast cancer among women aged 45-65 years; helminthiases in children aged 2-10 years (according to the order of the Ministry of Health of the Republic of Uzbekistan No. 210 dated 27 July 27 2022); phenylketonuria and congenital hypothyroidism in newborns; early diagnosis of congenital and hereditary diseases in the fetus by conducting a mass prenatal ultrasound examination of women; and biochemical prenatal (prenatal) screening for the detection of neural tube defects and chromosomal syndromes in the fetus; CVD risk stratification; early detection of tuberculosis; and monitoring of growth and development of children under 5 years of age (according to Presidential Decree No/ PP-3440, dated 25 December 2017, available at: https://lex.uz/docs/3471753

5 Way forward

In recent years, particular attention has been paid to strengthening the financial protection of the population, and expanding the coverage and types of health services provided to citizens by the State. However, problems related to the inadequacy of the benefit package in meeting the needs of the population are reflected in very high OOP payments nationwide, with large exclusions (including secondary and tertiary care as well as outpatient pharmaceuticals) leaving the population with very limited financial protection. Limited government allocation to health is also of concern, particularly given that the financing of the new SHIF is supposed to rely exclusively on taxation. Options to diversify sources of revenues should therefore be explored. Moreover, continued improvement of PHC and the availability of providers, specifically in rural areas, should be prioritized. A WHO-led feasibility study on the introduction of mandatory health insurance conducted in 2020-2021 recommended that the Government should focus on efficiency gains in the service delivery system, by introducing modern clinical and professional managerial practices underpinned by strong digitalization and performance monitoring to use limited resources more efficiently (WHO Regional Office for Europe 2021).

Through the continued implementation of the Concept on Health Development of the Republic of Uzbekistan 2019-2025 adopted in 2018, the main actions to address current gaps should involve (i) expansion of the benefit package; (ii) increased levels of public funding for social health protection; and (iii) capacity building and improved resource availability.

The Government has started to use intersectoral approaches to tackle social health protection-related issues. During COVID-19 for example, the Ministry of Health collaborated with a variety of sectors, including employment, transport and tourism to respond to the effects of the pandemic (European Observatory on Health Systems and Policies and WHO 2022). Prior to COVID-19, an area of intersectoral collaboration that yielded positive results was addressing risk factors related to NCDs. Furthermore, tobacco control could be an area in which an intersectoral approach could be used to strengthen existing policies (Robinson 2021).

6. Main lessons learned

- Enshrining the universality of social health protection coverage in the Constitution and related laws is the first necessary step towards guaranteeing social health protection for all, institutionalizing state liability for providing social health protection.
- Many health services are currently not covered by the SGBP, which hinders effective financial protection and access to care for the majority of the population (Robinson 2021). In addition, while service availability has improved over recent years, challenges remain, especially in remote rural areas.
- Low levels of health funding, underpinned by insufficient allocations to the health sector, should be addressed in order to guarantee the sustainability of the new SHI scheme. To this end, additional sources of revenue should be investigated.
- The introduction of a purchasing mechanism for medical services made it possible to monitor the system of referrals from family doctors, as well as to control the provision of medical care within the SGBP (WHO Regional Office for Europe 2023). Accordingly, in regions not covered by state health insurance, there may be gaps. Gradual consolidation of financial resources, first at the regional level (Syrdarya and other regions) and then at the national level, will make it possible to cover the population with a package of state guarantees, regardless of the place of permanent residence.
- The improvements in maternal and child health in Uzbekistan are commendable, and maternal and child mortality have decreased significantly as a result of consistent health resource commitment to this area. However, the rates are higher than the average for the Europe and Central Asia region, highlighting the need for further progress in this area (World Bank 2023; UNDP 2022).

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