CHAPTER 2. DEMAND FOR AND UTILIZATION OF HEALTHCARE SERVICES

2.1 Introduction

Understanding the main determinants of the demand for and utilization of healthcare services is essential for any policy intervention. Demand for healthcare is an expression of a perceived healthcare need. An individual demands healthcare services because he or she believes that they are needed, accessible and will help improve his or her health status. As Andersen asserts in his behavioral model, perceptions of both illness and healthcare needs can be determined either by the individual or the healthcare provider.61 Perceptions of illness, however, vary from person to person, depending on their level of discomfort, degree of symptoms and anticipated consequences, as well as their perception of the quality and effectiveness of the healthcare delivery system in restoring health.

Evidence shows that a perceived need triggers a demand for service when the barriers to healthcare are non-existent or negligible.62 Service use, or utilization, can be initiated by the patient or the healthcare provider. First contact with the provider, usually initiated by the patient, is a good indicator of access and is mainly determined by individual characteristics (predisposing factors), such as age, sex, marital status, education, occupation, etc. This initial contact is also determined by enabling factors, such as income, health insurance, price of health services, geographic location (rural or urban) and availability of healthcare facilities. Subsequent contacts, in addition to being conditioned by enabling factors, are also conditioned by characteristics of the provider and the health system. These contacts are a good indicator of utilization.

Use of services can be further differentiated by site (rural clinic, hospital, etc.), time interval and whether services are inpatient, outpatient, preventive, curative or follow-up (i.e., to prevent complications). It should be noted that individual decisions take place within the social, cultural, political, economic and legal context of a country, which also impact the healthcare system and, consequently, the behavior of providers.

In an ideal world, the demand for healthcare is fully met by an adequate supply. In a more realistic setting, demand and supply do not match perfectly, resulting in unmet demand for healthcare services. The reasons for this unmet demand will be described in this and subsequent chapters. First, however, it is very important to thoroughly understand how demand is determined so that policymakers can define the most suitable policies and reforms to balance this demand with adequate supply.

This chapter will use this theoretical framework to explore the demand for and utilization of healthcare services in Azerbaijan. The chapter seeks to identify the relative importance

of predisposing and enabling factors in service use; utilization levels of different types of services and their main determinants; as well as satisfaction levels with different types of facilities. The chapter follows the conceptual framework of Andersen's behavioral model, as shown in Figure 2.1.

**Figure 2.1 Theoretical Framework for Demand-Utilization Analysis**

<table>
<thead>
<tr>
<th>Determinants</th>
<th>Utilization</th>
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<tbody>
<tr>
<td>Illness level/Perception of health</td>
<td>Curative</td>
</tr>
<tr>
<td>Enabling factors</td>
<td>Inpatient</td>
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<tr>
<td>Availability of facilities</td>
<td>Preventive and other services</td>
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<td>Availability of healthcare personnel</td>
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<td>Health insurance</td>
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<td>Income and poverty levels</td>
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<td>Out-of-pocket expenses</td>
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<td>Predisposing factors</td>
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<td>Satisfaction with healthcare services</td>
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<tr>
<td>Age</td>
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<tr>
<td>Sex</td>
<td></td>
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<tr>
<td>Marital status</td>
<td></td>
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<tr>
<td>Education</td>
<td></td>
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<tr>
<td>Location (rural or urban)</td>
<td></td>
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<tr>
<td>IDP/refugee/regular citizen status</td>
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</tbody>
</table>

The first section of this chapter looks at utilization, followed by an examination of healthcare-seeking behavior. Next, perceived health status, enabling factors (e.g., availability of facilities, healthcare staff, insurance coverage, etc.) and satisfaction levels are analyzed. Variations in predisposing factors (e.g., age, sex, education and citizen status) and certain enabling factors (e.g., income and insurance coverage) are explored in all sections. The chapter then concludes with recommendations.

### 2.2 Data Sources

This chapter draws heavily on two types of sources. Primary data is drawn from the Health Financing Study prepared by G&G Consulting (G&G Survey, 2005) and the Household Survey and Patient Satisfaction Survey prepared by Western World Consultants (WWC Survey, 2003 and 2005), which were conducted as part of the World Bank-financed Health Reform Project in Azerbaijan. Other primary sources include the UNICEF Multiple Indicator Cluster Survey (MIC Survey) and the UNICEF Reproductive

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Health Survey 2001 (RH Survey). The main sources of administrative data are the State Statistical Committee (SSC) of Azerbaijan and the World Health Organization (WHO). It is important to note that these household surveys are not directly comparable. The G&G survey of 2005 is a nationally representative survey with a randomly selected sample, based on a category quota. It uses recall periods of six months for inpatient services, and two weeks for outpatient, preventive and other services. The survey reached around 5,500 individuals from 1,500 households. The WWC survey is district-wide representative, and is based on random multi-stage cluster sampling that uses a one-year recall period for all types of services.

The MIC Survey is a nationally representative survey of households, women and children, based on a multistage cluster sampling approach which uses the 1999 Azerbaijan census as the sampling frame. This survey reached a total of 5,861 households, including 6,959 women and 1,875 children. The RH Survey was the first population-based, nationally representative survey in Azerbaijan, which also used a stratified multistage sampling design with the 1999 census as the sampling frame. A one-year recall period was used for use of women's health services. The RH Survey reached 7,668 women age 15-44 from 11,162 selected households, including an over-sample of conflict-affected areas with a concentration of internally displaced persons and refugees (IDP/Rs).

2.3 Utilization

2.3.1 Utilization of Curative Services

Outpatient care

Outpatient contacts per person have declined over the past several years. These contacts have fallen from as high as 10.1 in 1986 to as low as 4.6 in 2003 (see Figure 2.2).

The EU average in 2002 was 6.6, compared to the CIS average of 8.8. Regardless of the absolute number, it is important to note the declining trend over time. Given that there have been no healthcare reforms in Azerbaijan, nor any substantial changes to the health

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65 UNICEF, MIC Survey and RH Survey.
66 The WHO definition of outpatient contacts is: “The total number of primary health care (PHC) or ambulatory contacts divided by the population. An outpatient contact is one episode of examination/consultation performed by a physician or by a nurse in the presence of a physician, in relation to one outpatient at one time and location, normally at the physician's office or the patient's home. The number of outpatient contacts includes: patient's visit to physician's office; physician's visit to patient's home or other place; call for ambulance; day-patient cases. The number of outpatient contacts excludes: telephone calls; visits for prescribed laboratory tests; contacts to perform prescribed and scheduled treatment procedures, e.g., injections, physiotherapy, etc.; visits to dentist.” The WHO definition of outpatient is: “A person attending a (PHC) unit or outpatient department in an outpatient establishment and who makes use of the diagnostic or therapeutic service but does not occupy a regular hospital bed.”
system, this trend is primarily caused by declining government expenditures and increasing out-of-pocket (OOP) expenditures on the part of patients, in combination with a declining quality in service.

Annual outpatient visits are higher in rural areas and for women and people with poor health; these visits increase with age. People in the highest income quintile have the highest utilization rates of outpatient care. The G&G Survey found an annual utilization rate of outpatient care lower than that found by the WHO, with 3.2 visits per persons. Annual outpatient visits for rural respondents were substantially higher than for the urban respondents (3.7 versus 2.7 per person), as well as for females compared to males (3.7 versus 2.7 per person). With increasing age, utilization of outpatient care increases from as low as 1.4 per person for the 0–4 age group to as high as 9.7 per person for the 80 and over age group.

![Figure 2.2 Outpatient Contacts per Person per Year, 1985–2005](image)

Education level does not seem to impact outpatient care utilization. Widowed and separated respondents, however, tend to utilize outpatient services much more frequently than other types of respondents. As expected, people with poor health utilize outpatient services more than those who define their health as “better” or “much better.” For example, in Sabirabad, a district where the number of IDPs is high and many people perceive their health to be poor, outpatient visits per person annually (6.4) were the highest among all other districts.

It is interesting to note that respondents without health coverage tend to utilize outpatient facilities more often than people with health coverage, indicating that health coverage does not play an important role in utilization rates. Lastly, with regard to income, respondents from the top income quintile utilize outpatient facilities the most (5.3 visits per person), with the other quintiles varying from 2.8 (middle quintile) to 3.8 (lowest
quintile), which does not suggest that income has a clear impact on outpatient service utilization.

**Less than half of the population utilizes health care services when ill.** Among all respondents, 86.7 percent had an illness episode, but only 48.3 percent utilized any type of private or public healthcare facility.

**Most people visit the pharmacy and the district or city hospital.** Respondents had almost twice as many contacts with a healthcare provider as they had illness-related utilizations (1,040 contacts versus 544 illness utilizations). Of total contacts with a healthcare provider, 38.3 percent were with a pharmacy, followed by district hospitals (20.9 percent) and general city hospitals (13.4 percent). The high proportion of people going to the pharmacy suggests that either people visited a healthcare provider and then a pharmacy, or that, patients went directly to the pharmacist given the low quality of care provided in healthcare facilities.

Visits to pharmacies accounted for the highest number of healthcare provider visits in both rural and urban areas (46.2 and 45.3 percent, respectively). In rural areas, the number of visits to pharmacies were higher than in general city hospitals (16.2 percent) and even higher than in district hospitals (13.2 percent). Twice as many people in rural than urban areas also went to traditional healers (5.9 percent). In urban areas, pharmacies were visited the most, followed by district hospitals (33.4 percent). Gender, age, education level, perceived health status and income were not determining factors of the facilities visited.

**Inpatient Care**

**Inpatient admissions have remained the same over the past few years. Admissions are higher in rural areas (particularly in certain districts) and for women and people with poor health status. Admissions also increase with age.** The G&G Survey found that the annual number of hospital admissions per person was 100/1000, compared to the WHO finding of 50/1000. The difference in these findings could be caused by differences in reporting methods and type of facilities covered. Figures were somewhat higher for hospital admissions in rural than urban areas. For example, hospital admissions in the districts of Nasimi, Xaqmaz and Qusar (219.1, 216.1 and 158.5 per 1,000, respectively) were substantially higher than in urban areas, a finding that can mainly be attributed either to higher incomes or geographic difficulties in access. Geographic problems in accessing outpatient care cause more hospitalizations (under normal conditions, such cases would not have to be treated in a hospital). For example, in Nasimi, where hospital admissions were 219.1/1,000, outpatient visits were the lowest compared to other districts (0.9/1,000). In some other districts, however, hospital utilization was very low (Lankaran, Ganja, Qaradag—43.2, 46.4 and 57.7 per 1,000, respectively). In Ganja, for example,

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57 Xaqmaz is a pilot district of the Health Reform Project.
outpatient visits were as high as 4.8 per person, but hospital admissions were only 46.4/1,000.

Similar to outpatient visits, women are admitted to the hospital more often than men. Admissions for both sexes increase with age except for people over age 80, the hospital admissions of which drop by more than 100 percent compared to the 70–79 age group. Another drop in hospital admissions occurs between the two age groups 0–4 to 5–14 years. With regard to education level, hospital admissions tend to be higher for people with higher levels of education.

Widowed respondents seem to be admitted to the hospital most often, when compared to other respondents. As could be expected, respondents who perceive their health status as “very poor” or “poor” (0.4 and 0.3 per person, respectively) are admitted to the hospital much more frequently than those who perceive their health as “better” or “much better” (0.07 and 0.04 per person, respectively). People with no health coverage are also admitted to the hospital more often than those with health coverage. Income is thus not a clear determinant of hospital admissions.

People mainly utilize public facilities, such as district and city hospitals, for inpatient care. Of the respondents in the G&G Survey who received inpatient care, 88.1 percent went to a public facility. Some 45.5 percent of this group went to a district hospital, followed by general city hospitals (29.3 percent), specialized hospitals (12.1 percent) and maternity houses (5.5 percent). The remaining 11.9 percent of respondents visited a private facility, with 71.1 percent of this number visiting a private general city hospital.

In addition to the 329 hospitalization episodes documented by the survey, there were 483 utilizations (1.5 visits per inpatient episode) of other facilities for a variety of purposes. Of these utilizations, 49 percent were for the purchase of drugs (41.8 percent of which took place in private facilities), 23 percent for the purchase of medical non-durables (19.5 percent of which took place in private facilities), 10.8 percent for laboratory services (procured in both public and private facilities), 9.1 percent for diagnostic imaging services (both public and private facilities) and 8.1 percent for medical durables (both public and private facilities). High utilization of non-hospital facilities, particularly to purchase drugs and medical non-durables, suggests insufficient hospital supplies of these items.

In rural areas, people seek inpatient care predominantly in public general city hospitals, while in urban areas, most people go to public district hospitals. Most

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68 Since patients were unable to identify the exact names of the facilities that they had visited during the survey, it was difficult to categorize them according to classical MOH hospital or district (rayon) hospital categories. For this reason, the category of “general city hospital” was created. These facilities are located almost universally in major cities and have either relatively or generally better financing and staffing, plus a higher standard of rehabilitation and care, than do public hospitals.

69 See previous footnote.
admissions to private facilities are in rural areas. Over one-third of respondents in the G&G Survey are most often admitted to a general city hospital, followed by a district hospital (15.8 percent), specialized hospital center (15.3 percent), general private city hospital (12 percent) or maternity house (8.7 percent). It is interesting to note that 78.6 percent of admissions to private general city hospitals were in rural areas, most likely due to the low quality of rural public facilities. In urban areas, on the other hand, 70.5 percent of respondents were admitted to a district hospital, followed by a general city hospital (13 percent).

With respect to private facilities, women visit private inpatient facilities more often than men. No respondent in the 0–4 age group utilizes such facilities. About half of the survey respondents went to specialized hospitals. Adults between the ages of 15 and 69 primarily use public district hospitals, while people between the ages of 70 and 79 primarily use specialized hospitals. Those who perceive their health status as “much better” visit private hospitals and public maternity houses much more often than do other respondents. In terms of income, private general city hospitals were mostly preferred by people in the highest income quintile. Lastly, people with health coverage visit specialized hospitals more often and private general city hospitals less often than those who do not have such coverage. However, utilization of public general city hospitals and district hospitals are the same for both groups.

The number of hospital beds in Azerbaijan over the past few years has remained approximately the same, indicating that there has been little rationalization of the healthcare system since the collapse of the Soviet Union. The current number of hospital beds reflects a lack of consideration for the epidemiological needs of the population. Azerbaijan has a rather high number of hospital beds: 840/100,000 population compared to the EU-25 average of 611/100,000 in 2002. This number has, however, decreased since 1989, when it was 1,020/100,000.70

The bed occupancy rate has fallen dramatically since independence. During the 1980s, the occupancy rate was between 70 and 80 percent. In 2000, it had fallen to 33.7 percent in Republican hospitals, 23.3 percent in urban hospitals, 31 percent in local hospitals, less than 14 percent in hospitals for infectious diseases (for adults and children), and only 6.3 percent in district hospitals.71 Based on WHO data, the bed occupancy rate (OR) in acute care hospitals was 26.1 percent in 2003. Due to the poor condition of such facilities, including their lack of equipment and drugs, patients who do stay in the hospital often do not receive appropriate care.72 Low ORs could also be explained by the fact that hospital patients are expected to cover almost all medical costs and other non-medical expenditures, such as food, laundry or drugs.73 As a result, many who need inpatient care cannot afford it, a reality reflected in the low occupancy rates. In addition, since the

number of beds is still based on the former Soviet planning model, many beds do not get utilized.

**The average length of stay in a hospital remains high.** According to the WHO, the average length of stay (ALOS) in a hospital in Azerbaijan was 15.8 days in 2003, higher than in any other country in the European region (see Table 2.1). In comparison, the EU average in 2003 was 6.77 days, while the CIS average was 12.08 days.

<table>
<thead>
<tr>
<th>Item</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admissions per 100 pop.</td>
<td>4.7</td>
<td>4.7</td>
<td>4.7</td>
<td>4.7</td>
<td>4.8</td>
</tr>
<tr>
<td>Average length of stay in days</td>
<td>14.9</td>
<td>15.4</td>
<td>15.5</td>
<td>15.3</td>
<td>15.8</td>
</tr>
<tr>
<td>Occupancy rate (%)</td>
<td>30.0</td>
<td>28.5</td>
<td>25.7</td>
<td>25.6</td>
<td>26.1</td>
</tr>
</tbody>
</table>


The inpatient facility utilization results of the WWC Survey were somewhat lower: approximately 11.1 days for adults and 2.6 days for children. The higher WHO numbers can be explained by two factors: (i) given obsolete treatment protocols and the absence of necessary equipment, patients need to stay much longer in the hospital than would otherwise be necessary, and (ii) given the low salaries of health personnel, keeping patients at a facility longer than necessary allows personnel to collect higher payments. Among respondents advised to admit themselves to a hospital, 61 percent refused, either because they thought it unnecessary (mainly in urban areas) or did not have sufficient money (mainly in rural areas).74

### 2.3.2 Preventive and Other Care

Utilization of preventive and other services°⁵ is higher in rural than urban areas. It is also higher for women and respondents from the highest income quintile, and tends to increase with age. Annual average utilization of preventive and other health visits is 0.6 per person and is substantially higher in rural than urban areas. For example, the G&G Survey found 1.6 annual visits per person in Xachmaz (a semi-rural area), followed by 0.9 in Nasimi (an urban area) and a low of 0.05 in Qaradag (a rural area). Women utilize preventive healthcare services more than men. Utilization rates also vary with age. Utilization seems to increase with increasing age (save for the 0–4 age group) and is highest for the 60–69 age group (see Figure 2.3), while it should be higher for the younger population. Low utilization of preventive services at younger ages may lead to a future burden on the healthcare system.


75 Throughout this chapter, wherever the phrase “preventive services and/or care” is used, it always refers to “preventive and other services.”
There is no clear utilization trend related to education; although people with tertiary education utilize preventive services more often than people with lower levels of education. Of note, divorced respondents (1.8 annual visits per person) utilize preventive services six times more often than those who were never married. Again, the better a person’s perception of their health, the less he or she utilizes preventive and other healthcare services. People without health coverage visit preventive service facilities almost three times more than those who have coverage. With regard to income, the higher the income, the more preventive healthcare services are utilized.

*Only a small proportion of all episodes documented for preventive and other care were actually for preventive care.* The G&G Survey found that only 10.6 percent of the total number of such episodes were for preventive and other health services. Medical check-ups are the most frequently utilized service, followed by dental prosthesis, immunization, eye glasses/lenses prescription, prenatal care, postnatal care and family planning. Different providers are utilized for different types of services (see Figure 2.4).

![Figure 2.3 Annual Preventive and Other Health Visits per Person, by Age, 2005](image)


![Figure 2.4 Utilization of Preventive and Other Health Services, 2005 (%)](image)

The private sector plays an important role in the provision of preventive and other services, particularly for the rural population and people from the highest income quintile. As the figure above shows, private-sector providers play a very important role in the provision of preventive services, except for family planning, postnatal care and medical check-ups. It is interesting to note that rural residents utilize mainly private facilities (25 percent go to private health diagnostic centers and 17.3 percent, to private general hospitals); only 26 percent go to public general hospitals. Urban respondents, on the other hand, go to district hospitals (44.1 percent), followed by private general city hospitals (16.2 percent) and private district hospitals (11.8 percent). Women tend to utilize public facilities more often than men. With regard to income, respondents from the highest income quintile utilize private facilities more often than respondents from other quintiles, but no definite increasing or decreasing trend can be discerned across quintiles.

2.3.3 Utilization of Reproductive Health Services

Antenatal visits and postnatal hospital stays in Azerbaijan are still very low compared to international standards, particularly for the poor and the rural population. The average number of visits for antenatal care was 2.3 (0.3 visits for the lowest income quintile and 4.5 visits for the highest), compared to the WHO norm of 4 to 6 visits overall during a pregnancy. The average postnatal stay in a hospital was 2.1 days, compared to an international average of 2.8 to 3.2 days. The number of days falls as low as 0.6 for poor households.

For both antenatal care and postnatal hospital stays, numbers are lower in rural areas. The UNICEF RH Survey in Azerbaijan found that only 70 percent of women who gave birth in the past five years had received some prenatal care, while only 25 percent had received postnatal care. Of the women who received prenatal care, the average number of visits was 4.3 visits, a higher number than the WWC Survey finding. Only 6 percent of births had, however, received adequate care based on the Prenatal Care Index (Kotelchuck Index). According to the UNICEF MIC Survey, about 87.5 percent of births occurring in the year prior to survey were attended by skilled personnel, an indicator that is strongly positively correlated with the level of the education of the mother.

In Azerbaijan, traditional methods of contraception are used most of the time. Despite a fall in the abortion rate over the past several years, abortion is also still used. According to the RH Survey of 2001, withdrawal (31 percent) and intrauterine devices, or IUDs (16 percent), are the most frequently used methods of contraception among married women aged 15–49.76 Contraceptive prevalence of any kind in Azerbaijan is only 55 percent for married or in-union women, one of the lowest percentages among the former Soviet republics. In fact, modern methods of contraception are used by less than a quarter (22 percent) of people who use any method of contraception.

76 UNICEF, RH Survey; UNICEF, MIC Survey.
In addition, abortion is still frequently used as a method of contraception, although there has been some progress in reducing its use since the 1990s. Abortions are mainly carried out in district polyclinics, but are also often conducted outside public facilities by unqualified staff. Many respondents said that they do not go to health centers for abortions due to the lack of necessary health equipment. Pharmacies are the main source for obtaining condoms or pills, while public hospitals are the primary source for IUDs. IDP and refugee women were less likely to obtain contraceptives in public hospitals and clinics and more likely to receive them from health clinics run by NGOs.

2.3.4 Utilization of Services for Children

Children are predominantly treated at home. Since no family pediatrician system exists in the areas where the WWC Survey was conducted, in the majority of cases, children were treated by their parents and did not seek care in health facilities. About half of all children interviewed for the WWW Survey reported being “generally healthy,” with rural children overall somewhat less healthy than urban children. Only 0.3–0.4 percent of children had gone for a general check-up. Of the children who reported themselves ill, treatment by adults in the household was the most prevalent form of treatment (60 percent), followed by no treatment at all.

When children receive treatment, they are mostly taken to a district polyclinic. According to the MIC Survey, of the 3 percent of children who reported having an acute respiratory illness (ARI) episode in the last two weeks, only 35.6 percent were taken to a health provider (22 percent to a hospital, 10.2 percent to a health center, 1.7 percent to a dispensary (for examination and treatment by a physician), 3.4 percent to a traditional healer, and another 3.4 percent to a private physician).

Home treatment of children is supported by the findings of the G&G Survey, which show that children aged 5–14, followed by the age group 0–4, have the lowest annual utilization rates of all healthcare facilities compared to other age groups: low hospital admissions (0.02 per person), outpatient visits (1.2 per person) and preventive and other health care visits (0.46 per person)—services for which utilization levels should be substantially higher in these age groups. As a component of the integrated management of childhood illnesses (IMCI), mothers in Azerbaijan were asked to name the symptoms that would cause them to seek care for their child. Some 75 percent said that they would seek care if their child developed a fever; 21 percent said if the child was becoming more sick and 10 percent said, if the child experienced difficulty in breathing and had blood in his or her stools. However, as the utilization rates cited above suggest, mothers are unlikely to bring their children to the hospital. If a health care facility is visited for inpatient care, children aged 0–4 are most often taken to specialized public hospitals, followed by a children’s hospital.

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For outpatient care, however, 43.8 percent reported that the pharmacy is the main provider of healthcare services, indicating either that many children are treated at home or that with each visit to a healthcare facility, the patient also visits the pharmacy. Roughly 18.8 percent of children visit a district hospital and around 12 percent, a diagnostic center or rural hospital. Children between the ages of 5 and 14 are taken to public district hospitals, general city hospitals or private general city hospitals for inpatient care, while for outpatient visits they are again taken to the pharmacy (46.2 percent), followed by a general city hospital (15.4 percent) and a district hospital (13.5 percent). For preventive services, children aged 0–4 are taken equally to public general city hospitals, public rural hospitals, or diagnostic centers (both private and public). For the age group 5–14, public district hospitals, followed by private general city hospitals, are visited most of the time.

Immunization rates for children in Azerbaijan, for both the initial and follow-up vaccine dose, range between 85 and 90 percent, according to the G&G Survey. Many children are immunized in private facilities, most likely because these facilities offer a wider choice and better availability of vaccines. Based on the MIC Survey, however, only 1.9 percent of children were found to have health immunization cards, so the G&G Survey results are probably estimated, based on the recall method.

2.4. Healthcare-seeking Behavior

*A large proportion of the population does not seek treatment in a health facility when sick.* Only 60 percent of respondents with an illness episode sought treatment in a healthcare facility. Of the 1,625 episodes reported in the G&G Survey, 89.4 percent were illness episodes and 10.6 percent were non-illness utilizations of healthcare services (e.g., immunization, family planning and other services). Among respondents who reported an illness episode, almost 40 percent did nothing or underwent self-treatment. Sixty percent of household members reported utilization of facilities when ill, with a total of 1,369 health provider contacts (329 for hospitalizations and 1,040 for outpatient care). When examining outpatient care alone, the proportion of people who did nothing or sought self-care rose to 51.7 percent.

*People from the lowest income quintile seek care less often than those from the highest income quintile.* Figure 2.5 shows that people’s attitudes toward seeking care differ across income quintiles, with 70.1 percent of the top quintile seeking care, compared to only 43 percent of the bottom quintile. People from the lowest quintile do not seek any treatment at all significantly more often than people from the top quintile (34.9 percent versus 11.6 percent). Self-treatment is also somewhat higher among the lowest than highest quintile. Overall, the fact that so many people treat themselves suggests that people in Azerbaijan have little trust in the quality of care received from the system and that high OOP costs act as a disincentive for seeking care.

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78 An illness episode is defined as a self-reported discrete incident of illness.
People from the lowest income quintile in urban areas, followed by people from the lowest income quintile in rural areas, seek healthcare the least. When examining the pattern of seeking care by income quintile and location, those from the lowest quintile in urban areas seek care the least, followed by the lowest quintile in rural areas. People who belong to the top quintile in rural areas treat themselves ten times more than the top quintile in urban areas, and get no treatment at all six times more often, a pattern best explained by the low quality and financial cost of healthcare services in rural areas. Almost twice as many people in the rural bottom quintile, as compared to the rural top quintile, do not seek treatment (33 and 18 percent, respectively), while the proportion of people choosing self-treatment in rural areas is about the same between the lowest and the highest quintile. People in the bottom urban quintile choose self-treatment (24.5 percent) over no treatment at all (40.7 percent) at substantially higher rates than do people from the top urban quintile.

The poor, as well as the better-off, cite lack of money as the main reason for not seeking treatment, indicating that healthcare services are not affordable for many people (see Figure 2.6).\textsuperscript{79} Overall, financial access problems seem to play a greater role in rural areas. They clearly play a role for the poor. However, lack of money is also cited as the main reason for not seeking care in urban districts characterized by high unemployment and a large number of IDPs and low-income of households (e.g., Qaradag and Ganja). An International Medical Corps (IMC) survey also found that the poor often

cite lack of financing as the primary reason for not seeking care. In fact, 31 percent of IDPs reported lack of finances as the major reason for their inability to access health services. Indeed, financial access was the most important deterrent across all income quintiles, with relatively less impact on the highest quintile. It is surprising that even for people from higher income quintiles, lack of money is an important factor. Regardless of whether or not people have health coverage, financial access remains the major deterrent to seeking treatment.

The second most important reason for not seeking care is the extended travel needed to reach a provider. Distance and travel time to health facilities varies greatly among types of healthcare services. Most people go to the nearest facility, with the exception of a few people who travel distances up to 300 kilometers. Availability of healthcare facilities is not an issue in Azerbaijan, but the distribution of these facilities and the extent and quality of care provided by them differ widely across the country. Other reasons why people did not seek care were negligence, lack of time, and a perception that the problem was not important. Lack of available good care was ranked only seventh (4.2 percent of all responses) as the main reason for not seeking care (see Figure 2.6). Even though ample evidence exists that the quality of healthcare in Azerbaijan has significantly deteriorated, respondents did not cite this fact as an important reason for not seeking

Figure 2.6 Reasons for Doing Nothing/Not Seeking Treatment, 2005 (%)


81 Most respondents in the IMC survey stated that they had no health coverage, even though everyone in Azerbaijan technically has the right to receive care from a state facility. This finding indicates that, given the problems of the healthcare system, most people do not feel covered.

treatment. Clearly, perception of the quality of patient care is subjective and closely related both to expectations and the extent to which one feels better after treatment.

Negligence as a reason for not seeking care occurs with substantially higher frequency among people in the highest than lowest quintile, but there is no clear increasing or decreasing trend across quintiles. People without health coverage, as opposed to those with health coverage, say more often that no good care was available or that the problem was not important enough. Those who have health coverage mention “other reasons” and “negligence” more often than those without health coverage. People who preferred self-treatment either did so out of habit, knowing the treatment needed, or because they lived close to a pharmacy.

**Pregnant women increasingly do not seek care in health facilities due to high out-of-pocket expenditures.** Among the sample of pregnant women in the WWC Survey, the highest number delivered their babies at home (66 percent in rural and 34 percent in urban areas), followed by deliveries at FAPs (Feldsher Ambulatory Points) in rural areas and maternity wards of central district hospitals (12.8 percent, of which 51 percent was urban and 2 percent, rural). The RH Survey found that only one in four births in the past five years occurred outside of a medical facility, a finding that seems to understate the situation when compared to the results of the WWC Survey.

**There is a large unmet need for family planning programs in Azerbaijan.** The prevalence of use of modern contraceptive methods among women in the country is very low (55 percent). According to the RH Survey, the following are the main reasons why women do not use modern contraceptive methods: fear of side effects (90 percent), lack of knowledge (71 percent), cost of other methods (61 percent), difficult to get other methods (53 percent), partner preference (49 percent), other person’s advice (26 percent), physician’s recommendation (24 percent) and religious belief (15 percent). Three out of four women want more information about contraception and would like to get it from their physician.

Given that expenditures for reproductive health-related matters, including contraception, are as high as 30–40 percent of all household expenditures, particularly in urban areas, the cost of these services becomes a barrier that prevents many women from getting the services they need. The RH Survey further estimates that the unmet need for modern contraception is 31 percent among all women (53 percent among married women); while about 38 percent of all women have a potential demand for contraception. This potential demand is highest among married women and IDPs and increases with age. Potential demand for family planning services can also be evaluated according to fertility preference (wanting to either space or limit births). Most of the demand for methods that

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84 The RH Survey defined the potential need for contraception as the sum of current contraceptive use (met need) plus the additional contraceptive use that would be required to eliminate the risk of unwanted or mistimed births (unmet need).
could effectively help couples limit childbearing remains unmet. Only 1.5 percent of the women in the WWC Survey, for example, stated that family planning programs were available. Overall, the RH Survey concludes that the largest share of unmet need is among women in rural areas, the less educated, the poor and women with more children—a finding that indicates that access for these disadvantaged groups needs to be improved.

2.5 Determinants of Service Use

2.5.1 Perceived Health

People in rural areas perceive their health status to be worse than people in urban areas. The G&G Survey collected information about the perception of health status of household members and found that almost two-thirds (60 percent) of the urban population considered their health status as “better” and “much better” than before, while only 43 percent of people in rural areas gave this answer. Twice as many rural than urban respondents perceived their health status as “very poor” and “poor” (see Figure 2.7). In Sabirabad, the proportion of people who perceived their health as poor was higher than in other districts, most likely because of the high concentration of IDPs in this district. These findings are consistent with the analysis above, which has shown that people in rural areas who perceive their health to be poor tend to utilize healthcare facilities more often. Perceived health is thus an important determinant of utilization patterns.

Figure 2.7 Perception of Health Status by Location, 2003 (%)


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85 UNICEF, RH Survey.
86 Health status was evaluated on the following scale: very poor, poor, average, better, much better and don’t know.
Perceived health status differs depending on age, marital status and income level. Overall, women and men tend to perceive their health status similarly and all respondents perceive their health status to be worse with age. Older respondents, for example, perceive their health status to be worse than do younger respondents. Perceived health status does not seem to be affected by the educational level of an individual. People who are divorced and widowed, however, define their health status as “poor” or “very poor,” and those who have never married, as “better” or “much better,” to a significantly greater degree than other respondents.

People’s responses were similar, regardless of whether or not they had health coverage. Only 4.8 percent of those who were covered by private insurance defined their health status as “poor,” while almost 60 percent defined it as “better” or “much better.” Households that benefit from health services covered by the Railways Department, Ministry of Defense, Ministry of Interior or State Oil Company defined their health as “average,” “better” or “much better;” none of these respondents considered their health “poor” or “very poor.” Lastly, as people’s incomes increased, they tended to perceive their health less often as “poor” or “very poor,” while the perception of health as “better” or “much better” did not differ significantly across income quintiles.

2.5.2 Enabling Factors

Availability of Healthcare Facilities

Overall, the availability of healthcare facilities at all levels of care is not an issue in Azerbaijan. However, the quality and types of services provided by these facilities does vary significantly across the country. There are over 2,300 health facilities in the system, a number that has not changed substantially over the past several years. Overall, the healthcare system in Azerbaijan continues to bear the characteristics of the overly centralized, inefficient planning system of the Soviet Union.

There are sufficient numbers of primary healthcare (PHC) facilities and physicians around the country, but the quality of healthcare that they provide is often very low. In 2003, the extensive PHC network consisted of 1,830 FAPs (the first point of contact in a village), staffed with fieldshers, midwives and/or nurses; 680 rural Doctor Ambulatory Centers (SVAs), staffed with physicians, midwives, fieldshers and nurses; and 360 outpatient clinics attached to rural district hospitals (SUBs), staffed with therapists, gynecologists/obstetricians, pediatricians and dentists. Lastly, there were 112 district polyclinics (DPOLYs) managed by central district hospitals (CDH) and their maternity wards.

The physical condition of rural facilities is dismal and reflected by decreasing utilization levels of primary healthcare facilities in rural areas, a WWC Survey finding. One of the

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87 The hierarchy and the organizational structure of the PHC system are explained in detail in Chapter 6.
reasons why people prefer to seek treatment in district polyclinics may be the deteriorating quality of service in rural clinics. Since 2003, the number of patients per month in all rural clinics has declined, as has the number of patients per physician per month. Poor power and water supplies, as well as poor sanitary conditions, are typical characteristics of most primary healthcare facilities in the country. In addition, obvious infrastructure problems, such as the deterioration of buildings and lack of medical equipment and supplies, make many PHC facilities unsuitable for the provision of healthcare. The IMC Survey, for example, found that by the end of 1990s, 70 percent of the facilities surveyed lacked such basic requirements as a clean piped water supply.

Azerbaijan continues to have an oversupply of hospital infrastructure. There are approximately 735 hospitals in the country: 63 central district hospitals (with an average of 233 beds), about 360 rural hospitals (with an average of 32 beds), 90 specialized dispensaries, 21 teaching hospitals and 25 private hospitals. District hospitals offer various medical and surgical specialties, whereas rural hospitals generally offer basic inpatient care and minor surgery, all provided by the surgeon or pediatrician in the facility. Specialized dispensaries and specialist Republican hospitals, mainly in Baku and major administrative districts, focus on a sole condition, such as tuberculosis, dermatology or sexually transmitted diseases.

In addition to these facilities, Azerbaijan has a large number of sanatoria, which offer rehabilitative services to supplement primary and secondary care. These facilities consist of 132 sanatoria for adults, 18 inpatient medical sanatoria for children and a number of “preventoriums,” rest homes and tourist centers that offer some healthcare. Such facilities are owned by the MOH, other Ministries, enterprises or unions. They are generally short of funds and do not offer more than occupational and physical therapy or curative baths.

In addition to MOH facilities, parallel health systems, NGOs and the private sector also provide health services. In addition to facilities of the Ministry of Health, there are polyclinics and inpatient facilities operated by the parallel health services of the Ministries of Railways, Defense and Oil. These facilities only serve about 5 percent of the population and their services are somewhat better-tailored to the needs of their target population. Nevertheless, they use very little epidemiological data in planning and make virtually no yearly adjustments to reflect uptake of services or unmet needs. In addition, a few NGOs in the country provide healthcare services. In fact, these organizations were the first to try to adapt healthcare service delivery to health needs. Although NGOs focus on local population needs, their drawback is that they have not yet managed to scale up their services.

Finally, the private sector tailors health services better to patients’ needs and demands than does the public sector, but only people with sufficient means can afford to go to private healthcare providers. So far, only dentistry and pharmacies have been privatized. The privatization of state-owned facilities has been very limited. There are now 25 private hospitals and one large operator, MediClub (which functions like a health maintenance organization), that owns 6 hospitals. These latter hospitals, which offer both inpatient and ambulatory care, function on the basis of walk-in fees, annual fees and co-payments.93

Availability of Healthcare Staff

The availability of physicians and nurses does not seem to be an issue in Azerbaijan (see Chapter 5 for details). In fact, the country has a 30 percent surplus of physicians at the national level. However, the ratio of healthcare staff to number of residents varies significantly across different regions and income groups. Rural areas, particularly those below the district level, tend to experience shortages of staff, while staffing is excessive in urban areas. The legacy of the Soviet period means that physicians are very narrowly specialized, with an oversupply of certain specialties and an undersupply of others. Due to the excess number of physicians, nurses often have limited skills and provide only very basic support to a physician.

While patients had an assigned physician during the Soviet era, the 1997 law “About the Protection of Health of the Population” gave people the choice of selecting a preferred provider. Primary physicians, however, rarely treat a patient, usually referring him or her immediately to a specialist. Given that there is no tradition of family medicine training in Azerbaijan, primary care in general is of low quality. The country has not yet adopted an integrated family medicine model. Most services are still provided by specialists, even in places where a primary-care physician would be sufficient, resulting in low productivity and high costs. Knowing the system, patients often bypass the primary level and go directly to a specialist in a hospital, particularly since they expect to pay for any service and this strategy may reduce the total cost of treatment. Specialists, therefore, play the role of the primary-care physician and gradually lose more specialized skills, particularly at the polyclinic level. The WWC Survey found that the urban poor either do not seek care at all or go directly to the hospital in their district, bypassing the primary-care level altogether. For the poorest in the population, even primary-care services, often of low quality, are beyond their financial reach, causing them to seek untrained help instead or to forgo services altogether.94

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Health Insurance Coverage

The concept of health insurance coverage is not clearly understood in Azerbaijan. About two-thirds of the population in Azerbaijan (74.7 percent in rural areas and 59.4 percent in urban areas) reported that they did not have institutional coverage. This finding is difficult to explain, given that, in theory, everyone in the country has coverage. However, in light of high OOP payments, most respondents perceive themselves to be without health coverage. This is why health coverage does not appear to have a clear cut impact on utilization levels. It should be noted that a small proportion of the population has private insurance (0.36 percent) or is covered by a parallel healthcare system (e.g., those provided by the Railways Department, MOI, etc.).

According to the WWC Survey, willingness to pay a premium for health insurance is zero in Azerbaijan. In the case of a premium payment for prescription drugs, about 1 percent of the population is willing to pay. In the same survey, respondents mentioned that informal payments collected at healthcare facilities create financial barriers to access. They noted that they would be more willing to pay for health insurance if they received a proper explanation of the nature of the system, the amount they would need to pay (with the assurance that no informal fees would be collected), and a guarantee of improved quality of service.

According to an International Medical Corps (IMC) survey, on the other hand, approximately 49 percent of the population is willing to contribute regular payments to a scheme that assures convenient access to healthcare and drugs. The poor, however, are less willing to contribute to such a scheme than the better-off. Among those willing to contribute, 47 percent were willing to pay at the time of receiving care, indicating that the concept of health insurance is not well understood. Another 28 percent were willing to pay once a year, 6.4 percent, quarterly; 8.2 percent, monthly; and 2.6 percent thought healthcare should be free of charge. Factors that determine a willingness to contribute financially to health insurance were improved quality of services, convenient access to drugs and services, increased professionalism of providers and better-quality medical equipment.

Income and Poverty Levels

Low income is an important determinant of healthcare-seeking behavior in Azerbaijan. With a GDP of US$1,022 in 2004, Azerbaijan is one of the lowest-income countries in Europe and Central Asia. Poverty is widespread in the country. The 2002 Household Budget Survey found that almost 46.7 percent of the population were living below the

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95 IMC, "Population Health Needs," 2000. This difference can most likely be explained by the fact that the IMC survey was designed differently, that households were better informed about the benefits of insurance schemes, and that the survey was undertaken in Southern Azerbaijan, where districts had already participated in projects sponsored by ICM and UNICEF.

national poverty line (defined as less than AZM 175,000 per month per capita) and 8.8 percent were living in extreme poverty, consuming less than AZM 125,000 per month per capita.97

As discussed earlier, lack of resources is the main reason why people do not seek healthcare, particularly people in the lowest income quintile. Figure 2.8 below shows the distribution of the rural and urban population by income quintile and location. In rural areas, the proportion of people in the top income quintile (quintile 5) is the biggest. In urban areas, the trend is reversed. This pattern of income distribution means that more people with low incomes live in urban rather than rural areas, which is typical of the FSU countries.

**Figure 2.8 Distribution of Urban and Rural Populations by Income Quintile and Location, 2005 (%)**

![Bar chart showing the distribution of urban and rural populations by income quintile and location, 2005 (%)](image)


**Out-of-Pocket Expenditures**

*Out-of-pocket expenditures (OOP) have increased over the past several years and, together with low incomes, they are the most important determinants of healthcare utilization.* According to the findings of the G&G Survey, OOP expenditures have risen from AZM 88,908 in 2003 (documented by the World Bank Household Budget Survey of 2002) to AZM 479,446 per capita in 2005. OOP payments now account for 75–78 percent of total health expenditures. Interestingly, the rural population spends more on such payments than does the urban population for all types of care. Transportation expenditures for the rural population are also higher than for the urban population. People with poor health spend the most on healthcare, compared to people whose health status is better. For preventive services, people of average health tend to spend almost as

much on healthcare as those who perceive their health to be poor. OOP expenditures also rise with age, both for outpatient and inpatient care (except for the group aged 80 and above). It is important to note that expenditures for preventive care are the highest for ages 60–69, but very low for younger age groups.

In terms of overall income, people in the highest income quintile spend substantially more on OOP payments. It is important to note that people in the lowest two quintiles spend about the same for hospitalization, but the amount paid is nevertheless more than that paid by people in other quintiles, pointing to the relatively high burden of OOP payments on poor households. For preventive services, people in the highest quintile spend twice as much as the average for all five quintiles. However, one should bear in mind that it is difficult to know whether all such payments were made for necessary treatments. On the other hand, those in the lowest two quintiles spend very little on preventive care. Utilization of preventive services by these quintiles is also low; indicating that poorer segments of the population usually cannot afford preventive care and seek only curative care, resulting in health problems for the poor that could have been prevented. Those who report having government coverage spend less on outpatient and preventive and other services, but more on hospitalization, than those with no institutional coverage. Out-of-pocket payments for preventive and other services were low among respondents with government coverage.

Out-of-pocket payments can be broken down as follows: 10.9 percent is spent on hospitalization, 20.5 percent on preventive care and 68.6 percent on outpatient services. Overall, 58 percent of OOP expenditures are made in cash to pay a provider bill and almost 20 percent are made in cash to health personnel. Almost one-third of all OOP expenditures are informal payments, of which 63.1 percent are cash payments to health personnel for services other than the provider bill and 33.6 percent are “donations” to the facility. OOP expenditures are predominantly for outpatient care, with drugs and medical goods representing the highest expenditure category (70.5 percent of formal payments), followed payments to providers (11.9 percent). Informal payments for outpatient care represent 35.2 percent of all OOP expenses. A very high proportion of these informal payments go to health personnel. It is interesting to note, however, that a certain proportion of the OOP payments for drugs and goods are also informal.

For inpatient care, 33 percent of OOP payments are paid in cash to health personnel, followed by 32 percent for medicine procured outside the provider and 16 percent for the provider bill. Roughly 40 percent of all OOP payments for hospitalization are informal payments, of which almost 33 percent is paid in cash to health personnel. These are not “gratitude” payments, but payments required to receive treatment.

One-fifth of OOP expenditures for preventive services are informal, of which 85.7 percent goes to health personnel. Most official OOP payments for preventive services are for dental prosthesis, medical check-ups and eye glasses or lenses. Overall, OOP payments cover both the salaries of health personnel and resource shortages in facilities
for all types of care. Given that people cite lack of money as the main determinant of not seeking treatment, OOP payments have a significant impact on people’s access to healthcare.

With regard to facilities, most OOP payments for hospitalization were made in public facilities (generally a general city or district hospital, followed by specialized hospitals). The amount of OOP payments in private institutions was low (6.8 percent), reflecting low utilization rates in these facilities. For outpatient episodes, most spending in private facilities was largely for pharmaceutical expenses. For preventive services, most payments were made in private facilities.

According to the IMC survey, a quarter of all private transactions were made in-kind, by giving jewelry, cattle, carpets or other household items. Some 85 percent of households were forced to sell livestock or exchange valuable items in order to pay for treatment and the services of medical staff. Only 14.1 percent of households cover health expenses from household savings. The cost of services and high OOP payments (both formal and informal) clearly affect access to healthcare services.

2.5.3 Attitudes, Beliefs and Satisfaction with Healthcare Services

People who live in pilot project areas seem to be quite satisfied with the health services that they receive. However, levels of satisfaction differ slightly depending on whether services are inpatient, outpatient or preventive. According to the WWC Survey, the overall satisfaction level of hospitalized patients in both public and private institutions is almost 66 percent in Azerbaijan, while dissatisfaction is 19 percent. For some facilities, the satisfaction level was as low as 25 percent (private specialized hospitals) while for others, it was as high as 100 percent (public health dispensary, general/city hospital of Caspian Shipping Company, or military hospital). The satisfaction level for outpatient services was as high as 55 percent, compared to a dissatisfaction level of 22 percent. Satisfaction with public children’s hospitals, hospitals of the State Railway Administration and State Oil Company, private district hospitals and private outpatient clinics was 100 percent, and around 80–90 percent for public outpatient clinics and military hospitals. About 66 percent of respondents were satisfied with traditional healers, whereas 22 percent did not know and only 12 percent were dissatisfied. Lastly, for preventive services provided by public and private institutions, overall satisfaction level was very high (75 percent), with the exception of military hospitals (33 percent).

2.6 Key Issues, Options and Recommendations

The main impediment to people’s demand for and utilization of healthcare in Azerbaijan is high OOP expenditures, both formal and informal, particularly for outpatient care.

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OOP expenditures have been increasing over the past several years and impose a significant burden on the population. People spend large amounts on both drugs and payments to health personnel. Informal payments as a component of total OOP expenditures are also high, suggesting a significant burden on the poor, particularly for inpatient care.

Although poorer segments of the population are most affected by OOP payments, it is important to note that the better-off also report lack of money as their main reason for not seeking healthcare. Only 6.5 percent of all respondents found their problem not important enough to seek care, indicating that if they could afford it, the majority of respondents would have gone to a healthcare provider. High OOP expenditures also seems to strongly affect reproductive health practices, as reflected in the high proportion of women delivering babies at home and the inability of many people to afford contraception. Children, moreover, are mostly treated at home by their parents.

The urban population, followed by the bottom income quintile of the rural population, seek treatment the least and often cannot afford any treatment at all, particularly preventive services that would likely decrease the future burden on the healthcare system. Rural residents visit private facilities more often than their urban counterparts, indicating either low quality or unavailability of public services in rural areas. Overall, people most often visit general public hospitals and district hospitals for care.

Interestingly, the low quality of health services did not seem to be very important for respondents of the G&G Survey, based on the fact that people reported rather high levels of satisfaction with healthcare services. However, other surveys found that the quality of health services is one of the main conditions that make people willing to pay for health insurance. The WWC Survey showed that the willingness to pay a health insurance premium was zero, indicating low confidence in the entire system. One of the main conditions that make people willing to contribute to a health insurance scheme is the assurance that that no informal fees will be collected, together with a guarantee of improved service quality. Other conditions that determine a willingness to contribute to health insurance were convenient access to drugs and health services, increased professionalism of providers and better-quality equipment. In general, however, the poor are less willing to contribute to a health insurance scheme than the non-poor.

Healthcare utilization rates in Azerbaijan, as shown by outpatient contacts per person, are low and have been gradually declining over time. Furthermore, the occupancy rate of hospitals is falling, admissions rates are low and the average length of stay remains high. These trends can be best explained by several factors: (i) only 60 percent of illness episodes result in the utilization of healthcare facilities, with many people treating themselves at home due to lack of money; (ii) many patients only visit a pharmacy for drugs rather than see a healthcare provider; (iii) more often than before, people visit private as opposed to public providers to receive better-quality care; and (iv) facilities are deteriorating and many do not have the equipment necessary to provide treatment.
Utilization of preventive services is high among older age groups. If this trend is not reversed and younger people do not start using preventive services more often, the country will have to bear significant curative costs in the future. Lastly, utilization rates differ widely across the country, indicating that serious distributional issues need to be tackled.

In order to improve access to and appropriate use of healthcare services, there is a need to:

- Reduce OOP expenditures, including informal payments.
- Increase public spending on health, targeting these outlays to outpatient and preventive services, particularly for women and children.
- Define an essential basic package of services and provide it free of charge to mitigate the financial risk of illness, prevent catastrophic destitution in times of illness and increase utilization of outpatient (especially PHC) and preventive services.
- Actively promote preventive services to increase utilization rates and therefore prevent a large future burden of curative services on the health system.