SARA RZAYEVA

Oil and Health Care in Post-Soviet Azerbaijan

Abstract

Health care systems reflect historical relationships between states and citizens, as well as predominant values and institutions marking a particular social milieu. Theories that place national health care in historical social context tend to exaggerate the forces of globalization and to underestimate the role of local specificities. A health care system and its social context, however, are shaped at the intersection of global, regional, and local factors, rather than by globalization alone. In this article I demonstrate this combined influence by tracking the transition in Soviet to post-Soviet health care Azerbaijan. I show that the dissolution of Azerbaijan's socialized health care was due not to neoliberal globalization, but rather to the historical constellation of global, regional, and national processes, including the political choice of a petroleum-based development strategy.

Keywords: Globalization; Health care; Social change; Post-Soviet; Azerbaijan.

IN THE LITERATURE THAT analyzes health care systems in a social context three postulates on how the global conditions the national are put forward.

Conceptualizing health care between the global and the local

Postulate 1: Extensive health care spending and universal health care coverage conflict with the fiscal "obligations" of the state to global capital and with the neoliberal ideology of governance.

The states' redistributive (social welfare) functions are said to contradict capital accumulation in the context of neoliberal globalization (Brodie 2003, Bakker and Gill 2003a and 2003b, Coburn 2011). As states take on more of the costs of capital accumulation and simultaneously cut back on (especially, corporate) taxation, state fiscal crises are inevitable (Armstrong and Armstrong 2002). Such crises tend to paralyze the

Sara RZAYEVA, Cornell University, Ithaca, New York [srr39@cornell.edu].
European Journal of Sociology, LIV, 1 (2013), pp. 33–63—0003-9756/13/0000-900$07.50per art + $0.10 per page

provision of social welfare. Simultaneously, the "continuous monitoring" of states "by international financial institutions, transnational corporations, and bond rating agencies" as "desirable sites for capital accumulation" or "best for business" carries the threat of capital flight if the costs of accumulation are not kept to a minimum (Brodie 2003, p. 56, Coburn 2011, p. 143). In the context of neoliberal globalization, then, not only economic growth but even the mere economic stability of states depends on shrinking social welfare functions.

The economic disciplining structures of the global world order that render states accountable to the global market contradict governments' obligations to their electorates, exposing a conflict between global capitalism and democracy (Bakker and Gill 2003b, Coburn 2010). Attempts to reconcile the operation of liberal democratic states within the neoliberal global economy have involved a redefinition of the meaning of social contracts and citizenship: Bakker and Gill argue that social citizenship, "secured and supported by governments", is giving way to "market citizenship, where citizens become responsible for helping themselves in a more privatized social order" (2003b, p. 29). This new notion of citizenship signals "a new division of responsibility as well as new frameworks of the allocation of resources for individual and social welfare between the state, the family, the market, and for the voluntary and informal sectors" (ibid.).

Postulate 2: In the search for new venues of profitability, the health care sector, like many other formerly state-controlled sectors, is opened up worldwide as a lucrative new arena for private capital accumulation.

The pressures to re-commodify health care within the globalizing capitalist system is enforced by the International Monetary Fund (IMF), the World Bank, and the WTO as a part of the global privatization wave (Coburn 2011, Laurell and Arellano 2002). Basic health care delivery, drugs, and financial access to these (e.g., health insurance) are all increasingly seen not as social rights but as profit-making realms around the globe.

Postulate 3: Simultaneous with privatization of health care, the states take on the costs of minimal health care for those who cannot pay and who are not potential customers for the market (Laurell and Arellano 2002).

According to Coburn, D'Arcy, and Torrance (1998), public health care systems, while under attack for ineffectiveness and inefficiency around the world, are still seen as needed. Unlike social welfare or unemployment support, which are viewed

> as negatively influencing both corporate bottom lines and the power of labour *vis-à-vis* capital, education and health appear as necessary, if inefficient. And, although the ideology of business [...] emphasizes market solutions to all difficulties,

> including recommodifying or privatizing health care, complete privatization is not necessarily in the interests of big capital – since government sponsored health insurance shifts the costs from corporate payrolls to the public in general (p. 533).

These three postulates illuminate important concerns and limitations within which national governments make decisions about public health care systems. However, focusing on the global system in order to understand national health care systems conceptually overplays similarities and underplays differences between cases within the same global context. Embracing globalization as developed capitalist economies, the United States, the United Kingdom, Japan, and Canada nevertheless have very different public health care systems (Armstrong and Armstrong 2008, Cockerham and Cockerham 2010). The post-Soviet countries, all of which opened up to the global market during the same period, exhibit very different levels of marketization and government spending on health care. Some without pressing fiscal constraints – such as the oil-rich nation Azerbaijan – spend proportionally least on health care. Understanding the global system's effect on national decision making (*e.g.*, welfare-health care) can complement, but cannot replace, a necessarily specific study of the social contexts of health care systems.

Attributing the differences between national health care systems in a globalized world to national level class negotiations (Coburn 2010, Coburn 2011) alone is not sufficient. This focus still leaves out factors very important to national welfare and health care systems, such as cultural contexts, form of government/authoritarianism, regional geopolitics.

How do we conceptualize a health care system in its social context, encompassing all the complexity of local, regional, and global dimensions? In this article I suggest looking at a public health care system as a constellation of ideas, institutions, and power relations. This draws on Bakker and Gill's (2003) proposed method for analyzing social reproduction. Adapted to public health care, this prism explores the following areas:

1. Dominant ideas about/ideology of health care: what is the official understanding of the role of public health care?
2. Structure of planning, financing, and organizing public health care: what is the basis for understanding the different forms of state and policy priorities characterizing each period?
3. Power relations in which the public health care system is shaped: what class relations and political struggles explain *whose* interests and health needs are served by the public health care system?

This prism allows us to talk about public health care as located in the historical interrelationship of the global, national, and local. A study of

changes in the health care system in post-Soviet Azerbaijan, as this country moved toward oil-based economic development, will demonstrate this.

Why Azerbaijan? Azerbaijan's case is interesting both in itself and in relation to the globalization-based postulates above. After the fall of the Soviet Union in 1992, government spending on health care steadily shrank, and was accompanied by a dramatic decrease in life expectancy and increases in the rates of communicable and non-communicable diseases and death. As indicated by a World Bank executive summary, "between the years 1990–2002 life expectancy at birth (in Azerbaijan) shortened by six years – the highest downtrend in the world excluding the countries of Sub-Saharan Africa", where a higher loss was due to the HIV/AIDS pandemic (World Bank 2005a:1). Azerbaijan's postsocialist existence was accompanied by a resurgence of infectious diseases, and sharp increases in infant, child, and maternal mortality. These, of course, were not just a result of the deterioration of public health care services. But why did funding for public health care shrink despite the apparent increased need for it? Indeed, as post-Soviet Azerbaijan stepped into the process of steady economic growth and as state revenues grew, the decline in its public health care spending as a share of budget grew more steeply (Mehtiyev *et al*. 2005).

Azerbaijan's case is different from that of most post-Socialist countries, where public health spending is paralyzed by a "scarcity of resources" or by fiscal constraints (Kornai 2001, Witter 1997). According to a World Bank report, Azerbaijan is underspending on public health care in the context of *sufficient* resources for allocation to health (2005a). With significant oil reserves geographically distant from the politically fragile Middle East, Azerbaijan – which produced more than half the world's oil supply at the beginning of the twentieth century – gained strategic importance for Western capital as the breakup of the Soviet Union allowed Azerbaijan's integration into the world market. This has provided Azerbaijan with resources that many other post-Socialist countries lack. Ironically, in 2005 only one country in all of the former Soviet Union (Tajikistan) spent less on health care than oil-rich Azerbaijan (Mehtiyev *et al*. 2005). But why did this happen, and how? A framework of ideas, institutions, and power relations can be used to assess changes in public health care through the historical interconnectedness of the global, the regional, and the local.

In what follows I analyze Soviet and post-Soviet health care systems in Azerbaijan as historical constellations of ideas, institutions, and power relations. I then trace the transition from one system to another, and

show how the changes in public health care were inseparable from the specific political path of Azerbaijan's reintegration into the global economy as a raw oil exporter.

The research leading to this article combined a set of interviews in Azerbaijan with archival research conducted in both Azerbaijan and the United States. The interviews were collected from current and former public health officials in Azerbaijan, as well as from representatives of international organizations working with public health in Azerbaijan, and medical administrators at various levels of the bureaucratic hierarchy. The IMF archives in Washington DC provided copies of the Fund's recommendations and agreements pertaining to Azerbaijan, including those issued before the beginning of the partnership between the IMF and Azerbaijan.

Ideas, institutions, and power relations shaping public health care in Soviet Azerbaijan

Ideas

The Azerbaijan SSR's "Law on Health Care" (1971) stated that the foundations of Azerbaijan's health care system were defined by the central legal documents of the USSR, above all, its Constitution. Article 120 of the USSR's Constitution stated: "The citizens of the USSR have a right to material welfare/social protection (*materialnoe obespechenie*) in old age, and also in case of illness or loss of work ability. This right is enforced by: the comprehensive development of social insurance of workers and public servants by the government, provision of free health care and a wide range of sanatoriums[1] to the workers" (quoted in Vinogradov 1962, p. 19). The state's responsibility for the health of its citizens was central to how the Soviet Union defined itself, as a people's/workers' state *vis-à-vis* the "*bourgeois* states" in the context of the Cold War. For example, a key postgraduate textbook for medical system administrators stressed the USSR's different stance on such matters: "a *bourgeois* state does not recognize the health care of the working population as its responsibility" (Vinogradov 1962:19).

Health care organizations in the USSR incorporated I. P. Pavlov's findings on protective inhibition, unity and integrity of the organism, and cortico-visceral laws concerning the origins of disease. Pavlov's findings

[1] Rest and rehabilitative facilities akin to spa resorts.

were cited in the USSR Ministry of Health publications and health care management textbooks, and were reflected in medical assessment and treatment methods as well as in the Azerbaijan SSR's Law on Health. The findings most emphasized by the USSR Ministry of Health were the following:

> all of the organism's reactions, are entirely the result of interaction between the internal and external environments [...] due to the unity and integrity of the organism [...] psychological traumas or emotional shocks have very physical manifestations in the autonomic nervous system and impair the activity of various organs [...] Words, (the second signaling system) like any other external environmental factor, are a powerful, tangible stimulant, sometimes extraordinarily so (Maystrakh 1957, p. 78).

These findings translated into the need to incorporate a patient's overall living conditions, and his or her social and emotional environment considerations, into public health practice. An outstanding example of this was the Soviet practice of visiting patients in their workplaces and living spaces in order to observe their usual physical and emotional environment before completing a diagnosis and assigning a treatment. Such visits could be scheduled by a polyclinic or hospital on the basis of perceived need without the patient's request. As a Soviet professor stressed:

> the execution of comprehensive therapeutic and preventive measures [...] is determined only after a careful study of the working and living conditions of the people. The effectiveness of the entire system depends precisely on this investigation, which is the most laborious aspect of the job, requiring great persistence, care, and attentiveness on the part of the medical workers. (Maystrakh 1957, p. 66, emphasis added).

The significant time and resource requirements of the home-visits practice were recognized in the Soviet period (Popov 1971, p. 57). However, it was considered crucial to maintain the practice because of the Pavlovian view of health and health care (Popov 1971, pp. 57-61, Maystrakh 1957, p. 66).

Pavlov's findings were embedded in public health care law: the Azerbaijan SSR's 1971 Law on Health, in addition to emphasizing occupational medicine, included provisions on the organization of active rest opportunities for people (tourism, physical education, sanatoriums) and regulations for controlling noise levels (Articles 68-74 and Article 30, respectively). Incorporation of the "creation of pleasant conditions of life and work" into the Law on Health as a duty of health care institutions echoed Pavlov's theory on the unity of mind and body.

The Azerbaijan SSR's Law on Health Care defined the aims of the health care system as "ensuring harmonious development of citizens'

physical and mental powers, their health, high level of productive capacity, and ability to live a long and active life; preventing and decreasing cases of sickness; further reducing cases of disability and death; facilitating social relations that diminish factors that negatively affect citizens' health" (Article 1, Azerbaijan SSR's Law on Health Care 1971, my translation). This formulation expressed a positive conception of both health and health care as areas with unlimited development potential. With health defined as synonymous with the "harmonious development of citizens' physical and mental powers", the official target of health care was expressed as a process and not just a state of physical condition. Theoretically and ideologically, health and health care were seen as arenas amenable to continuous perfection. This understanding was consistently upheld in the Soviet literature on the organization of health care (Maystrakh 1957, Vinogradov 1962, Alimirzayev 1970, Popov 1971, Fel *et al*. 1978).

Institutions of public health care

Health care delivery was organized around medical districts (*uchastok*). Facilities and medical personnel in a given medical district were *directly responsible* for the health of the people residing in that district. This was linked to the Soviet concept of health care as a public duty rather than an individual responsibility:

> Each district physician (general practitioner, physiologist, pediatrician, obstetrician-gynecologist) attends a fixed number of people in his district, thereby *eliminating the lack of personal responsibility* in medical care. The district physician is completely responsible for the health of the people entrusted to him. He not only treats patients, but also observes hygienic conditions in his district, detects diseases in their early stages, prevents the development of foci of infections, uncovers sources of contamination, and introduces prophylactic hygienic measures. The district principle enables the physician to know his district well – the hygienic conditions, composition of population, working and living conditions (Maystrakh 1957, p. 63, emphasis added).

Urban centers combined large hospitals with multiple smaller outpatient facilities. The capital city was home to what Navarro called "super-specialized care" (1977, pp. 59-65) at the central hospitals that merged medical research with practice.

Rural medical districts had to cover fewer people over greater distances. Rural district hospitals were located as close as possible to the most populated areas.

The outskirts of a district were serviced by feldsher-midwife stations (FMSs), and by health units located in state and collective

farms, lumber and peat camps, and day nurseries. FMSs were essential to the rural care structure. They were financed from the budget of Village Soviets. Located in rural settlements and far from a district hospital, the FMSs[2] were to provide emergency medical assistance, and to rapidly detect and isolate persons with infectious diseases in order to prevent epidemics.

Ideologically, the Soviet state was committed to providing quantitatively and qualitatively equivalent health care in rural and urban areas. This included establishing maximum specialized facilities and medical experts as close as possible to rural dwellers (Maystrakh 1957, Vinogradov 1962, Alimirzayev 1970, Popov 1971, Fel *et al*. 1978). The Azerbaijan SSR's Law on Health Care (1971) provided doctors and medical personnel working in "*non-urban*" areas[3] with free housing, electricity, and heat (Article 17). However, the location of specialized research hospitals in dense population centers and the Communist Party's elevation of academic medicine (Navarro 1977) over primary-care practice characterized the inequalities between rural and urban health care provision.

Health care plans in the USSR were prepared as part of 5-year national economic plans and adjusted yearly as necessary. Health plans employed data for a number of years preceding the plan on (1) the size of the population and its age, sex, occupational structure, and geographic distribution; (2) morbidity, morbidity involving temporary loss of working capacity, infant mortality, and mortality from particular causes; and (3) data on infrastructure and available medical personnel (Popov 1971, p. 23, Fel *et al*. 1978, pp. 18-19). Health planning also required some estimation of future changes that could potentially affect the overall health situation and health care. Thus, health planning used forecasts of changes in environment (housing, water supply, waste and sewage disposal, the air and soil, noise control), in the social-well being of the population (real income, work, leisure, diet, education, etc.), in demographic shifts (birthrates, death rates, natural population increases, etc.), and in the morbidity and health status of population groups, sanitary and epidemiological control, and specialization of medication care (Popov 1971, pp. 44-47).

Budget was determined through "norms and *normatives*". Soviet "health norms" were official standards, such as for environmental conditions, medical care required by various population groups, and expected

[2] "Feldsher" was the term for the highest degree of medical assistant.

[3] Including not only rural areas, but also work camps.

use of health facilities. Among the basic types of norms were, for example, hygienic norms (such as the maximum permissible concentration of air or water pollutants); norms for treatment visits (*i.e.*, the average number of attendances for treatment per first consultation); and productivity norms (such as the number of patients consulted or visited per hour by physicians) (Fel *et al*. 1978, pp. 18-19, Popov 1971, pp. 130-131). *Normatives* were the resources considered necessary to meet the needs specified by norms. For example, there were *normatives* for the total number of medical, paramedical, and support personnel required; *normatives* for average length of hospital stay and average bed occupancy; *normatives* for medical and other equipment, and so on. *Normatives* were the basis for allocating resources to public health facilities. *Normatives* represented "socially necessary", "socially acceptable", "scientifically justified social" indices – hence the term *normative* (Turchins 1968, USSR Ministry of Health 1990). Norms and *normative*s were continuously updated through statistical analysis of hospital data and "time-and-motion studies" of the work of health personnel (Popov 1971, p. 129). The successful operation of the norm and *normative* system was believed to depend on constant renewal/updating via analysis of the latest data in order to prevent the indices from becoming "'static' or traditional" (Popov 1971, p. 129, also Fel *et al*. 1978, pp. 18-20, Spravochniy komplekt Normativno-Metodicheskix materialov 1990). Wages were determined according to a certain basic rate (*stavka*) responsive to *normatives* adjusted for skill, experience, working conditions, and geographic region. Main priorities, as well as norms and *normatives* of 5-year and 1-year plans, were set by the USSR Ministry of Health in coordination with the State Planning Agency, Ministry of Finance, and State Committee of Labor of the USSR.

The medical profession was central in the decision making process from two perspectives. From the top down, academic medicine, the central medical research institutes of the USSR, set the scale and nature of health care provision by defining norms and *normatives*, including factors such as the ratio of medical personnel and hospital beds to population. From the bottom up, local health offices set the framework for planning and budget allocation by preparing draft needs assessments, priorities, and budget estimates to be discussed and negotiated with local Party and legislature representatives. Navarro (1977) observed:

> "the entire planning machinery of the health sector, including manpower planning, seems to rely very heavily on what are usually referred to as 'laws of scientific development,' i.e., laws defined by experts and scientists. The scientist or expert defines the norms and standards in almost every area of endeavor, the

scientists and experts in the health sector being academic medicine and medical care professionals" (p. 95).

Public health care in Soviet Azerbaijan was financed exclusively from public funds until *perestroika*. In 1978, during the tenth 5-year plan, shortly before perestroika sentiments started to rise, the top three areas of health care spending in Azerbaijan SSR were (1) hospitals and polyclinics, (2) sanatoriums-hygiene, and (3) anti-epidemic measures (Fel *et al*. 1978, p. 11). The largest share of the republic's health budget was spent on hospitals and polyclinics, followed by sanatoriums and hygiene measures and anti-epidemic measures. This reflected the Soviet emphasis on prevention.

Ideology and institutions in the context of power relations: economic challenges and the State-society relationship

The conceptualization of health care as an expanding and expandable public responsibility was based on the specificities of the Soviet economy and society, in particular, on the labor shortages of Soviet economy and the symbolic power of workers resulting from Soviet discourse/ideology.

The extensive industrial development path of the Soviet economy, and the politics of the enterprise-center relations, produced chronic labor and material resource shortages in the USSR (Burawoy and Krotov 1993, Clarke *et al*. 1993). In this context, the Communist Party saw health care as a strategic mechanism for expanding the active labor force. As early as the 1930s, the USSR Commissar of Health represented the Party's approach to a pressing economic dilemma thus: "the annual production loss due to illness in Leningrad alone was equal to one-quarter of the yearly production in 1930, with half of those absences preventable" (quoted in Navarro 1977, pp. 43-44). This view of public health as directly related to public production did not change under subsequent regimes of the USSR.

Throughout the first 50 years of the USSR's existence, a key problem and priority for the Communist Party's agenda was to match the speed of the development of public health with the needs and tempo of the developing national economy (Maystrakh 1957). In this socioeconomic context, public health was seen as a factor that if undeveloped or developing with insufficient speed would impede development of the national economy. This was the context in which the positive conception of Soviet health care emerged and that it in turn sustained and perpetuated. As a result, the USSR's and Azerbaijan SSR's health care

system was a continuously expanding network of facilities and medical personnel. Even during the difficult years of World War II, Soviet health care facilities and personnel networks continued to expand (Maystrakh 1957, pp. 105-116).

An expansive health care system, specifically, preventive care, was viewed not only as central to economic development but also as a tool for budgetary management (Vinogradov 1962, Petrovsky and Vinogradov 1967, Popov 1971, Fel *et al*. 1978). It was understood that as the number of people in the active labor force increased, the amount of social-insurance allocation needed to support those unable to work would decrease (Fel *et al*. 1978).

From the Russian Communist Party's 1919 program through the Azerbaijan SSR's Law on Health Care in 1971 and one to *perestroika,* prophylaxis was first on the list of objectives for the public health care system of the USSR and the Azerbaijan SSR[4], *and* received a large share of the state budget for health.

That the Soviet state felt discursively compelled to support those who were unable to work due to illness had to do with a specific aspect of power relations shaping the ideology of Soviet health care: the material and symbolic power of the workers.

Although the Soviet Union and the socialist formations of Central and Eastern Europe were not classless (Szelenyi 1978, Clarke *et al*. 1993), the USSR was ideologically/discursively committed to workers' prosperity. Michael Ryan has called this "doctrinal adherence to egalitarianism" (1978, p. 21). The "celebration of worker images in socialist ritual and state policies promoting working-class types into positions of authority and requiring a modicum of attention to worker material needs" have been argued to provide workers with "a degree of symbolic capital" (Kideckel 2002, p. 118). This was coupled with the very material power of the workers – their relative autonomy and control over the production process on the shop floor (Clarke *et al*. 1993). With this control, a workers' strike in one plant could significantly hinder the production process and possibly paralyze the larger production chain of which the plant was a part. The ideology and organization of public health care in the USSR was shaped by this sociocultural context, in which the economic success of a production enterprise was defined not only by the amount of output produced toward the state plan but also by the quantity and quality of housing, health care, and other social benefits provided to employees.

[4] Followed by the "maintenance of appropriate sanitary-hygiene conditions at production sites / workspaces and households," and *then* "free and universal access to health care."

Ideas and institutions of public health care in post-Soviet Azerbaijan

Now, let us move forward to post-Soviet Azerbaijan, for a snapshot of the ideology and institutions of public health care.

Ideas

The 1995 Constitution of the Republic of Azerbaijan recognizes "every person's" "right to health and medical treatment" (Article 41), provided that "*Helping those in need is, first and foremost, the responsibility of their family members*" (Article 38.2, emphasis added). The institution of the family is now responsible for the social and material welfare of persons in need. The state's responsibility in securing "every person's right to health and medical treatment" is now confined to creating the basis for the operation and development of public and private health care facilities and medical insurance, and ensuring sanitary-epidemiological safety in post-Socialist Azerbaijan (Constitution of the Republic of Azerbaijan, Article 41.2). The "protection of population health" is officially defined as:

> the sum of political, economic, legal, scientific, medical and sanitary-epidemiological services directed at the *maintenance* of physical and mental health, increasing productive life of individuals and providing them with medical services. This Law regulates the relationship between citizens and state, and the relationship between public and private sector on matters concerning protection of public health (Introduction to the "Law on Protection of Public Health" of Azerbaijan Republic, emphasis added).

The current conception of public health care in Azerbaijan is minimalist compared with the Soviet conception. The post-Soviet Azerbaijanian state does not assert any ambitious aims for its public health system. This is in contrast to Soviet Azerbaijan, where public health care had to "ensure harmonious development of citizens' physical and mental powers, their health, high level of productive capacity and ability to live a long and active life, and […] facilitate social relations that diminish factors with negative effect on citizens' health." The Soviet system operated on the understanding that public health was a dynamic, continuously developable phenomenon – a process of continuous "development of physical and mental powers". The current system, by contrast, views health as the sum of minimal conditions required for a person to be able to work. It confines the definition of health care to the "maintenance" of health and to cure in case of need,

while shifting responsibility for health care from the state to the individual.

Institutions: planning, financing, and health care delivery

In 2005, the World Bank observed that there is no "functioning government unit that could be tasked with leading or steering the (health care) policy design process" in Azerbaijan (2005a, p. 24). Twenty years into transition Azerbaijan was still working on a mechanism for setting priorities and designing policies for public health care, observed the authors of the WHO's *Azerbaijan Health System Review* (Ibrahimov *et al*. 2010, p. 42). Lacking unified plans or priorities, Azerbaijan's public health care is not responsive to changing (that is, deteriorating) population health. Public health care is funded mainly from budgetary allocations of the Ministry of Finance and partly from the formal fees that public medical facilities charge. The role of the medical research institutes in the Soviet Union is replaced by the Ministry of Finance. Each year the Ministry of Health and district administrations report expenses incurred in the medical facilities under their administrations, and forecast budget needs for the following year to the Ministry of Finance. The Ministry of Finance uses these forecasts to establish the health care budget for the following year while obeying the fiscal priorities set by the Cabinet of Ministers.

As shown in Table 1, the years 1995-2003 saw a steady decline in public health spending as a share of the state budget (Mehtiyev *et al*. 2005). The country's public health spending per capita is one of the two lowest in the entire former Soviet Union (Mehtiyev *et al*. 2005). In post-Soviet Azerbaijan, maintenance of hospitals takes up almost 70 % of the state health budget, followed by polyclinic maintenance (13.6 %) and emergency services (5.4 %).

This represents a sharp decline in spending on preventive measures as a share of the public health care budget, compared to 1978, when sanatoriums and hygiene-promotion measures were the second largest budget item after combined hospital and polyclinic expenditures. In post-Soviet Azerbaijan, the combined budget for health centers and hygiene education accounts for just 0.03 % of an already small health budget. Sanatorium expenditures make up another 1.5 %[5].

[5] It is important to add here that many sanatoriums have been closed or privatized. Despite the 1.5 % expenditure, there is no free or even realistically subsidized sanatorium accessible with the income of the average Azerbaijanian family.

TABLE 1
Distribution of State Health Care Funding among Services

Expenditure	Percentage of Total
Hospitals	67.7
Polyclinics	13.6
Emergency services	5.4
Sanitary-epidemiological services	4.6
Other health office and service costs	3.3
Feldsher Ambulatory Stations	1.8
Maintenance of accounting	0.9
Sanatoriums for tuberculosis patients	0.9
Sanatoriums for children and youth (non tuberculosis)	0.6
Pandemic prevention measures	0.5
Disinfection stations	0.3
Infant care	0.3
Blood transfer stations	0.1
Health centers and hygiene education measures	0.03

Note: Adapted from Mehtiyev *et al*. (2005, p. 14).

Prevention, the central aspect of public health in Soviet Azerbaijan, has disappeared – conceptually and materially.

Despite the large share of the public health care budget spent on wages, the salaries of public-sector doctors are among the lowest compared to other professions in the country. This is because the salaries are defined by the *modified* normative system: *normatives* in Azerbaijan today are completely detached from the realities of living costs. For example, the "norm" for a young doctor's monthly salary was 125,000 old Azeri manats – about US$25 in 2005, and the maximum "norm" for a senior doctor managing a hospital was 1,000,000 old Azeri manats – about US$200 (Mehtiyev *et al*. 2005, p. 42). The salary range was utterly below minimum subsistence needs. Special non-monetary benefits provided to health care personnel working in rural areas during the Soviet administration, such as free housing and utilities, have also been abolished.

Districts remain the basic administrative-geographic units into which public health care facilities are organized. However, the rationale for

TABLE 2
Summary of the Conceptual and Structural Changes in Azerbaijan's Health Care System

	Public Health Care in Soviet Azerbaijan	**Public Health Care in Post-Soviet Azerbaijan**
Ideology	Health of citizens as a state responsibility	Health as an individual responsibility
	Maximal, expansionary understanding of public health – continuous "development of physical and mental powers", "decreasing disease and death rate"	Minimalist understanding of public health – "maintain and cure"
	Organic unity of body and mind: health is not separable from working conditions, from relationships with family and society	Health as functioning of one's physical body that allows productive activity

	Public Health Care in Soviet Azerbaijan	Public Health Care in Post-Soviet Azerbaijan
Institutions	Free health care	Health care is a commodity available only to those able to afford it. Extreme corruption and manipulation.
	Policy emphasis on containing differences in health care provision between rural and urban areas	Exacerbation of urban–rural inequalities in the access to health care
	Centrality of the medical profession	Centrality of the Ministry of Finance. The institutional structure does not allow room for local decision making.
	Prevention is the core of the system, and receives a very large share of resources.	The concept and practice of comprehensive prevention measures has been lost. Emphasis is on acute care.

district-based organization – personal responsibility and close-up observation of population health – is gone. District physicians are no longer seen as guards of the health of their districts, but as persons competing in the market for health care services. Because primary care in Soviet Azerbaijan was organized through district polyclinics, the dissolution of the district principle in practice has meant the dissolution of the primary-care system as well. As the World Bank Report described the situation: "Indeed, the term primary health care is a misnomer, since the care provided is very fragmented and has no continuity. People freely 'shop' for physicians depending on their need and ability to pay" (2005a, p. 41).

Doctors in the public health sector demand informal fees for public health care services that are formally free (World Bank 2005a). The delivery of public health care is also characterized by "position sales". To practice in a public health care facility one must pay a significant sum of money. The price depends on the desired location of work. The cost of practicing the medical profession at central, specialized hospitals tops the list (Various interviews 2005, 2009). The unofficial understanding is that purchasers will have a chance to compensate themselves through their official position. The price tag is commensurate with the informal prices the doctor will be able to charge patients who need urgent medical intervention. The institutionalization of informal payments means that even access to formally free public health care services is gained through purchasing power. Public health care in post-Soviet Azerbaijan is a commodity produced for sale rather than an institution for protecting the health of the population at large. Patients are viewed as customers who need to be sold more health care.

About three-fourths of health care costs are funded out of pocket (World Bank 2005a, pp. 29-31). The extreme commodification of public health care provision effectively cuts the majority of the population off from the care they need. Since 50 % of Azerbaijan's population lives below the poverty line, the fact that only half of the population seeks health care when sick (World Bank 2005a) should not be surprising.

In Azerbaijan's current health care system, regulated by the informal "supply-and-demand" mechanism[6], it is only acute care that is "in demand".

Since the special benefits to rural personnel were abolished, urban areas have become overstaffed with doctors and medical support personnel, while rural areas are understaffed (World Bank 2005a,

[6] The term was used by Peter Hauslohner, the representative of the International Medical Corps in Baku, Azerbaijan, during an interview (2005).

pp. 44-45). Feldsher Ambulatory Stations (FASs) still operate in their old form in rural areas, but "people frequently bypass these facilities to seek care in district hospitals" (World Bank 2005a, p. 40). FASs in their old form were equipped and staffed to provide primary care and to oversee disease prevention. On the one hand, the commodification of public health care, and on the other, the impoverishment of the countryside in the post-Soviet urban oil economy, has made health care a luxury good for the majority of Azerbaijan's population today. When people finally decide to turn to medical care their situation is already beyond the authority of a feldsher and requires specialist or surgical intervention.

But what happened? How did Azerbaijan's state and citizens move so far away so quickly from the concepts and practices of health care that they lived in for decades? The changes were not the result of impersonal globalization, such as the manifestation of budget deficits induced by cuts in corporate taxes. The retraction of the government from responsibility for public health care in oil-rich Azerbaijan was more radical than in most other, more financially challenged post-Soviet republics, as shown above. Nor were the changes due to privatization of health care: as of 2011 a majority of health care facilities in Azerbaijan were still state-owned. These post-Soviet changes grew out of a very specific context, as a particular government tried to balance international financing with internal legitimation in the context of oil resources.

What does oil have to do with health care?

Azerbaijan's post-Soviet health care system was born of the combination of an oil-based uneven economy and neoliberal policies (adopted to attract international financing and support) and institutionalized corruption and authoritarianism (to procure domestic stability). The shaping of this social context had involved the disempowering of workers in a new capital-intensive oil economy staffed mostly by international labor power. Workers lost their symbolic and material power. In this new economy, ensuring maximum labor-force participation (e.g., reducing sickness through an extensive health care system like the USSR's) was no longer imperative. The new health care, with its redefined concepts and logic, reflected the new social realities.

Regional geopolitics and domestic power relations

When Azerbaijan just started its post-Soviet journey towards capitalism, a market based vision of its public health care system was not in sight. The first elected post-Soviet government of Azerbaijan – the Azerbaijan Popular Front Party (APFP) – prioritized social protection of the population, refused to liberalize the economy or to borrow from the IMF, and despite these choices managed to stabilize the economy and achieve a budget surplus, in volatile 1992-1993 with ongoing military conflict in Nagorno-Karabakh (Spatharou 2002, Bagirov 2003). Yet, this nationalist government's anti-Russian, pro-Western stance, and the commitment to exclude Russia from access to Azerbaijan's oil, led to the arming of Azerbaijan's insurgent militia groups with Russian weapons (Swietochowsky 1999, p. 426). The resulting complex constellation of political events brought to power Heydar Aliyev, a former high-ranking Communist Party official. Heydar Aliyev appeased Russia, granting it stakes in Azerbaijan's oil contracts, and ensured immediate flow of funds to finance its regime by signing a partnership agreement with the IMF. His choice of the structural adjustment and oil-export-based development recommended by the IMF brought in both loans and a faster inflow of the oil-investment funds much needed to support the regime in its precarious political situation. It also redistributed the power of workers within the country, while institutionalized corruption provided a degree of support for the regime internally.

Shifting social and symbolic power and the marginalization of workers in the new economy

Cooperation with the IMF involved the abolition of subsidies and the liberalization of prices. While the pre-exisiting social safety net was effectively eliminated, an alternative social safety net was yet "being prepared" to be tested in 1999 (IMF 1995, 1997). The elimination of subsidies was crucial in that it subjected workers to market forces:

> Since a very large part of consumption under the old regime was nonmonetized, the wage made up only a small part of workers' means of subsistence. Massively subsidized housing, fuel, transport, and food made up the bulk of employee living standards. Thus, ending these subsidies while freezing wages involved an enormous shift of wealth out of the hands of labor and made labor suddenly and overwhelmingly dependent upon the wage relation (Gowan 1998, p. 157).

Moreover, existing jobs and wages in the public sector were utterly insufficient for subsistence. For example, while the minimum amount for meeting subsistence needs per person was estimated to be $50 per month in 2000 (Icon Group 2000, p. 63), the minimum salary was about $12 US dollars in 2004 (IMF 2005, p. 70). The protection from market failure provided by many formal jobs was so minimal as to be considered nonexistent.

In this context, the encouraged informal flow of income – bribery – ensured the support of the public sector. In fact, Alec Rasizade called rampant bribery in Azerbaijan's public sector "institutional corruption", explaining that it involve sharing of bribes through the chain of command:

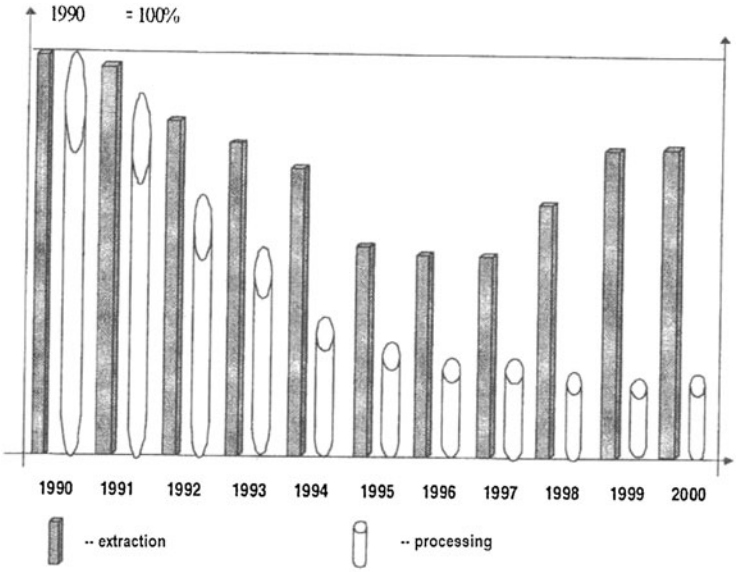
> For example, a customs officer ordinarily gives 75 % of received pay-offs to his supervisor who keeps his 25 % cut and then passes the rest to the upper level, and so forth (2002, p. 354).

In the context of symbolic wages, institutionalized corruption came to define the public sector, including health care.

The 1997-2000 Policy Framework Paper by the IMF and the Azerbaijan Republic aimed, along with further liberalization of trade and capital-account transactions, at the development of oil reserves for export (p. 2). Azerbaijan had extracted oil for the USSR as well. However, Soviet Azerbaijan's economy was predominantly agricultural (Lerman and Sedik 2009), diversified with textiles and various forms of processing (Ayyubov 2003, Hasanov 2003). As a result of implementing the "comparative advantage" policy of specializing in oil extraction, Azerbaijan was transformed from a diversified economy producing industrial technology, finished petroleum products, and food for the Soviet Union to a crude-oil extractor for the global economy (see Figure 1).

Moreover, important parts of the new oil-extraction processes were either outsourced or performed by teams of professionals imported from various countries (interviews in Baku, 2005). Azerbaijan's workers lost the important degree of control they had exercised over production in the Soviet structure. In the Soviet context, workers' relative control of the shop floor (Clarke *et al*. 1993) in the full-employment and labor-shortage economy granted them a degree of bargaining power in the production system. The post-Soviet reorganization of the economy around a capital-intensive and mostly transnationally staffed oil sector, and the collapse of the non-extractive industry, meant that the market could not utilize the labor of most workers. A once-useful person's labor

FIGURE 1
The Dynamic of Production in the Extraction and Processing Sectors, 1990–2000.



Reprinted with permission from Ayyubov 2003, p. 204.

was now redundant. A new Labor Code passed in 1999 left virtually all labor regulations to be determined by a "free" contract between employer and employee. The context of high unemployment, disintegration of the social safety net, and sudden obsolescence of Soviet-era skills shaped a worker's ability to enter into a contract. In the key industry – oil – control over the know-how related to production had passed on to imported expertise and labor. This combination left workers with little or no effective negotiating power.

As the masses found themselves more and more deeply dependent on the market relation, they discovered that they had little to offer on the new market. In an economy that now specialized in oil exclusively, the majority of Soviet workers – once central to the economy and glorified in public speeches – were now redundant.

These post-1995 changes did not take place in a democratic environment. The period was characterized by aggressive policing of

contending political orientations, incarcerations, gross violations of human rights, and government control of labor unions (Amnesty International reports on Azerbaijan, various years). The only independent labor union in the country, the union of oil workers, was taken over by the government-created Union of Oil and Gas Industry Workers without a vote of union membership in 1997 (Icon Group International 2000, p. 62-63). In this context, it was not the prosperity and cooperation of the workers – the ideological ground for Soviet public health care –by which the government measured its political-economic success. Now the government's target was managing the market, creating the conditions for market operation, and managing discontent as much as inflation.

Health care – An afterthought to market reforms

Changes to public health care were coincidental by-products of the Aliyev-IMF reforms and the institutionalization of corruption, rather than targeted changes on their own. Rural/urban imbalances in public health care were one such combined outcome. The inflow of foreign investment and the development of oil production in the capital city went hand in hand with declining non-oil production. Spatial socio-economic inequality within the country increased (IMF 2000, pp. 36-37). In 2003, the capital, Baku, accounted for 93 % of all taxes collected, while the rest of the country, including large cities such as Naxchivan, Gence, and Sumqayit, contributed only 7 % (Imanov 2003, p. 147). In the absence of jobs, massive outmigration from the rural areas ensued (Rasizade 2002, Hajizade 2003). In this context, when state support to rural doctors and health care facilities was abolished, the rural areas had no resources with which to attract quality care providers and equipment. Since positions in public health care facilities cost providers a great deal of money (because of the informal market in positions), the incentive is for them to extract this sum from patients. Few health care providers can afford to serve impoverished and underpopulated rural areas. This was the context for laments on overstaffing in Baku and understaffing in rural areas (World Bank 2005a, EurasiNet 2008).

Post-1994 legal changes placed the neoliberal economic discourse above the medical science discourse in health care planning, financing, and delivery. Ministry of Finance priorities (*i.e.*, reducing public spending), rather than *normatives* based on population health data, began to dictate the extent of public health care (table 3).

TABLE 3
Chronology of Legal Changes to Public Health Care in Post-Soviet Azerbaijan

Year	Law
1992	State Law "On Sanitary-Epidemiological Safety" is ratified (health care is still a public responsibility).
1994	President's Decree No. 234 ordered public health care institutions to shift to self-financing to support their activity and to supplement personnel wages. The Minister of Health's Decree No 170: • set out the framework for intensifying self-financing of medical establishments; • established "The Office for Self-financing and Extra-budgetary enterprises" as a new administrative unit of the Ministry to coordinate and regulate self-financing activities across the republic as well as to oversee privatization.
1995	The Republic of Azerbaijan's new Constitution declares social welfare to be the responsibility of families (not of the state), and confines the state's role in health care to "regulating the relations between different stakeholders."
1996	State Law "On the approval of the 1996 budget for Azerbaijan Republic" rules that "no less than 40 % of a public health care provider's budget should come from self-financing". Special decree of President Aliyev "On preparation of the social-economic development forecast and state budget for 1997" orders preparation of comprehensive programs for the shift to self-financing in health care, education, and science.
1997	Azerbaijan Republic's Law on the "Protection of Population Health" is ratified.
1999	Azerbaijan Republic's Law "on Medical Insurance" is ratified. Azerbaijan Republic's Law "on Private Medical Practice" is ratified.

Note: From Ministry of Health of Azerbaijan Republic 1997, 2004.

The chronology in Table 3 suggests that the main motivation for changes was the ubiquitous "market transition/privatization/liberalization" *for its own sake*, and that a functioning, effective health care delivery system in the republic was an afterthought. For example, whereas health facilities began to be privatized and fees for medical services were introduced as early as 1994, the law regulating the activity of private health care providers and the legal framework for health insurance was enacted only in 1999.

Health care changes explained

Changing concepts of health care were rooted in now-different experiences of social reality by both the government and ordinary people.

Health care and economic development

The 1995 and 1996 decrees on public health care firmly stated that the Republic's foremost priority was macroeconomic stability, fiscal management, market liberalization, and economic growth for the state. For example, the 1996 Special Decree made clear the view that a shift to self-financing in health care was "optimal for [the Republic's] socio-economic development forecast and social welfare". Public financing for the expansion of health care was no longer seen as an investment in production, as in the Soviet period. Health care spending and economic development were now viewed as not just separate but conflicting realms. Restructuring the economy and redefining the concept of economic development almost completely around oil extraction, an industry with few local employees, provided the basis for the notion that economic development and health care provision for all are indeed two different realms.

From a whole to a fragmented concept of health

With the start-up of the market reforms, workers who had once been involved in economic activity (and in social life) through the agency of their collective labor in the Soviet state were now structurally positioned to enter the economy (and social life) *individually.* The law and

the rules of the market acknowledged the worker (teacher, doctor, etc.) as a (n almost) disconnected, independent individual. Correspondingly, the language of the communal being and social formation of the citizen flowing from the Soviet policy was replaced by the language of the individual being and citizenship. The one relationship that the emerging discourse did not separate workers from was their relationship with family. In its turn, the state utilized Azerbaijan's familial tradition to justify low levels of wages and social security, upholding the idea that nobody was completely on his or her own, and that if everyone in a family "brought in a little" there now would be "enough for all". The specific establishment of the wage relation as a medium for economic and social life in Azerbaijan led to the individualization of the social policy discourse with a strong family element.

The specific form of social relations instituted in Azerbaijan under the Aliyev government, those that left workers with no protection against the market or employers, supported a transition to a minimal understanding of health care and health. The rise of the wage as the mediator between laborer and capital-owner in Azerbaijan took place in the absence of any social safety net, and under aggressive state surveillance. The result was the near-complete commodification of human labor: the transformation of human labor into a commodity for sale at a price determined by market demand. As David Harvey pointed out:

> This is a very different kind of market exchange. Capitalists when they purchase labour power necessarily treat it in instrumental terms. The labourer is viewed as a "hand" rather than as a whole person [...] and the labour contributed is a "factor" (notice the reification) of production. The purchase of labour power with money gives the capitalist certain rights to dispose of the labor of others without necessary regard for what the others might think, need, or feel (2004, p. 104).

For a capitalist in this relation, a worker's health is the state of being that allows his or her production-related activity. What emerges is a fragmented understanding of human health according to which each part is viewed as separable, and medically treatable on its own. The Azerbaijani state, whose top bureaucrats were also the chief capitalists of the new economy (Imanov 2003), moved away from the idea of human health as an organic whole toward a minimalist and fragmented view of health in its public health discourse. This is how the state, and the social group controlling the state, came to experience and perceive public health.

In Azerbaijan, the discourse changed from aspirations to "ensure harmonious development of citizens' physical and mental powers,

their health, high level of productive capacity and ability to live a long and active life; preventing and decreasing the cases of sickness; further reducing cases of disability and death; facilitating social relations that diminish factors with negative effect on citizens' health" (Azerbaijan SSR's Law on Health 1978) to "the sum of political, economic, legal, scientific, medical and sanitary-epidemiological services directed at the *maintenance* of physical and mental health, increasing productive life of individuals and providing them with medical services" (State Law "On the Protection of Public Health" 1997). Health is now presented as a concept detached externally and fragmented internally. It is detached externally, so we now can speak of health separately, without reference to a person's working and living conditions. It is fragmented internally, exemplified in the new law's distinction between physical and mental health as two different kinds of health (in contrast to the Soviet understanding, which distinguished between "physical and mental powers" within a unitary, holistic concept of "health"). The new concepts of health and health care are reflected in the new politico-social relations.

When is one sick enough? A minimalist conception of health

Subjective experiences of health and labor by workers also supported a minimal view of health. The "demand" for (commodified) public health care in Azerbaijan is determined by the number of people with enough "consumption power" to *acknowledge* and undertake the treatment of illness. What does it mean to have enough "consumption power" to *acknowledg*e an illness? I noted earlier the finding that only 50 % of the population seeks care when they are sick (World Bank 2005a). In the context of a literal struggle to earn enough to eat, defining when a family member is sick enough to justify a doctor's visit is a difficult choice. Usually a health problem is not acknowledged as sickness unless it endangers the ability to work (and the flow of meager income). In this context, the meaning of health for the overwhelming proportion of the population is reduced to *the absence of acute, non-post-ponable* health problems. Prevention, widespread during the Soviet era, is now a luxury, unaffordable in the broader sense as it involves adequate nutrition and living and working conditions in addition to medical visits and specialist information on one's health. A telling example of what this means was provided by one of my interviewees. A practicing doctor as well as a bureaucrat, he reported to me a conversation he had with a

construction worker – a distant acquaintance met at a funeral. When the doctor inquired about the worker's (failing) health and whether he had had a medical checkup lately, the worker replied:

> Why should I go? I know what he will tell me – I know I have a hernia. I was told this before. He [the doctor] will either tell me to have an operation and/or to be careful, not to lift heavy things […] Who will work if I undergo an operation? And how can I "stop lifting heavy items" with my profession? Will the doctor feed my kids if I stop working? Will he find me a new job? I don't need to see a doctor; I know what he will say. You doctors just talk without thinking. I just have to go as long as this body takes it. Wherever it breaks, it breaks [*Harada qirilar, qirilar*] (Interview, January 2006).

In a health care system with no central planning or articulated role – left to thrive on its own as a residue of the economic system, and molded into an informal market in services – prevention declined because there was no "demand" for it. That is why, in a health care system regulated by the informal "supply-and-demand" mechanism, it is only acute care that is "in demand".

The global, the regional, the local, and Azerbaijan's health care

The characteristics of Azerbaijan's current health care system were shaped in the context of the Aliyev government's adoption of a specific transition path based on oil extraction since 1995, through the social and political marginalization of the majority of the population. The result of the 1995 reforms combined with the Aliyev regime's institutionalized corruption was a health care system that facilitated private accumulation through public institutional structures. This created a de facto informal market for public health care services. The lure of bribes, the encouragement of bribes from above coupled with the inability of medical personnel to support themselves on the meager salaries of the new Azerbaijanian state, triggered the sale of formally free medical services to the population. As care provision became shaped by the effective (paying) demand, its nature and geography came to reflect the consumption ability in a highly unequal and predominantly poor society: we observed the erosion of the preventive care system and the exacerbation of rural/urban inequalities in health care provision.

Underlying these changes in health care was a change in the social system at large, a movement from a society based ideologically and materially (through extensive industrial production) on "workers' labor"

to one in which the majority's productive labor was redundant both materially (due to the concentration on oil extraction) and ideologically (due to the dissolution of labor's value and perceived worth). The new system was based on the rule of a small elite who monopolized political and economic power in the country and who were financed by oil bonuses and by grants from international financial institutions. The new government of the new oil economy did not see a need to create an extensive pool of workers. Nor did it depend on the vote of the populace. The benefits of implementing the IMF-suggested welfare cuts – new loans and international approval – were more immediate and tangible than attempting to sustain the welfare of a disenfranchised population. What took place on this political economic ground was a radical rewriting of the terms of the state-citizen relationship.

It may be tempting to read these changes in the health care system as another example of the widening reach of global economic structures, especially in light of the role of the IMF. But the specificities of Azerbaijan's post-Soviet public health care resulted from a combination of market reforms designed to gain international recognition *and* domestic compliance through institutional corruption. These market reforms themselves were a historical choice of a particular government, which were not ineluctable. Azerbaijan, upon the breakup of the USSR, had taken a different path to development due to a peculiar constellation of historical events:

(1) a regional geo-strategic scramble for control over Azerbaijan's oil and politics (with Russia as a key actor) succeeded in ousting a government that rejected the IMF model of transition and that was smoothly carrying out an alternative transition path; (2) the particular political context of the successor Aliyev regime made the IMF, and the international recognition associated with it, a strategic contact for the maintenance and consolidation of power; and (3) the Aliyev regime succeeded in breaking resistance to the system (partly by repression, and partly by incorporation into the new structures via bribery chains).

Thus were the building blocks of a new state–society relationship, and a new health care system in Azerbaijan, set. Neither the IMF nor Aliyev would have played the role they did in the shaping of post-Soviet Azerbaijan and its public health care system if not for a particular constellation of local, regional, and global interests and events.

BIBLIOGRAPHY

1971. "Azerbaijan SSR's Law on Healthcare" [Sehiyye Haqqinda Azerbaycan Sovet Sosialist Respublikasinin Qanunu] (Baku, Azerbaijan SSR Supreme Soviet).

Alimirzayev X. 1970. *Tehsil, Elm veSehiyye 50 ilde* [*Education, Science and Health in 50 years*] (Baku: Azerbaycan Dovlet Neshriyyati).

Amnesty International, 2010. *Amnesty International Reports - Azerbaijan*, 1995-2010. 28 May 2010, available at: http://www.unhcr.org/cgibin/texis/vtx/refworld/rwmain?page=country&skip=0&coi=AZE&publisher=AMNESTY&type=ANNUALREPORT [accessed 10 August 2010].

Armstrong Pat and Hugh Armstrong, 2002. *Wasting away: the undermining of Canadian health care* (Oxford, Oxford University Press).

—, 2008. *Health care* (Nova Scotia, Fernwood Publishing).

Ayyubov Mezeddin, 2003. "Bazar iqtisadiyyatinakech idvesenaye kompleksi" [Market transition and the industrial complex] *in* Abasov A., ed., *Musteqilliyimizin on illiyi: ugurlarimiz, itkilerimiz* [*The first ten years of independence: successes, losses*] (Baku, Yeni Nesil, pp. 195-213).

Bagirov Sabit, 2003. "Azerbaycan: Bazar iqtisadiyyatinagedenchetinyol" [Azerbaijan: The difficult road to the market economy] *in* Abasov A., ed., *Musteqilliyimizin on illiyi: ugurlarimiz, itkilerimiz* [*The first ten years of independence: successes, losses*] (Baku, Yeni Nesil, pp. 213-262).

Bakker Isabella and Stephen Gill, 2003. "Global Political Economy and Social Reproduction" and "Ontology, Method, and Hypotheses" *in* Bakker Isabella and Stephen Gill, eds., *Power, Production, and Social Reproduction: Human In/security in the Global Political Economy* (Toronto, Palgrave Macmillan, pp. 3–41).

Brodie Janine, 2003. "Globalization, In/Security, and the Paradoxes of the Social" *in* Bakker Isabella and Stephen Gill, eds., *Power, Production, and Social Reproduction: Human In/security in the Global Political Economy* (Toronto, Palgrave Macmillan, pp. 47-65).

Burawoy Michael and Pavel Krotov, 1993. "The economic basis of Russia's political crisis", *New Left Review* I, pp. 49-69.

Clarke Simon, 2004. "A Very Soviet Form of Capitalism? The Management of Holding Companies in Russia", *Post-Communist Economies*, 16, pp. 405-422.

Coburn David, 2010. "Health and Health Care: A Political Economy Perspective" *in* Bryant Toba, Dennis Raphael and Marcia Riou, eds., *Staying Alive: Critical Perspectives on Health, Illness, and Health Care* (Toronto, Canadian Scholars' Press, pp. 65-91).

—, 2010. "Health and Health Care: A Political Economy Perspective" *in* Bryant Toba, Dennis Raphael and Marcia Riou, eds., *Staying Alive: Critical Perspectives on Health, Illness, and Health Care* (Toronto, Canadian Scholars' Press, pp. 65-91).

—, 2011. "Global Health: A Political Economy of Historical Trends and Contemporary Inequalities" *in* Teeple Gary and Stephen McBride, eds., *Relations of Global Power: Neoliberal Order and Disorder* (Toronto, University of Toronto Press, pp. 118-151.

Coburn David, Carl D´Arcy and George Murray Torrance, 1998. "Introduction to Part VII: Society, Health and Health care" *in* Coburn David, Carl D´Arcy and George Murray Torrance, eds., *Health and Canadian society: sociological perspectives* (Toronto, University of Toronto Press).

Cockerham Geoffrey and William C. Cockerham, 2010. *Health and Globalization* (Cambridge, Polity Press).

EurasiNet. 2008. "Azerbaijan: Energy Rich, Healthcare Poor", vol. 2011.

Fel I.I., A.A. Aliyev, and G.L. Truman. 1978. *Sehiyyede Iqtisadiyyat, Planlashdirma, Idareetme, Maliyyeleshdirmeve Emeyin Elmi Teshkili* [*Healthcare: The Economics, Planning, Management, Financing, and Scientific Organization of Labor*] (Baku, Azerbaijan State Medical Institute named after N. Narimanov).

Gowan Peter, 1998. "Communists and Workers in Ex-Communist Europe" *in* Meiksins Peter, Michael D. Yates, Ellen Meiksins Wood, eds., *Rising from the Ashes? Labor in the Age of "Global" Capitalism* (New York, Monthly Review Press, pp. 153-163).

Hajizade Hikmet. 2003. "Yeni Azerbaycanuchunyenikimlik [New identity for the new Azerbaijan] *in* Abasov A., ed., *Musteqilliyimizin on illiyi: ugurlarimiz, itkilerimiz*

[*The first ten years of independence: successes, losses*] (Baku, Yeni Nesil, pp. 352-367).

Harvey David, 2004. *The condition of post-modernity: an enquiry into the origins of cultural change* (Malden, Blackwell Publishing).

Hasanov Rasim, 2003. "Azerbaycaniniqtisadiinski shafparadiqmasiveiqtisaditehluke sizlikkonsepsiyasininsechimi" *in* Abasov A., ed., *Musteqilliyimizin on illiyi: ugurlarimiz, itkilerimiz* [*The first ten years of independence: successes, losses*] (Baku, Yeni Nesil, pp. 162-180).

Ibrahimov Fuad, Aybaniz Ibrahimova, Jenni Kehler and Erica Richardson, 2010. "Azerbaijan: Health system review", *Health Systems in Transition*,12, pp. 1-117. Available online at: http://www.euro.who.int/__data/assets/pdf_file/0004/118156/E94132.pdf

Icon Group International. 2000. "Executive Report on Strategies in Azerbaijan", Icon Group International.

Imanov Nazim. 2003. "Ilk on ilinyekunlari: iqtisadiyyat" [Summary of the first ten years: the economy] *in* Abasov A., ed., *Musteqilliyimizin on illiyi: ugurlarimiz, itkilerimiz* [*The first ten years of independence: successes, losses*] (Baku, Yeni Nesil, pp. 136-150).

International Monetary Fund, 1995. "Press release n° 95/24" (Washington, IMF).

International Monetary Fund, 1997. "Enhanced Structural Adjustment Facility and Extended Fund Facility Policy" (Framework Paper, 1997-2000).

International Monetary Fund, 2000. "The IMF Staff Country Report n° 00/21" (Washington, IMF).

International Monetary Fund, 2005. "The IMF Country Report n° 04/322." (Washington, IMF).

Kideckel David, 2002. "The unmaking of an East-Central European working class" *in* Hann Chris M. ed., *Postsocialism: Ideals, Ideologies and Practices in Eurasia* (London/New York, Routledge, pp. 114-132).

Kornai János, 2001. "The Borderline between the Spheres of Authority of the Citizen and State: Recommendations for the Hungarian Health Reform" *in* Kornai János, Stephan Haggard, Robert R. Kaufman, eds., *Reforming the State: Fiscal and Welfare Reform in Post-Socialist Countries* (Cambridge, Cambridge University Press, pp. 181-209).

Laurell Asa Cristina and Olivia Lopez Arellano, 2002. "Market Commodities and Poor Relief: The World Bank Proposal for Health" *in* Navarro Vicente, ed., *The Political Economy of Social Inequalities: Consequences for Health and Quality of Life*, (Amityville/New York, Baywood Publishing Company, pp. 191-208).

Lerman Zvi and David Sedik, 2009. *Rural Transition in Azerbaijan* (Plymouth/New York, Lexington Books).

Maystrakh K. V. 1957. *The Organization of public health in the USSR*. Translated by W. D. C. U.S. Joint publications Research Service. (Moscow, USSR Ministry of Health).

Mehtiyev Azer, Rovshan Agayev, Samir Aliyev and Vuqar Bayramov, 2005. *Dovlet-budcesi: Sehiyyexercleri. (State Budget: Healthcare Expenses)* (Baku, Iqtisadi Tedqiqatlar Merkezi).

Navarro Vicente, 1976. *Medicine Under Capitalism* (New York, Prodist).

—, 1977. *Social Security and Medicine in the USSR* (Lexington, Lexington Books).

Petrovsky B.V. and N. A Vinogradov, 1967. "Teoerticheskie ii organizacionnieosnovi Sovetskogo Zdravooxraneniya" [Theoretical and Organizational bases of Soviet Healthcare] *in* Trofimov V. V., ed., 50 *Let Sovetskog oZdravooxraneniya:* 1917-1967 (Moscow, Meditsina, pp. 9-42).

Popov Georgii A., 1971. *Principles of Health Planning in the USSR* (Geneva, World Health Organization).

Rasizade Alec, 2002. "Azerbaijan after a decade of independence: less oil, more graft and poverty" *Central Asian Survey*, 21, pp. 349-370.

Ryan Michael, 1978. *The Organization of Soviet Medical Care* (Oxford, Basil Blackwell).

Spatharou Angeliki, 2002. "The political role of oil in Azerbaijan, 1989-1994", *Journal of Southern Europe and the Balkans*, 4, pp. 29-35.

Swietochowsky Tadeusz, 1999. "Azerbaijan: perspectives from the crossroads", *Central Asian Survey*, 18, pp. 419-434.

Szelenyi Ivan, 1978. "Social Inequalities in State Socialist Redistributive Economies: Dilemma for Social Policy in Contemporary Socialist Societies of Eastern Europe", *International Journal of Comparative Sociology*, I, pp. 63-87.

Transparency International, 2004. "Country Corruption Assessment: Public Opinion Survey in Azerbaijan".

TURCHINS Yan B., 1968. *Ceni ii optimizacia-narodnogoxozaystva* [Prices and optimalization of public economy] (Riga, Izdatelstvo Zinatne).

USSR Ministry of Health. 1990. *Spravochniy Komplekt Normativno-Metodicheskix Materialovpo Voprosamdeyatelnostiorganizaciy ii uchrejdeniy v novixusloviyaxxozaystvovaniya* [Collection of Legal-Methodological Materials on the Activity of Enterprises and State Organizations within the framework of New Economy] (Moscow, Soyuzmedinform).

VINOGRADOV N.A. 1962. "Teoreticheskieosnovisoveskogozdravooxraneniya" [Theoretical basis of Soviet Healthcare] *in* VINOGRADOV N. A., ed., *Organizaciya-Zdravooxraneniya v SSSR* [Organization of Healthcare in the USSR] (Moscow, Gosudarstvennoe Izdatelstvo MedicinskoyLiteraturi, pp. 6-156).

WITTER Sophie., 1997. "Introduction" *in* WITTER Sophie and Tim ENSOR, eds., *An Introduction to Health Economics for Eastern Europe and the Former Soviet Union* (New York, John Wiley and Sons, pp. 1-10).

World Bank, 2005. "Azerbaijan Health Sector Review Note" (Washington D. C).

World Bank, 2006. "Project Appraisal Document on a Proposed Credit in the Amount of SDR 34.3 Million (US $50 Million equivalent) to the Republic of Azerbaijan for a Health Sector Reform Project", International Bank for Reconstruction and Development (Washington, International Bank for Reconstruction and Development).

Résumé

Les systèmes de soins reflètent l'histoire des relations entre les citoyens et leur État, tout autant qu'un milieu social particulier est façonné par les valeurs dominantes. Voir la politique santé dans un contexte d'histoire sociale globale dont on exagère l'influence, c'est sous-estimer les spécificités locales. Le système de soins et son contexte social sont à l'intersection de facteurs globaux, régionaux et locaux. L'article analyse cette combinaison sur le cas de l'Azerbaïdjan en transition vers l'ère post-soviétique. La dissolution de l'organisation sanitaire soviétique a été beaucoup moins le fait de la globalisation que d'un processus aux trois niveaux cités incluant le choix politique d'un développement reposant sur le pétrole.

Mots clés : Globalisation ; Politique de santé ; Azerbaidjan ; Changement social ; Transition post-soviétique.

Zusammenfassung

Die Beziehungsgeschichte zwischen Bürger und Staat spiegelt sic him Gesundheitswesen wieder, ganz ähnlich wie vorherrschende Wertesysteme und Institutionen ein bestimmtes soziales Milieu beeinflussen. Wer die Gesundheitspolitik nur im Rahmen der allgemeinen Sozialgeschichte, deren Bedeutung übertrieben wird, betrachtet, unterschätzt die örtlichen Gegebenheiten. Das Gesundheitswesen und sein soziales Umfeld befinden sich an der Schnittstelle globaler, regionaler und örtlicher Faktoren. Der vorliegende Beitrag untersucht diesen doppelten Ansatz am Beispiel des aserbaidschanischen Gesundheitswesens und seinem Übergang von einer sowjetischen zu einer postsowjetischen Struktur. Die Auflösung des aserbaidschanischen Gesundheitswesen wurde weniger durch die Globalisierung hervorgerufen, als durch die drei bereits erwähnten Faktoren, zu denen auch die politische Entscheidung einer erdölgestützten Entwicklung zählt.

Schlagwörter: Globalisierung; Gesundheitswesen; Sozialer Wandel; Post-sowjetischer Übergang; Aserbaidschan.