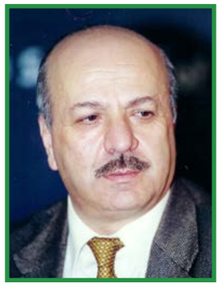
# Health Care System in Armenia: Highlights



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## Summary

*Health care in Armenia has suffered as a result of the socioeconomic decline that followed the collapse of the Soviet Union. Since independence in 1991, Armenian healthcare reforms have been carried out but achieved their full scale starting in 1995–1996.*
*There are still large numbers of elements typical for the Soviet Semashko model in Armenian healthcare structures. Implemented reforms have separated the institutions of the public payer and the providers, but did not manage to change the model of financing to be based on compulsory insurance. The level of financing is similar to the average in Central and Eastern Europe, but is based mainly on out-of-pocket payments contributing to about 80% of all system resources. The informal payments reach even 45% of expenditures. The health system is based on the primary health care approach and the structure of hospital beds remains ineffective. There are still no mechanisms of increasing the quality of services. Privatization has been applied, but the role of private providers is still limited.*
*The reforms have not caused satisfactory improvement in healthcare performance, although the health indicators are better than at the beginning of the transformation period. The stability of the reforming processes in previous years as well as the engagement of international institutions is a chance for positive changes in the near future.*

## Background

The Republic of Armenia is one of the smallest of the former Soviet republics. This mountainous country covers 29,743 km$^2$ and has a population of about 3.2 million. After declaring independence in September 1991, Armenia became a sovereign republic headed by a president. Since this time the country has entered a path of transition towards a free market economy, although impeded by numerous difficulties.
Armenia's early years of independence have been impacted by severe economic decline and energy shortages. The transition to a market economy has been hampered by the legacy of central planning, major economic shocks arising from the collapse of the Soviet Union and then the "ruble crisis" (the former Soviet Union currency). The country was also involved in regional conflicts, and reforms were hampered by the limited ability and political will of decision-makers to undertake the critical steps needed to restructure the country's economic and governmental systems. All of this also influenced the healthcare system, resulting in its collapse. During the Soviet era, the government guaranteed–at least in theory–access to a wide range of services for the whole population, which was in line with the assumptions of the Semashko model. After independence, the economically weakened state withdrew the financing of healthcare, which became dependent on out-of-pocket payments and was highly perverted by the omnipresent corruption. Since the mid 1990s the government has started to work on a radical program of reform aimed mainly at strengthening primary healthcare and introducing an insurance-based system of financing, but many of these efforts, similarly to those in other post-Soviet republics, particularly those from the South Caucasus region (Azerbaijan, Georgia), have had no effect.

*Healthcare services are regulated by the government decrees as well as the orders of the Minister of Health*
Although a sort of structural reform was undertaken during the first years of transition, the organization of the system still has many elements typical for the centralized Semashko model. The Ministry of Health is responsible for supervising the system, for financing the state-guaranteed health services and delivering some of them through the subordinate institutions, as well as for projecting and implementing the reform processes. The Ministry also stimulates the legislative processes for the health sector, which are generally placed in the National Assembly. The lower levels of the hierarchy have a limited independence in decision making, although some of the former reforms were aimed at improving it, as for example the changing of the status of medical facilities (to economically independent state enterprises and to state closed joint-stock companies afterwards) and the new administrative-territorial division of the Republic. This, however, unexpectedly resulted in substantial weakening of the mechanisms of quality control and management of the healthcare system.
An important institution in the system is the State Health Agency established in 1997. The agency fulfills the role of a payer, being responsible for covering the costs of stateguaranteed health services. This role was taken by the agency from the district authorities. Although its aim was to introduce and develop compulsory health insurance, it has not been implemented yet.
Generally, the agency is responsible for: efficient and effective utilization of state healthcare funds in the framework of annual state guaranteed healthcare programs; contracting with healthcare providers on provision of the services financed from public resources and paying for these services; supervising the volume and quality of provided care by the facilities; organizing and conducting the observation of accounting data provided by the healthcare facilities; participating in the development, introduction and implementation of the organizational, managerial and financial modern mechanisms in the Armenian healthcare system.
The regional and local authorities have a limited range of functions concerning the organization of the healthcare system. The regional level authorities have the ownership of most of the secondary care facilities; since 1998 most rural outpatient clinics have come under the ownership of the communities (the lowest level of self-government) and a few of them under the ownership of regional authorities. The ministry still maintains the ownership of the tertiary level institutions.

## Financing the Health System

Since the establishment of the State Health Agency, the model of financing health services has been based on a division between the purchaser of the services and the providers. Nevertheless, the general taxes and central budget are still the basic source of health system finances. In spite of the necessity for healthcare development, there is no compulsory health insurance system in Armenia.
The Armenian healthcare system has undergone a radical transformation in its system of finance as of March 1996, when a law "On Medical Aid and Medical Services for The Population" was adopted by the National Assembly. This act legalized the alternative means of financing, including private out-of-pocket payments (RA Law 1996), which in fact is a main source of covering the costs of services. The range of services financed from the public resources is defined in the Basic Benefit Package.

Out-of-pocket payments are the main source of covering the costs of health services, contributing to nearly 89% of the total expenditures on health in Armenia. Public expenses amounted to only 1.7% of the GDP in 2005 (National Statistical Service). Interestingly, the total expenditures as a percentage of GDP do not vary significantly from the average for all Central and Eastern European countries (WHO 2005).

The amounts per capita are much lower than the average for the region, where in 2004 it amouted to 437.3 international dollars in the CIS countries (Commonwealth

of Independent Countries: most of the former Soviet Republics; WHO Health for All database 2007) and nearly 2,334.3 in the whole European Union (WHO Health for All database 2007). Given the scale of collapse of the system during the transition period–the general government expenditure on health in the Soviet period was about US $300 per capita.

Due to the estimations, the scale of informal payments in Armenia may exceed 45% of the total healthcare resources.

The most evident trend indicated by these data is the systematic decrease of expenditures on hospital care and the increase of financing of ambulatory care. This is the positive result of the implemented reforms that were assisted by USAID/Armenia, the World Bank, WHO and other international organizations.

The structure of providers still has many elements of the former Semashko model, although a sort of change was implemented during the period of transition. For example, the state-owned hospitals and polyclinics are now semiautonomous, self-financing enterprises with considerable decision-making powers.

Since 1999, the healthcare facilities have been able to set prices for chargeable services, to some extent to determine staffing levels and to negotiate contracts with the staff. The facilities are responsible for covering their own costs and should autonomously make efforts to attract a sufficient volume of patients to secure their financial stability (each facility has its bylaw defining policies and procedures). The number of hospital beds in Armenia in 2004 was 443 per each 100,000 population (Ministry of Health 2004). It was similar to the number in Georgia (407 per 100,000 population), and much lower than in Azerbaijan (824 per 100,000) or the whole CIS region (866 per 100,000 population). This is even lower than in the European Union, where in 2004 it had 586 hospital beds per 100,000 population (all data: WHO Health for All Database 2007).

A major problem is the low effectiveness of the hospital sector; in the late 1990s the average length of stay in the hospital was nearly 13 days. In 2004 it decreased to 10 days, which was much lower than in Azerbaijan (16.4 days), slightly lower than the average for the CIS region (13.4 days) and only slightly more than the average for the European Union (9.25: WHO Health for All Database 2007). At the same time the level of utilization remains dramatically low, being only slightly higher than 41.8%, compared to 75.9% in the European Union and 85.7% in the CIS region (WHO Health for All Database 2007; data for year 2004).

The RA law “On Medical Aid and Medical Services for The Population” of March 1996 allows patients to freely choose their primary healthcare physicians.

Primary healthcare facilities are paid on a “per capita” basis. Since the catchment area for the appropriate facility is defined by the Regional Health Authorities and it cannot be changed by either the facility or the patient (since 1 January 2007 the Open Enrollment System has allowed changing the physician, but the financial implications will start on 1 January 2008), in fact it can be said that the primary care physicians’ (therapeutists, pediatricians and family physicians) salaries are set preliminarily.

The role of private health facilities is becoming more and more crucial in the whole healthcare framework of Armenia. They are recognized as being much more well organized, ensuring a higher quality of services, and familiarized with the client-oriented approach and modern costing mechanisms. The first document outlining privatization of healthcare facilities was submitted by the Ministry of Health to the government in 1994. In subsequent years, additional approaches to privatization were developed. Presently, nearly all pharmacies, medical technical services and almost all huge medical

centers are privatized under private companies and non-profit organizations. Besides, any kind of hospital and/or independent practice is allowed to practice if it meets all the requirements for and obtains its license. In 2005 17% of hospitals (24.9% of hospital beds) and 11% of primary healthcare facilities were private (Ministry of Health 2005).

## The General Changes and Challenges of the Recent Transitions

During the Soviet era, Armenia had one of the best developed healthcare systems in the Soviet Union. However, the economic crisis has decreased the government’s ability to provide adequate funding for healthcare, with major implications for health status. Life expectancy, which in the early 1980s was the highest in the Soviet republics (73 years), fell in the early years after independence (71 years in 1991-Ministry of Health 2004). Since the mid 1990s, this factor has been climbing steadily and reached 72.5 in 2000 and 73.4 in 2004 (Ministry of Health 2004). This was much higher than in Russia (65 years) or the average for the CIS region (67 years), and comparable to the average for the “new” EU Member States (74 years; WHO Health for All Database 2007). At the same time the infant mortality factor was improving systematically and reached 11.6 cases per every 1,000 live births in 2004, to be compared with 18.5 cases per 1,000 live births in 1990 (Ministry of Health 2004). It was lower than the average for the CIS region (more than 13 cases per 1,000 live births), but much higher than the average for the EU Member States (5.25 cases per 1,000 live births; WHO Health for All Database 2007).

In the context of the recent transitions and current main health problems of the Armenian population, the basic challenges for public health in Armenia may be characterized as follows:

- Primary healthcare should be emphasized.
- In Armenia, the sense of individual responsibility for one’s health is low. Probably the main reason for this situation is the absence or low level of health education. Health education and health promotion are core components of primary healthcare.
- The situation with the health workforce is inefficient in Armenia. Particularly, the Armenian healthcare system has suffered from an overproduction of medical personnel, unemployment and underemployment. In spite of an overproduction of medical personnel, there is a shortage of health specialists in rural areas, because there are no incentives for physicians to move there.
- Health planning is not adequately developed in Armenia. One of the main reasons is the absence of effective tracking mechanisms for health expenditures.
- Informal payments remain one of the most vulnerable issues in the Armenian healthcare system. It is said that it can be solved by the introduction of compulsory health insurance, the implementation of effective costing models and decreasing taxes.

## Conclusions

1. The whole period of transition that started with the independence of Armenia resulted in the improvement of the healthcare system in the country, but still the majority of the aims of the reforms has not been achieved.
2. There is still a need to enforce the mechanism of health financing based on the state’s compulsory health insurance and complementary private insurance, which should lead to a more adequate allocation of financial resources in healthcare.
3. Nevertheless, health education is still a great challenge for Armenia.
4. Armenian healthcare legislation and regulations are relatively well developed. Nonetheless, there are still problems with the practical implementation of the existing law due to the lack of political will and corruption.