TECHNICAL SUPPORT FOR UNIVERSAL HEALTH COVERAGE IN ARMENIA

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FINANCING UNIVERSAL HEALTH COVERAGE IN ARMENIA:

WHY AND HOW?

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The urgent imperative for health reform in Armenia

Rationale 1: Armenia is facing a growing burden of non-communicable diseases

An Armenian born today can expect to live up to 75 years on average, an increase of seven years since 1990.[1] Most of the rise in life expectancy in Armenia has resulted from falls in infectious diseases, and improved survival of children and mothers.[1]

While Armenians are living longer, they are not necessarily living healthier lives. Chronic illnesses, like heart disease and diabetes, account for over 500,000 years of life lost and 280,000 years lived in disability annually.[2] Also, compared to countries with similar socioeconomic profiles, Armenia has a higher burden of heart disease, stroke, and diabetes.[1]

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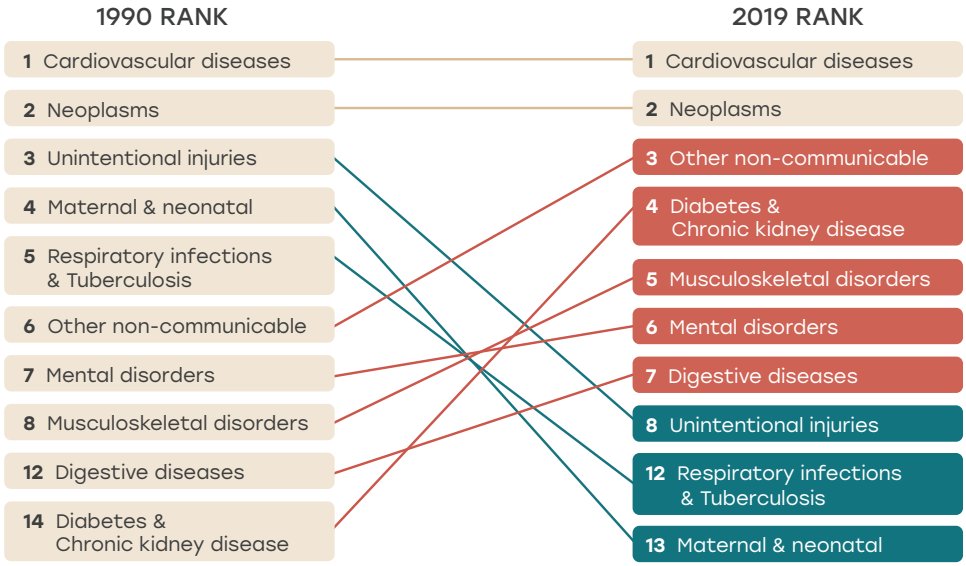
FIGURE 1: CHANGE IN BURDEN OF DISEASE IN ARMENIA IN 1990–2019

Both sexes, All ages, Disability-adjusted life years per 100,000



SOURCE: Institute for Health Metrics and Evaluation (IHME), 2021

Chronic diseases are also an economic challenge. Every year, these illnesses cost the Armenian economy over 360 billion AMD due to losses in workforce productivity and the cost of care (Figure 1).[1] Yet, about 3,000 deaths and 53,000 years of life lost could be prevented annually with better access to and quality of health care respectively.[3]

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Rationale 2: Private health spending creates financial barriers to access for the poor and sick

For nearly one in five Armenians, cost is the main barrier to using health care when needed.[4] In the average upper-middle -income country, one-third of all health spending is made by households, out-of-pocket (OOP), at the point of care. In Armenia, OOP spending rises to an alarming 85 percent of health spending, higher than Afghanistan (76 percent) or Yemen (81 percent) (Figure 2).[4]

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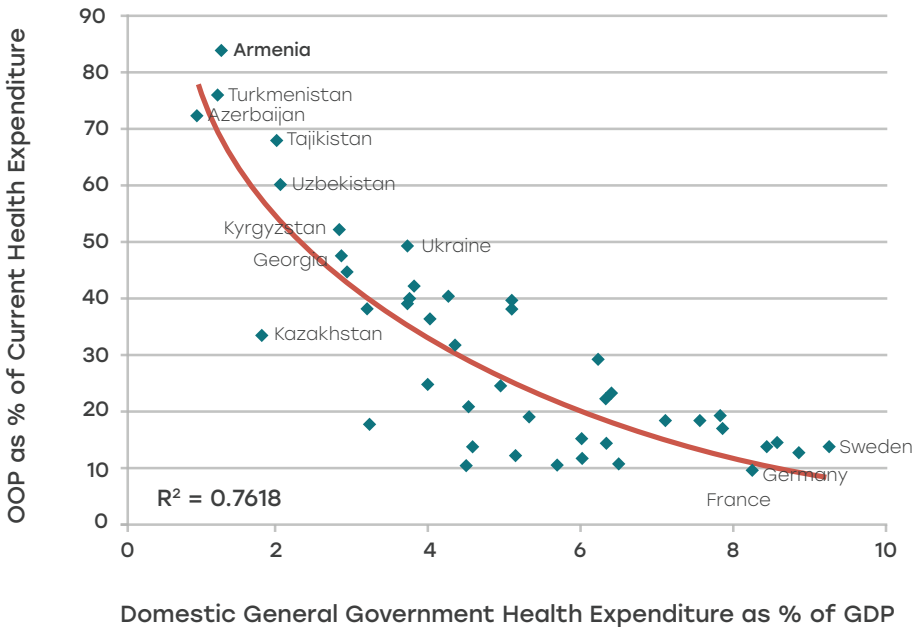
Private health care spending is akin to a tax on the sick and poor in Armenia. Catastrophic health spending, a measure that captures if households allocate up to 10 percent of total spending to health care, is six times more common in households with at least one person living with hypertension. In 2018, 19 percent of Armenian households experienced catastrophic health spending, more than twice the average of seven percent in Europe. While 20 percent of the poorest households experienced catastrophic health spending, only 16 percent of the richest households did.[3]

FIGURE 2: ARMENIA HAS ONE OF THE HIGHEST LEVELS OF OOP HEALTH SPENDING GLOBALLY



SOURCE: WHO Global Health Expenditure Database, 2018

OOP spending results in lost opportunities to prevent disability, death, and low productivity from chronic diseases. In 2015, the average Armenian visited an outpatient provider four times, far below the average in Europe of seven times per person.[4] The Armenian experience illustrates the critical role for public financing in ensuring access to care for all, regardless of socioeconomic status, a central tenet of Universal Health Coverage (UHC).

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Rationale 3: Low and inefficient public spending drives financial protection gaps

OOP spending for health in Armenia is high because public spending on health care is low. Annual public spending in Armenia is USD 52 per capita, far lower than that of neighbouring Georgia who spends USD 123 per capita on health care.[5]

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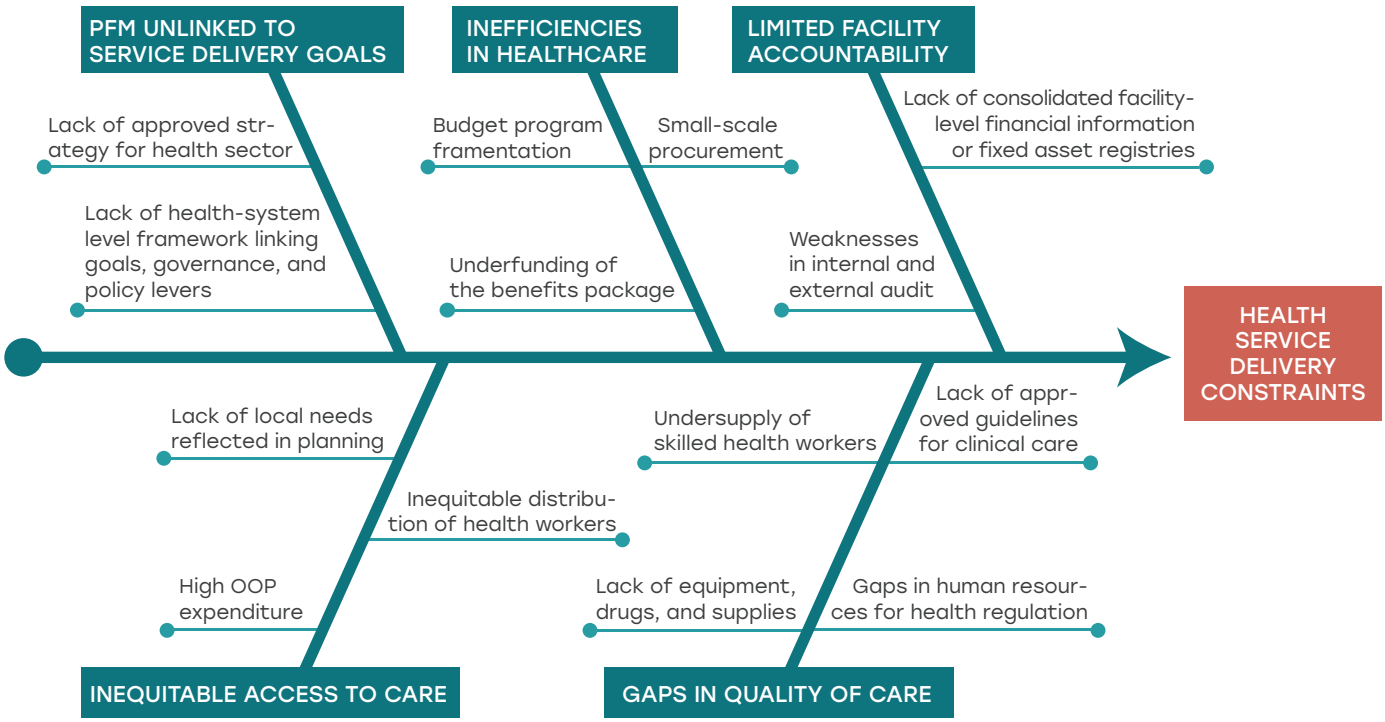
At least 85 percent of health spending in Armenia is not pooled and does not spread the financial risks of illness. At the individual level, the size and timing of health spending are largely unknowable, making it difficult to plan for future needs. The net transfer of resources from rich to poor, through pooling, also increases population health and productivity, as the poor tend to have a worse health status.[4] Compared to OOP spending, pooling health financing is more equitable and efficient.

Health spending decisions tend not to be driven by the potential to advance UHC. The original role of the State Health Agency (SHA) was to contract providers and pay for services covered by the benefits package. However, the SHA has been subordinated to the Ministry of Health (MoH), which through its involvement in service delivery prevents the separation of purchasing and provision, and objective decision-making on provider selection for better quality. Meanwhile, the benefits package only covers limited medicines and hospital services for only 30 percent of the population.[1]

FIGURE 3: HOW SPENDING DECISIONS HINDER IMPROVEMENTS IN HEALTH CARE



SOURCE: World Bank, 2020

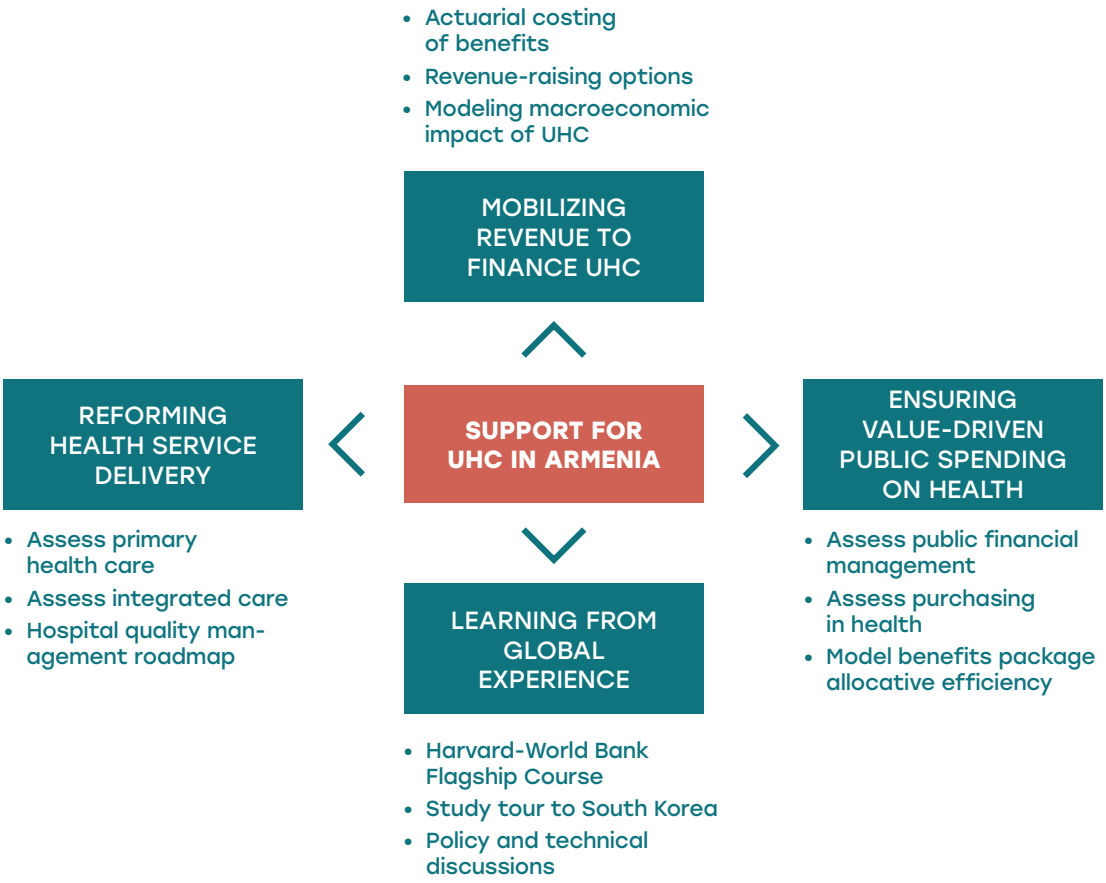
Over 30,000 life years could have been saved in 2019 if spending within the budget were optimized, based on health needs and cost-effectiveness.

Decisions on provider payment and selection of facilities for contracting are not tailored to health needs or utilization patterns. Benefits package revisions are often driven by political considerations. Over 30,000 life years could have been saved in 2019 if spending within the budget were optimized, based on health needs and cost-effectiveness. In Figure 3, we highlight other opportunities to strengthen public financial management in Armenia to facilitate UHC.[6]

Evidence-driven reforms for UHC in Armenia

Considering these challenges, the MoH is championing health financing reforms to ensure universal access to health care, by mobilizing domestic government revenue for health, setting up an accountable and effective purchasing agency, and introducing a benefits package that covers essential medicines, inpatient care, and more as determined by the population's health needs.

FIGURE 4: WORLD BANK TECHNICAL SUPPORT FOR UHC REFORMS IN ARMENIA



SOURCE: World Bank, 2021

At the request of the MoH, the World Bank has provided technical support to inform the design of these reforms, through rigorous analysis, convening stakeholders, and facilitating knowledge exchanges with the other countries (Figure 4). Reports capturing the findings of these analyses have been published under the **"Technical Support for Universal Health Coverage in Armenia"** series. Below, we summarize three main recommendations for health financing reforms:

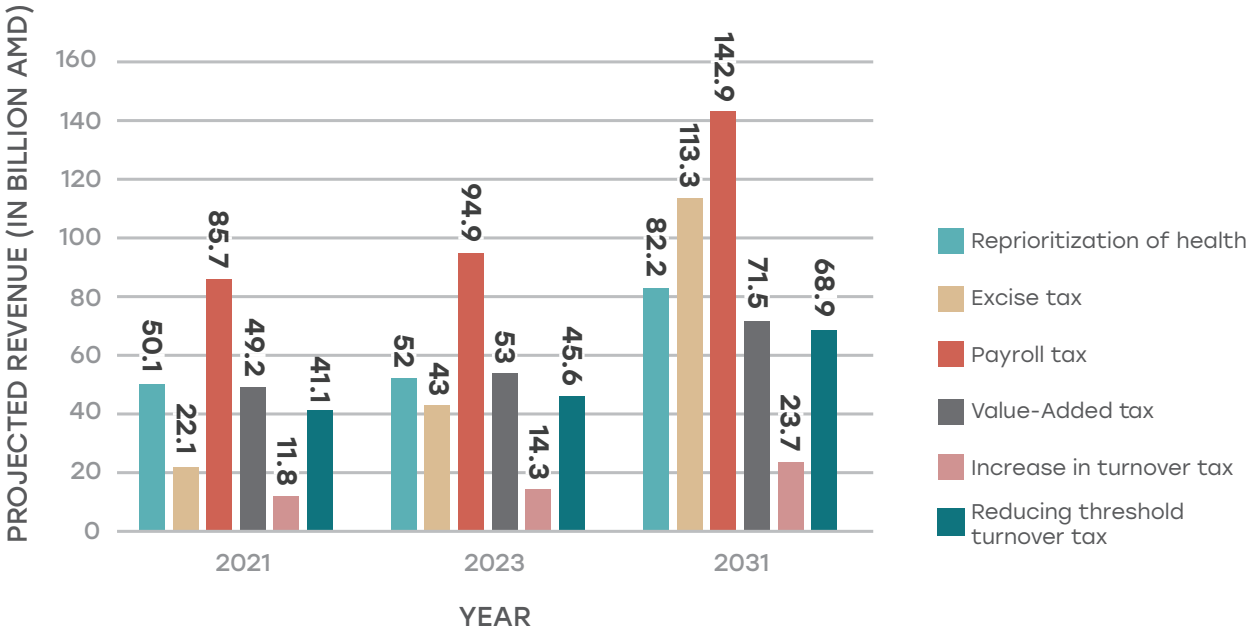
Recommendation 1: Mobilize additional compulsory, pre-paid, and pooled public financing

An estimated 310 billion AMD is needed in 2031 to subsidize 95 percent of household expenditure for health care.[5] In 2019, the health budget was 103.8 billion AMD, leaving a financing gap of approximately 206 billion AMD.[4] The necessary funding should be mobilized through compulsory prepayments with subsidies for vulnerable groups, in line with global evidence, and pooled to share risk and facilitate strategic purchasing of health services.

"No nation achieves universal coverage without subsidization and compulsion. Both elements are essential. Subsidies without compulsion will not work; indeed, they could make matters worse since the healthy flee from the subsidized common pool, only to return when they expect to use a great deal of care. Compulsion without subsidies would be a cruel hoax for the millions of poor and sick who cannot afford health insurance."

–Victor Fuchs, 1996

FIGURE 5: SUMMARY OF FISCAL SPACE PROJECTIONS



SOURCE: World Bank, 2021

Analysis conducted by the World Bank has explored a range of options, where the final decision will be made by the Government. Armenia could mobilize 50 billion AMD in 2021 by matching peers like Georgia on the percentage of the budget allocated to health. Armenia could raise an additional 11.18 - 85.70 billion AMD of additional fiscal space through taxation in 2021 (Figure 5).[5] Regardless of how these funds are raised, we find that GDP growth becomes positive by 2050, due to increases in productivity from better health (Table 1).[5,7]

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TABLE 1: THE ECONOMIC RETURNS TO INVESTING IN UHC IN ARMENIA

TAX SCENARIO	IMPACT ON GDP (%)		SHORT-TERM			LONG-TERM			Additional revenue by 2031 (in Billion AMD)
	2021	2050	Total informal employment	Rich household welfare	Poor household welfare	Total informal employment	Rich household welfare	Poor household welfare	
Payroll tax	-2.85	-0.43	-	+	+	+	-	-	142.90
Excise tax	-4.43	-0.11	-	+	+	+	+	-	113.37
Value-added tax	-1.68	+0.04	-	+	+	+	-	-	71.45
Direct tax (excluding payroll tax)	-0.87	+1.00	+	+	+	+	+	-	NA
Corporate income tax	-0.52	+0.18	+	+	+	+	-	+	NA

SOURCE: World Bank, 2020

negative impact positive impact

Recommendation 2: Institute an accountable and independent purchasing agency

To maximize value for money, there is a need to institute an accountable, evidence-driven, and independent institution to undertake purchasing of health services - including benefits package design, provider payment, facility selection, and provider monitoring. For the Armenian population, value means better access, quality, efficiency, and health outcomes.

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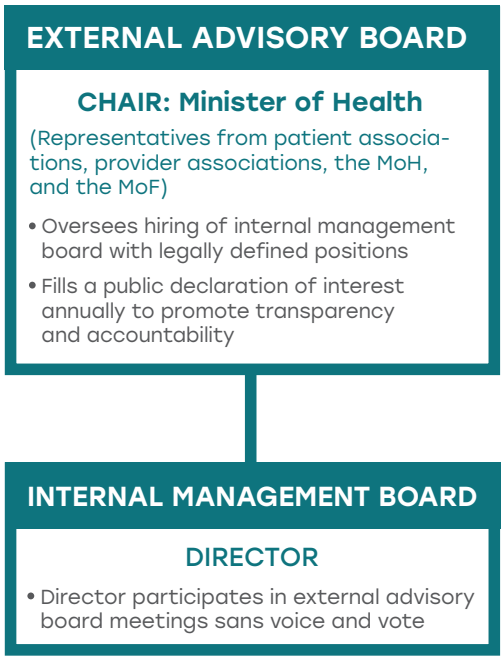
We recommend that this agency – SHA or a new body – be able to make objective and transparent decisions and be legally autonomous from the MoH, but accountable to an external advisory board that is chaired by the Minister of Health and involves representatives from patient associations, provider groups, the Ministry of Finance (MoF), and other stakeholders (Figure 6).

FIGURE 6: PROPOSED GOVERNANCE STRUCTURE FOR PURCHASING AGENCY



SOURCE: World Bank, 2020

Given the advantages of pooling, we highly recommend a single purchasing agency be responsible for procuring services within the scope of the benefits package. The roles of private insurers can be limited to providing additional coverage for services outside the package for self-funding individuals and households.[4]

Recommendation 3: Undertake evidence-driven purchasing for improved access and quality

Drawing on the vast amounts of data on population health, service delivery, and provider behavior, the purchaser can make strategic decisions that promote access, quality, and efficiency, in collaboration with the MoH.

We propose that revisions of the benefits package be based on a defined, legally backed process, that incorporates assessments of the disease burden, budgetary impact, and cost-effectiveness, in addition to inclusive stakeholder consultations on proposed revisions (Figure 7). The responsibility for technical assessments can be housed in a research or academic institution.[4]

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FIGURE 7: AN INCLUSIVE AND OBJECTIVE APPROACH TO BENEFITS PACKAGE REVISION

SOURCE: Ministry of Public Health, Thailand; World Bank, 2021

To strengthen the link between health spending and quality of care, we also recommend that the MoH and purchasing agency implement quality-based purchasing, through defining indicators for priority health conditions, monitoring of provider performance on said indicators, publication of provider performance, selection of providers for contracts based on quality (where possible), and paying for improvements in quality.

An evidence-based approach to purchasing health services from providers will require the regular supply and use of relevant and accurate data. We recommend that designated officials in the SHA be allowed unfettered access to ArMed, the electronic health system, to include or exclude indicators for quality, access, and efficiency. ArMed should also be made interoperable with other databases in the health sector, including from the National Institute of Health.[4]

We also advise that the MoH require the national e-health operator to implement for the SHA an operations dashboard that analyzes and visualizes the selected indicators in real-time to provide feedback on purchasing decisions. The dashboard can be revised on an annual basis, following approvals of revisions by the external advisory board.[4]

Endnotes

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About this brief

This brief was developed under the technical support for UHC in Armenia which includes Advisory Services and Analytics aimed at supporting the government's efforts to expand access to high-quality health care. This brief, "**Financing Universal Health Coverage in Armenia: Why and How?"**, is a chapeau piece drawing on the volume series to provide tailored recommendations for financing health coverage in Armenia.

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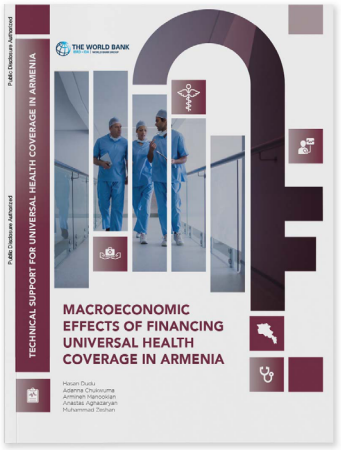

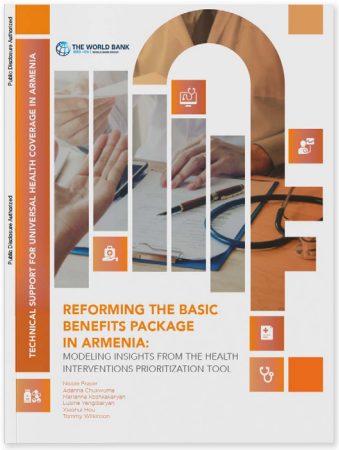

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