EXECUTIVE SUMMARY

TECHNICAL SUPPORT TOWARDS UNIVERSAL HEALTH COVERAGE IN ARMENIA

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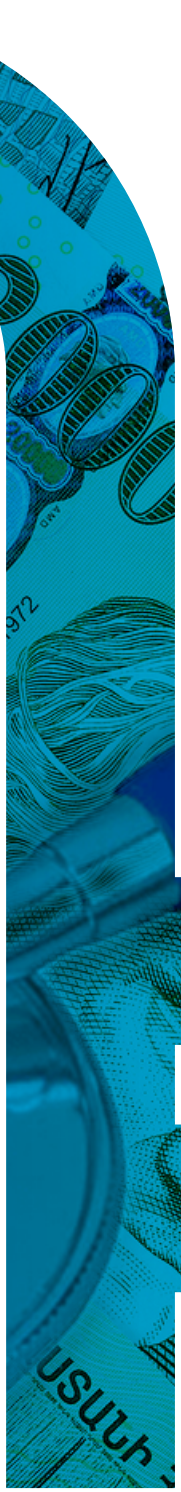

STRATEGIC PURCHASING

FOR BETTER HEALTH IN ARMENIA

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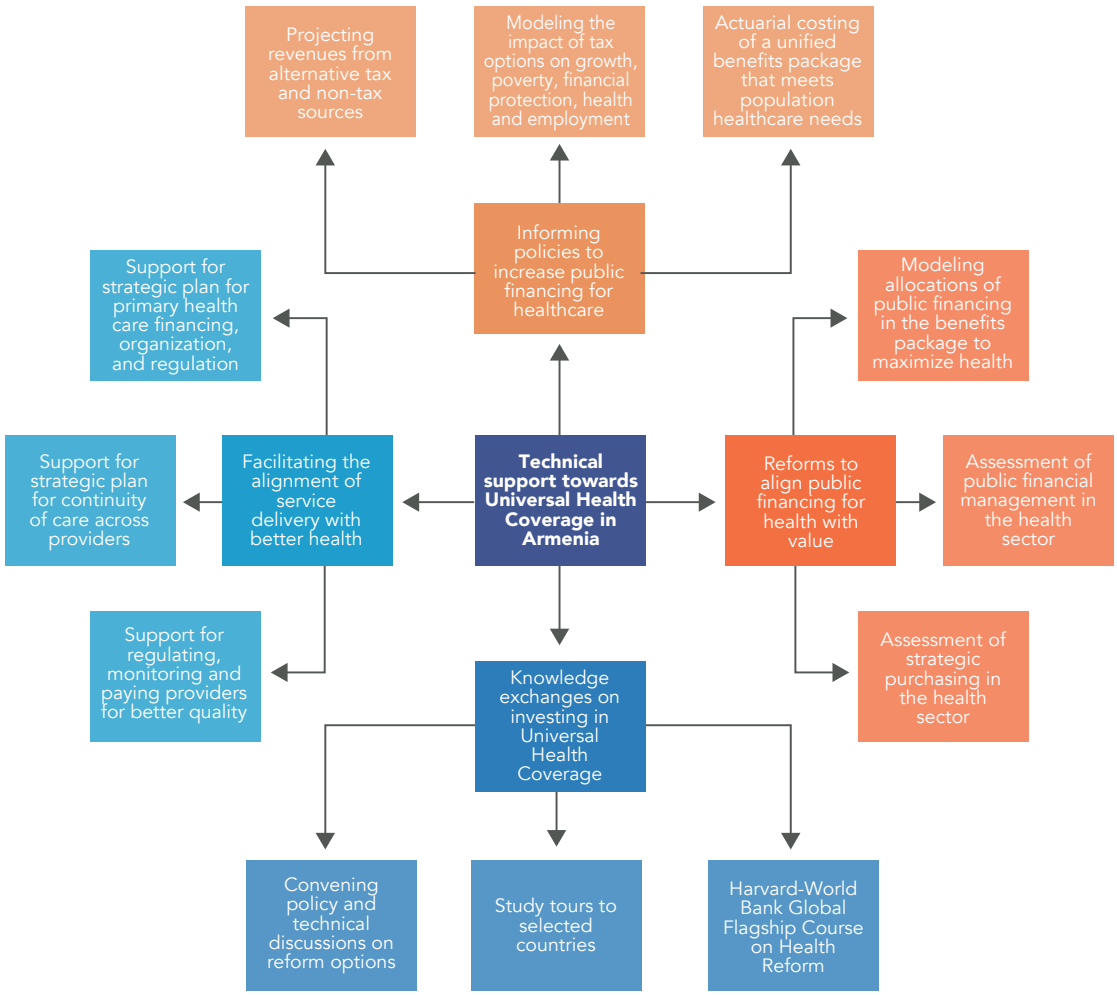
ABOUT THIS REPORT

This report is an activity under the Technical support towards Universal Health Coverage in Armenia, which includes Advisory Services and Analytics aimed at supporting the government's efforts to expand access to high-quality health care. The report, *Strategic Purchasing for Better Health in Armenia*, draws on an adaptation of the strategic purchasing progress framework to examine the country's experience in purchasing healthcare, identify contextual factors that limit the potential of purchasing to reform healthcare, and integrate these findings with relevant global examples of strategic purchasing reforms. We conclude the report with tailored recommendations for strategic purchasing that can improve population health. This technical support is financed by the Korea-World Bank Partnership Facility (KWPF).



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The authors of the report are Adanna Chukwuma, Bruno Meessen, Hratchia Lylozian, Estelle Gong, and Emma Ghazaryan. A background paper developed by Ajay Tandon on the global landscape on expanding fiscal space for health informed the final report. We acknowledge the helpful comments received on the report drafts from Armineh Manookian, Ajay Tandon, Susanna Hayrapetyan, Marion Jane Cross, Rafael Cortez, Toomas Palu, and Triin Habicht. This report also draws on conversations with key national stakeholders, including during the Global Flagship Course on Health Reform and the High-level Policy Roundtable for Universal Health Coverage. Logistical support was provided by Arpine Azaryan, Gabriel Francis, Marianna Koshkakaryan, and Maya Razat.

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EXECUTIVE SUMMARY

THE CASE FOR STRATEGIC HEALTH PURCHASING IN ARMENIA

Armenia has made dramatic strides in improving population health over the last three decades. The country performs better on measures of adult and child survival than the average middle-income country, which is a testament to the success of past health reforms and improvements in household welfare. For example, since 1990, life expectancy at birth has increased from 68 to 75 years. However, non-communicable diseases (NCDs) now account for 93 percent of deaths. The burden of heart disease, diabetes, and cirrhosis in Armenia exceeds the average among countries with similar sociodemographic indicators. NCDs are long-term illnesses that can increase premature death, reduce productivity and increase health spending. The estimated annual cost of NCDs to the Armenian economy was 362.7 billion AMD in 2017, equivalent to 6.5 percent of the country's annual national income. Most of this cost falls on Armenian households as out-of-pocket (OOP) payments, which constitute 85 percent of health spending. This is higher than levels seen in fragile states, such as Afghanistan (76 percent) and Yemen (81 percent).

Access to quality healthcare is essential to preventing and managing NCDs. However, in 2018, 20.9 percent of individuals in non-poor households and 25 percent of individuals in impoverished households in Armenia reported health deprivation, due to gaps in the access to quality healthcare. Healthcare is underutilized. In 2015, Armenians had an average of 4 outpatient visits per person, which is below the average of 7.1 in Europe. Healthcare is not received despite severe self-reported illness in 87 percent of cases and one in five Armenians states that costs are a barrier to use. Further complicating challenges in access are the gaps in the quality of healthcare. Guidelines for appropriate clinical care are often not adhered to

or monitored. For example, following a diagnosis of hypertension, only 39 percent of service users are advised on weight control and 17.8 percent on smoking cessation. In 63 percent of cases, individuals bypass their primary care physicians and obtain hospital and emergency care directly, in part due to the perception that quality at the primary care level is poor. This pattern of healthcare use is at odds with evidence from global experience that specialist-centric healthcare is inefficient and ineffective at managing NCDs.

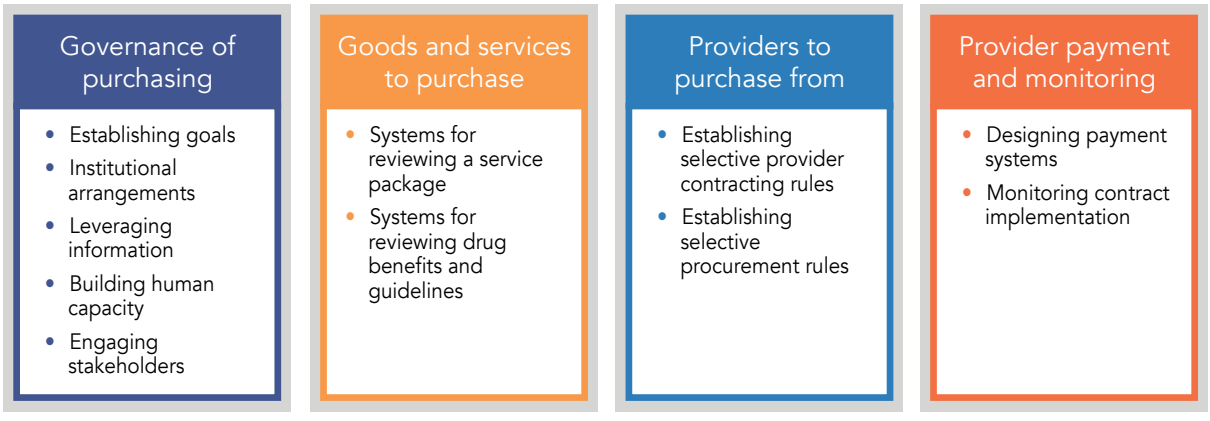
No health reform blueprint will apply in every context in making progress towards improving access to high quality healthcare and attaining Universal Health Coverage (UHC). However, there are important lessons for Armenia from global experience in designing health reforms. Successful countries have mobilized revenues through predominantly public sources and pooled risk across social groups for equity and efficiency. Global experience also highlights the importance of strategically allocating resources or purchasing using evidence to facilitate better access to and quality of care. Healthcare can be purchased by households directly, or on their behalf by third-party purchasers such as ministries of health and insurance agencies. However, asymmetry of information in service provision markets, particularly in the face of life-threatening medical concerns, limits the ability of households to adequately discriminate among sources of supply. Hence, third-party purchasing arrangements are often used, but require coherent national purchasing policies to facilitate the attainment of UHC.

National purchasing policies should define the objectives of purchasing, the actors to be involved and their roles, the health services in the benefits package and their quality standards, and how providers are selected and reimbursed. The degree to which these decisions are aligned with broader policy goals and informed by evidence, via strategic purchasing, determines the match between health system spending and progress towards UHC.

The potential of purchasing to improve healthcare depends on the mobilization of sufficient, pre-paid, and pooled revenues to confer purchasing power on the payer. At the same time, sufficient inputs, including health workers, equipment, infrastructure, and supplies, and an adequate regulatory environment for quality, are necessary for purchasing incentives to translate to high quality services. Faced with the need to contain health expenditure growth after the dissolution of the Soviet Union, Armenia has undertaken purchasing reforms in the past and adopted complementary initiatives to mobilize revenues and improve service delivery readiness. A systematic examination of these experiences and lessons from other countries should inform the next generation of strategic purchasing reforms towards attaining UHC in Armenia. The Ministry of Health (MoH) requested technical support from the World Bank towards the development of health insurance mechanisms in Armenia. This report examines Armenia's experience in purchasing, explores complementary policies to ensure an enabling context for purchasing reforms, and develops recommendations to strengthen strategic purchasing for better health.

ARMENIAN EXPERIENCE IN HEALTH PURCHASING

We examined purchasing experience in Armenia by reviewing the relevant literature and interviewing key stakeholders involved in the allocation of financing in the health sector. We organized our findings using an adaptation of the strategic health purchasing progress framework, which has been used to examine purchasing in other contexts. This framework classifies purchasing decisions along four main dimensions, including the governance of purchasing, the healthcare goods and services that are purchased, the providers to purchase from, and provider payment and monitoring. We summarize our main findings below.



Purchasing reforms in Armenia have focused predominantly on improving efficiency and service coverage. Since the 1990s, passive line-item budgeting has been replaced with payment mechanisms that reward higher service coverage, including capitation and case-based payments. There have, however, been challenges in defining institutional roles and decision rights for purchasing in Armenia that facilitate better efficiency and quality. The State Health Agency (SHA) was established as an independent third-party purchasing agency in 1997, responsible for the allocation of the public budget to health services. However, it was brought under the MoH and lost its independent status in 2002. This decision negated the separation of financing and provision, which is necessary for objective decision-making, as the MoH has continued to be involved in service delivery.

The functions of the SHA now overlap significantly with the roles of the MoH. Furthermore, the introduction of private insurers to process claims and coordinate care for the social package has been associated with lower efficiency relative to the SHA, with reported claims ratios of 33 to 76 percent, despite oversight from the Central Bank of Armenia. Finally, the SHA's oversight over the private sector, an important segment of service delivery, is limited to services provided using state property and funded through public health financing. Complementary policy levers are needed to ensure that purchasing arrangements, whether facilitated by the SHA or another entity, ensure high-quality healthcare in both public and private delivery.

The purchasing toolbox in Armenia has been limited to contracting, claims processing and monitoring of spending patterns, with less attention paid to quality assurance and data-driven decision-making. Armenia has invested in the ArMed system that provides real–time updates on service delivery for primary, hospital, and emergency care. However, data is not systematically used to monitor the quality of care, regulate drug prescribing behavior, refine contract design, or inform revisions to the benefits package. There is a need to clearly delineate institutional responsibility for health technology assessments to inform benefit package revision and actuarial costing of health services. There is also no clear institutional responsibility for ensuring that clinical standards are updated, that their technical quality is ensured, and that these standards are used in contracting. Purchasing has therefore not been fully leveraged to incentivize better quality of service delivery.

The design of the initial basic benefits package (BBP) was informed by population health needs and value for money, but subsequent modifications have been driven primarily by political considerations. There is a need for regulations that specify an official process for revising the benefits package, that prioritizes changing health care needs, value for money, and stakeholder engagement. To this end, Armenia can draw on the clear and systematic process that has been successfully implemented for updating the essential medicines list. The current financing gap for the BBP also generates a strong incentive for providers to demand informal payments from service users, which contributes to financial access barriers.

Contracting of health care providers needs to better incorporate conditions regarding meeting clinical standards, provider competency, and local needs, to improve the quality of care. However, the spatial monopolies created by the Semashko model limit opportunities to selectively contract by excluding poorly performing providers. Medicines are also procured inefficiently and are not guaranteed to be of high quality, due to an overemphasis on minimizing costs under decentralized procurement of medicines by facilities. Local facilities often do not have capacity to negotiate prices or define accurate technical specifications.

THE CONTEXT FOR PURCHASING REFORMS IN ARMENIA

The political, fiscal, and health system context has implications for the design and effectiveness of purchasing reforms to address the above bottlenecks. Renewed political commitment to improving governance and building human capital, following the Velvet Revolution, has presented a window of opportunity to push through relevant health system reforms. However, the COVID-19 pandemic has shifted the political agenda dramatically towards policies that control the spread of the virus, strengthen the health system response, protect household welfare, and support business growth. In addition, due to the COVID-19 pandemic, the economy is projected to contract by 2.8 percent in 2020, rebounding to 4.9 percent growth by 2021. Therefore, the opportunity to advance significant health reforms will be constrained by available public spending and be facilitated where these reforms are linked to the pandemic response. Disciplined spending since the fiscal consolidation effort was launched in 2017 offers prospects for stable allocations across sectors in the medium term. Armenia has also increased fiscal space for public spending significantly over the past two decades through higher tax revenues. However, a large informal sector and a shrinking labor force will limit the feasible options for raising revenue to finance reforms in the short-to-medium term.

The low level of public financing and fragmentation of risk pools limit purchasing power in the public sector, and the potential for purchasing reforms to improve equity and efficiency. Financing from pre-paid public sources is 16.5 percent of current health spending compared to an average of 77 percent in the region. Investing in health is not prioritized in the state budget despite the high absorption capacity within the sector of above 95 percent. There is

some potential to improve the efficiency of public health spending. For example, assessments by the World Bank indicate that improvements in the efficiency of public health spending could yield per capita savings of up to USD 7.24. Efficiency gaps result in part from price variation in decentralized procurement in the health sector and challenges in optimizing the supply of health services in Yerevan. Fragmentation of financial flows in the health sector also contributes to inefficiency. Public health financing is pooled in the SHA but flows to multiple private insurers for a subset of public sector employees, duplicating administrative costs and decreasing efficiency. There are expenditures caps on different groups, limiting opportunities to improve equity in financing. Finally, multiple employer-subsidized schemes create separate pools of voluntary contributions. Health spending is financed mostly through OOP rather than pooled resources.

Ensuring service delivery readiness, including an adequate supply of inputs and compliance with appropriate clinical guidelines, is a precondition to implementing quality assurance through purchasing in Armenia. Since the 1990s, Armenia has invested in optimizing service delivery. However, there is an undersupply of skilled health workers as a result of emigration due to non-competitive wages. The density of health workers in Yerevan far exceeds the supply in the underserved Marzes. A strong regulatory environment is particularly important in Armenia given the role of private providers in service delivery and high OOP spending, which may not be significantly influenced by the SHA. There is a need to better regulate market entry via licensing of physicians, and to ensure provider competence via enforcement of regulations on continuous education of health workers. Governance of the quality of care in Armenia would also benefit from consolidated information on the state of infrastructure and equipment in health facilities, routine monitoring of the quality of the guidelines, and the adherence of providers to these standards.

GLOBAL LESSONS IN STRATEGIC PURCHASING

We reviewed lessons from countries that have a similar political history or faced the same macro-fiscal constraints when implementing purchasing reforms. The review focused on solutions to the bottlenecks in purchasing in Armenia. Below, we summarize the main lessons for governance of purchasing, defining goods and services to purchase, selecting providers, implementing payment mechanisms, and monitoring provider performance.

Regarding the **governance of purchasing**, strategic purchasing requires clear objectives, coordination among key actors, transparent decision rights, and the use of health information systems to support decision-making. Armenia has hitherto faced challenges in reflecting purchasing objectives in policy documents, ensuring a clear separation of roles between the SHA, MoH, and private insurers, and drawing on the ArMed system to inform purchasing decisions. Hence, critical lessons for the governance of purchasing include the following:

- As the transition to strategic purchasing is often incremental, countries should have mechanisms to review and update their objectives as the challenges in the health system evolve.

- Institutional arrangements should be established through legal documents and should be appropriately designed to prevent the capture of the decision-making space by influential actors.

- For small countries, there are no strong arguments in favor of more than one purchasing agency. Centralizing purchasing capacity within one single entity will prevent fragmentation of the small pool of funds, allow the country to build a critical mass of technical expertise, and spread the fixed cost of operating the purchasing agency over the whole population.

- Collecting, analyzing, and using data to inform purchasing is what makes purchasing strategic. Purchasing agencies should use the very rich datasets generated by their digitalized payment systems to identify opportunities to improve service content, change prescribing practices, and manage the health system inventory.

Regarding the **goods and services that are purchased**, strategic purchasing requires a comprehensive understanding of decisions by actors in the health system and their implications for optimal resource allocation, as some of these decisions may be influenced through contracting, the payment mix, and benefits package design. Armenia faces key challenges, including the need for a systematic process for reviewing the benefits package to reflect changing health needs, developing the capacity to cost the service package, and developing and implementing regulations for quality that can inform contracts with service providers. Essential lessons from global experience for optimizing the coverage and quality of healthcare goods and services that are purchased include the following:

- The process for reviewing benefits should draw on the evidence of effectiveness, cost-effectiveness, disease burden, and other objective criteria. A clear benefits package is also a mechanism for controlling expenditure growth in the health sector.

- The focus of actuarial costing should shift to the use of pricing in establishing provider payment rates that encourage desired behaviors. Costing exercises should be used as a productive entry point for policy dialogue rather than solely for highlighting the difference between actual and optimal resource levels.

- Compliance with clinical guidelines to improve the quality of care can be increased through training of clinicians, developing a system for regularly updating and disseminating clinical guidelines, monitoring of provider compliance, and implementing a reward or sanction system.

- Traditionally, gatekeeping by primary care is instituted in clinical guidelines when there is overutilization of specialized care for ambulatory-care-sensitive conditions. Gatekeeping reforms are often sophisticated, with mixed results, and the difficulty of introducing these changes must be carefully weighed against the potential benefits.

Regarding the **selection of providers**, since the 1990s, health sectors in developing countries have changed in line with broader societal shifts in favor of liberalism and privatization. However, the public sector also continues to provide preventive healthcare and curative care for acute illnesses. Armenia faces key challenges in terms of defining regulations for selective contracting that do not exacerbate gaps in access to care in segmented health markets while improving incentives for high quality service provision. Below are lessons on ensuring the selection of competent providers of healthcare through strategic purchasing:

- The purchasing agency can signal what is valuable from the perspective of the society by rewarding high-performing facilities, sanctioning those creating hazards, and ensuring coherence in service delivery.

- The routine collection and use of information on performance in both the public and private sector across services within the benefits package is a precondition for selective contracting.

- The exclusion of providers below required standards promotes a better quality of healthcare. It requires clear decision-making rules, including legitimate authority, independent review, and the right of providers to appeal.

- In contexts where there are spatial monopolies and access barriers are created by provider exclusion, countries may resort to introducing financial incentives for potential new entrants into the market, facilitating changes in management of public sector facilities, and benchmarking of provider performance to provide incentive for better healthcare.

Regarding **provider payment and monitoring**, the purchaser often has incomplete information about provider performance, the clinical outcomes of service delivery, and the role of external factors. Hence, strategic purchasing requires designing the contract that aligns the provider with the objectives of the principal and monitoring compliance within reasonable costs. In Armenia, reporting via ArMed primarily focuses on prevention of fraud and monitoring coverage levels. However, payment and monitoring mechanisms do not incentivize high-quality service delivery. Critical lessons on provider payment and monitoring from global experience include the following:

- The main technical challenge is identifying the right mix of payment mechanisms as individual methods have positive and negative effects.

- Starting with a simple payment model, piloting new proposals, and adding complexity over time will allow the supporting systems to develop the capacity to handle more sophisticated mechanisms.

- To incentivize high-quality healthcare for NCDs, countries have adopted add-on payments that reward improved provider coordination and population-based payments that allow groups of primary and specialist providers to retain all or part of their savings if they meet quality criteria.

- Monitoring and refining payment mechanisms are conditional on data collection, management, and analysis by the purchaser. In many countries, routine data is still underused for updating the payment formula. Monitoring, benchmarking, and publishing provider performance can provide non-monetary incentives to improve service delivery.

Regarding the **context,** the success of purchasing reforms is often dependent on factors that may be beyond the remit of the purchaser, including provider autonomy, risk pooling, and the sufficiency and flow of financial resources in the health system. These factors influence purchasing power and service delivery readiness. A significant constraint to strategic purchasing in the Armenian health system is the low level of public health financing. Below are lessons on policies that are compatible with attaining UHC:

- Purchasing reforms can only improve service delivery if providers can respond to incentives and regulations by changing their behavior or restructuring their operations.

- Higher-level hospitals will need more autonomy than smaller facilities that provide primary care. Facility managers may need training in personnel management, procurement, administration, accounting, or reporting.

- It is easier to influence providers if resources are pooled, managed by a limited number of purchasers, and send non-conflicting signals to providers. Where multiple pools exist, interactions across schemes should be monitored. Achieving equity with multiple funds requires complex risk equalization mechanisms.

- Effective mechanisms for raising revenues must include both subsidization and compulsion, as population coverage is limited in voluntary schemes due to adverse selection, and eliminating subsidies excludes poor and vulnerable groups that cannot afford health insurance.

- Health authorities should remain focused on the total levels of public spending on health. General revenue allocations can be reduced to compensate for earmarking. Also, advocating for shares of public financing for health has not been an effective strategy for expanding fiscal space.

TOWARDS STRATEGIC PURCHASING IN ARMENIA

This assessment demonstrates that suboptimal purchasing arrangements contribute to the challenges in accessing high-quality health care in Armenia. Overlapping institutional roles, political capture, and the difficulties in engaging stakeholders have prevented effective and responsive governance of public health financing allocations, to address health system challenges. Furthermore, while the first BBP addressed the prevalent healthcare needs, revisions have not reflected the changing burden of disease and are driven by political interests. In addition, challenges with costing benefits and setting appropriate tariffs have contributed to informal payments for health care, increases in OOP spending, and financial barriers to access. Moreover, the ArMed e-health system has supported monitoring of fraud and service outputs by the SHA, but has not been leveraged to monitor prescription practices, referral behavior, and the content of care. Also, provider payment and selection procedures do not reward high-quality service delivery. Therefore, purchasing reforms will be imperative to advancing the UHC agenda in Armenia.

Akin to the purchasing reforms after the dissolution of the Soviet Union, aimed at improving efficiency, Armenia has turned to purchasing to facilitate the health system response to COVID-19. Faced with a rising incidence of COVID-19 cases and the need to mobilize surge capacity for case management in the health system, purchasing arrangements have been adapted. The scope of services covered through contracts with providers was expanded to include COVID-19 tests, case management, and telemedicine. Payment incentives were introduced to mobilize intensive care beds at the hospital level and relevant indicators on provider performance were added to the ArMed e-health system. Given the central role of strong health systems in the COVID-19 response, to detect and manage COVID-19 cases, and ensure continuity of essential services through the pandemic, the implementation of feasible reforms in health financing and service delivery continue to be urgent and salient.

We conclude this report with recommendations to strengthen strategic purchasing to improve access to high-quality healthcare in Armenia. We also consider complementary reforms that will be needed to strengthen provider autonomy, improve service delivery readiness, and ensure sufficient pre-paid and pooled financial flows to increase purchasing power. In proposing these reforms, we identify actions that are feasible in the short-term, within two years, given the ongoing COVID-19 pandemic, political priorities, and budgetary constraints. The proposed reforms may provide a foundation for further actions in the medium-to-long term to fundamentally reform the governance and implementation of purchasing in Armenia.

SHORT-TERM REFORMS TO LAY A FOUNDATION FOR ENHANCED STRATEGIC PURCHASING

- **Recommendation 1:** The Government should redefine the legal status for the SHA, ensuring that it is independent from the MoH, with clear decision rights and external oversight to promote accountability for results. The role of private insurers should be restricted to the coverage of health services outside the BBP to increase the purchasing power of the SHA.

- **Recommendation 2:** The MoH and SHA should develop and implement an annual strategy for quality-based purchasing, through defining indicators for priority health conditions, periodic monitoring of provider performance on said indicators, publication of comparative provider performance, and rewarding improvements in the quality and integration of healthcare.

- **Recommendation 3**: The MoH and SHA should pilot and periodically review an operations dashboard to facilitate the use of evidence in stakeholder negotiations over purchasing decisions.

MEDIUM- TO LONG-TERM REFORMS TO EXPAND THE SCOPE OF STRATEGIC PURCHASING

- **Recommendation 4:** The Governmental decision on the proposed UHC reforms should be informed by the potential effectiveness of these reforms to reduce out-of-pocket payments, improve the quality of care, and expand the coverage of essential services for NCD prevention and control.

- **Recommendation 5:** The MoH and SHA should design and implement selective contracting of competent healthcare providers, financial incentives for market entry of new players, or changes in the management of health facilities depending on the degree of segmentation in the service delivery market and facility ownership.

- **Recommendation 6:** Given the quality and efficiency gaps in decentralized procurement of medical supplies, the MoH should scale up centralized procurement and framework contracts, while building capacity for procurement coordination, planning, and execution at the facility level in the long-term.

MEDIUM- TO LONG-TERM REFORMS TO STRENGTHEN THE PRECONDITIONS FOR STRATEGIC PURCHASING

- **Recommendation 7:** To alleviate financial barriers to accessing health care, Armenia needs to mobilize pre-paid and pooled health financing to fund an expanded benefits package that is revised through a transparent, inclusive, and systematic legal process, and aims to cover essential health services and outpatient medicines for prevalent diseases for the entire population.

- **Recommendation 8:** To increase service delivery readiness for healthcare, the MoH should enforce appropriate regulatory standards for infrastructure, human resource for health, and clinical interactions, including provider licensing, service delivery network planning, and the development of clinical pathways for prevalent diseases.

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