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PAPER

Health Care and Compulsory Medical Insurance in Armenia: Problems and Prospects

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Abstract Armenia is a developing country with a lower-middle-income economy. Economic growth of the country depends by more than 50% on human capital. Human capital is a fundamental factor for the progressive economic development. Health care and education are the most important components influencing human capital.

This article is focused on health care in Armenia, on problems and prospects of the implementation of the system of compulsory medical insurance in Armenia. It analyzes and shows the optimal way to implement the compulsory medical insurance, in such a lower-middle-income economy as Armenia.

Keywords Medical insurance - Compulsory medical insurance - Health care

JEL Classification I13

Introduction

Despite incredible improvements in health since 1920 and modern medical technology in the 21st century millions die from easily preventable diseases, there are millions of sick people who cannot be cured, because they have no resources for that or do not do general medical examination. A lot of people lack access to health care systems. 56 million people died worldwide in 2012[1], 36 million deaths are caused by non communicable diseases, such as cardiovascular disease (17 million deaths), cancer (7.6 million deaths), chronic lung diseases (4.2 million deaths) and diabetes (1.3 million deaths). This is almost two-thirds of the total estimated number of deaths worldwide. A quarter of these take place before the age of 60. Over 7.5 million children under the age of 5 die from malnutrition and mostly preventable diseases each year. Tuberculosis kills 1.3 million people each year[2] with 9.4 million new cases a year. 1.6 million people still die from pneumococcal diseases every year (more than a half of the victims are children). Malaria causes some 225 million acute illnesses and over 780,000 deaths annually.[3] The urgency of the mentioned problem cannot be refuted. The quantity of deaths per 1000 people in 2014 in Armenia[4] increased by 15% as compared with the year 2000, 65% of them died from easily preventable diseases. Life expectancy at birth in Armenia for women was

1 http://www.who.int - World Health Organization
2 "Tuberculosis" WHO Global Tuberculosis Report 2013
3 http://www.globalissues.org
4 http://armstat.am - National Statistical Service of RA (http://www.armstat.am/file/doc/99493598.pdf)

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75 years in 2012, one year higher than in 2000, and for men it was 67 years, one year lower than in 2000 according to the World Health Organization. According to the World Bank assessment of the economies of 192 countries, economic growth depends on human capital in amount of 64%, natural capital in amount of 20%, physical capital in amount of 16%. Having a healthy and productive population, especially for such low-middle income country like Armenia with low natural capital, human capital is fundamental factor for the progressive economic development. Health care and education are the most important components influencing human capital.

This article will focus on health care in Armenia, on problems and prospects of the implementation of the system of compulsory medical insurance in Armenia. The main aim is to show the optimal way to implement the compulsory medical insurance in such a lower-middle-income economy as Armenia.

Implementation of the System of Compulsory Medical Insurance in RA.

According to the Constitution of the Republic of Armenia it is ***a sovereign, democratic, social state governed by rule of law.***[5] The main mission of the social state is the achievement of public progress based on the principles of social equality consolidated by the right, general solidarity and cross liability. The social state is urged to help the weak part of its population, to influence distribution of economic goods proceeding from the concept of justice to provide everyone with aworthy existence. Human capital is a fundamental factor for the progressive economic development of Armenia which can be increased by investing in health care, education and job training. The number f deaths in 2014 in Armenia[6] increased by 15% as compared with the year 2000[7], 65% of them died from easily preventable diseases which show the weakness of our health sector. The leading causes of deaths are listed below (Table 1).

Table 1 The leading causes of death in Armenia in 2014

	January-December 2014 (pers.)
Number of deaths including deaths of:	27 700
Cardiovascular Disease	13 329
Accidents, unintentional Poisoning and Injuries	1 296
Malignancies	5 700
Respiratory System Diseases	1 724
Diseases of the Digestive System	1 200
Infectious and Parasitic Disease Deaths	300
other Diseases	4 151

Registered health care visits increased by 34% in 2014 compared with the year 2013. 66% of them are children up to 14 years.

Main cases:

- Influenza 93% (63% are 0-14 years old children)
- Gastrointestinal diseases 5% (4% of 0-14 years old)
- Syphilis is about 1% of adults

Here are negative trends of socio-demographic and health indicators in Armenia in terms of socio-political change: birth rate and natural growth rate decline, life expectancy at birth remained the same (71 years, both sexes) compared with the year 2000, a steady increase in the

5 The Republic of Armenia is a sovereign, democratic, social state governed by rule of law.

6 http://armstat.am - National Statistical Service of RA

7 http://www.armstat.am/file/doc/650.pdf

overall mortality rate due to the increase of socially significant causes of death, in particular, the number of cardiovascular diseases, malignancies, diabetes, respiratory system diseases, diseases of the digestive system, etc., increased the number of the registered diseases with the diagnosis set for the first time (increased by 113% in 2012 since 2001 per 100,000 population, particularly the number of sick people with all the types of diseases increased).

Steps of development of the health system in Armenian

- the collapse of the Soviet health system, providing the population with affordable and free medical care;
- The rapid commercialization of the health care system in the Armenian market conditions and a growing number of private clinics, which increases the share of private funding in the health care system (Number of medical institutions rendering out-patient and dispensary aid to population increased by 12% comparing to 2001, Number of antenatal clinics, children's polyclinics and number of institutions with antenatal clinics and children's policlinics increased by 7% compared to 1997 and decreased by 4 compared to 2001, the number of hospitals decreased by 29% comparing to 1997,
- Provision of health services on a fee basis by many government clinics.
- Inequalities in access to health services;
- Change true stratification of the population, based on today is not the social background, and income level;

Reasons for not receiving the necessary treatment in Armenia

- Unavailability;
- Lack of information;
- Mistrust in relation to providers of medical services;
- Mentality, "A peasant needs thunder to cross himself and wonder."

The process of the healthcare system reform in the newly formed states, including the Republic of Armenia, began after the collapse of the USSR. The most important document and basis for changes was "The development and reform Program of health care in Armenia" (approved by the Government in 1997), the main directions of which became: a) implementation of compulsory medical insurance of citizens of the republic; b) development of primary medico-public assistance; c) improvement of quality of the provided medical services; d) development of various patterns of ownership in health sector. In 1997-1999 attempts were made to implement the compulsory medical insurance of citizens, but they did not find sufficient support in the Parliament due to concerns that the government does not have sufficient funds to maintain health insurance.

Instead, some reforms were made, caused mainly by changes in governance mechanisms and sector financing: decentralization of management, unitsipalizatsiya (and further privatization) the main part of medical institutions, the introduction of multi-channel and multi-structured financial system management, implementation of targeted programs for financing. Some structural changes were also carried out: the creation of regional health authorities, a number of changes in medical education (introduction of a new system of postgraduate training of health care managers, physicians and nurses).

Eventually the following reforms were carried out:

- Financing of maternal healthcare services, of treatment and prevention of diseases for children up to 7 years, of the treatment of certain diseases (infectious diseases, cancer, and others.), A number of urgent treatment of diseases and conditions within the framework of the so-called "state order";
- The Government finances certain social groups (persons with disabilities, persons with high score insecurity receive poverty benefits, etc.)

- Free primary health care in Armenia since January 1, 2006.
- Implementation of the principle of a co-payment for the persons which do not enter the above national groups since February 1, 2011 which means that the part of the expenses on treatment cares the patient himself.

Reform Results:

- Increase of system work productivity;
- Reducing a shadow health care (in form of the gratitude money);
- Some increase in availability of medical care;
- They do not promote reducing of direct expenses of the population therefore decrease the level of financial security of the population.

Real development of voluntary health insurance started in 2005. Insurance companies sign contracts with corporate clients mostly. 1.3% of the population (some with family members) had voluntary health insurance with different coverage, most of which was financed by employers in 2013. 90% of them were insured against accidents in 2013. 63% of that insurance premium was paid as insurance indemnity. There are some nuances in that market. Insurance companies do not trust the insured persons because they know the mentality of the population of Armenia who does not have a culture of care of their health. Furthermore the population does not have extra money to spend on "some promise about help". Poverty according to official statistics is 32% with the calculation of the minimum wage and about 60% with the calculation of the consumer basket.[8]

The analysis of health system reforms in different countries, including the countries of Central and Eastern Europe and CIS countries, suggests the possibility of selecting one of the two alternatives of health care reform: the first is to improve the existing model, the second is to switch to a fundamentally different model.

We partially understand the existing health system model in Armenia. Private health expenses are higher than public expenses. There is voluntary health insurance, but this service is suitable for corporate clients but not for individuals. The prices for healthcare services increase annually. The incomes of the population decrease or remain unchanged. A lot of people do not do general medical examination because they do not have money for expensive medical services and there is a lack of trust to cheap and free medical services. As we saw the causes of deaths are preventable diseases mostly, which could be cured if a person made general medical examination every year and started the treatment in time. So, where is the solution of the problem? How to make people trust the health system and how to acculturate caring of your health, how to make most services available for the majority of people? Worldwide there are the following forms of medical care, sometimes complementing each other:

- Private medicine;
- Voluntary health insurance;
- Compulsory health insurance;
- (National) Public health system.

For choosing the required form for Armenia, we have to understand advantages and disadvantages of each, which are listed below (Table 2).

The effective healthcare is formed with a combination of compulsory and voluntary medical insurance.

8 Sandoyan, E. M. and Avetisyan, A. G. The problem of poverty reduction in the context of the formation of long-term financial resources in Armenia (p. 187-188). VIII International Conference Kondratievskaya "Cyclical global processes, Kondratieff cycles and long-term vision of development of Russian and world peace", International Fund for ND Kondrateva.- M: IFC, 2012. ISBN978-5-8211-0605-6.

Table 2 Advantages and disadvantages of different types of Medicare system

	Advantages	Disadvantages
Public health system	Full coverage of the population Control of the prices of medical services Guarantee of free provision of the minimum amount of medical services	The monopolization of health care Ability to ignore the rights of patients Lack of opportunities to choose a doctor and hospital
Insurance Medicine	Possibility to choose a doctor Possibility to choose a medical institution Optimal distribution of financial resources Availability to have insurance policies through participation of employers or funds of social security Possibility of free granting medicine	Medical services depends on conditions of the policy Existence of exceptions on insurance coverage Possibility of financial frauds
Private medicine	Rationing of medical expenses Possibility to choose a doctor and a medical institution	Commercialization of health care Lack of professional control over the volume and quality of services

However, taking into consideration the population social status, the already high taxation of medium business, I consider necessary to offer the following changes in health system:

1) Financing

The main source of financing of the health system in Armenia is the private sector. Total expenditure on health in 2012 was 4.4% of GDP where 2.6% is private expenditure and 1.8% public expenditure, less than in European countries. However, for the proper functioning of Medicine WHO recommends the minimum required value of the public health expenditures by 6.8% of GDP for developed countries and not less than 5% of GDP for developing countries. Thereby preliminary it is offered to raise public health expenditures to 4-5% of GDP.

2) Payment mechanism

That means a mechanism of paying to doctors and medical organizations for the provided medical care. The suggested scheme is introduced in Structure 1. It needed to open an autonomous body in an insurance company to practice medical insurance, to involve specialists (physicians) that supervise the volume and quality of provided services.

In this case everybody would have a Compulsory Medical Insurance policy which would cover:

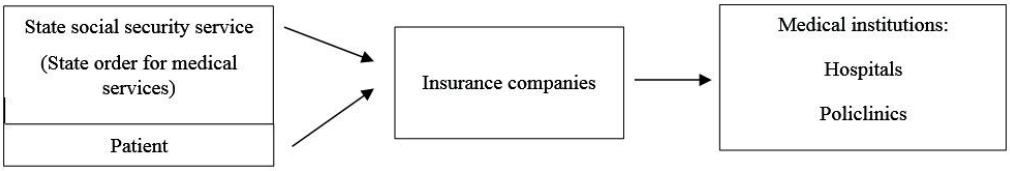
- Annual general medical examination
- Ambulance and emergency medical service
- Stationary medical care
- Medicines
- Pregnancy

The process would be the following: if the insured has health problems he calls the insurance company, the company starts the treatment process organization and supervision. After providing medical services to patients the hospital gives the bill for payment to the insurance company, and if it is a state order or a voluntary health insurance, the insurance company pays for the patient and takes money from the relevant authority. Medical institutions are interested in granting qualitative medical services, however this is not realistic in case the state or the patient pays to medical institutions directly as they have no opportunity to trace and supervise the process, volume and quality of the provided services. As a result of this the medical institutions which are much more qualified receive much more financial flows and thus the health care develops and improves, the newest medical equipments are received, and the quality of medical services get

better, the wellbeing of the population increases.

After healthcare acculturating, people may have voluntary medical insurance and the structure will develop better.

Figure 1 Treatment payment mechanism



Conclusion

The effective healthcare is formed with a combination of compulsory and voluntary medical insurance. We can see the following outcomes of that reform.

Positive results are:

- Full coverage of the population
- Increase of annual general medical examination visits
- Discovery and treatment of preventable diseases in time
- Optimal distribution of financial resources
- Professional control over the volume and quality of provided medical services
- Fixed price list of medical services
- Financial flows in a high qualified medical institutions
- Medicine development + new equipment, etc.
- Quality growth of medical services
- Reducing a shadow health care (in form of the gratitude money)
- Possibility to choose a medical institution
- Clear access to medical services
- Health care culture

Negative Results:

- Medical services depend on conditions of the policy
- A limited list of covered diseases
- Exceptions in the voluntary insurance policy
- Giving privilege to several medical institutions from the side of insurance companies
- The risk of making a business on this structure (e.g. both the insurance company and the medical institution belong to the same person)

Implementation problems:

- Absence of cooperation practice between governmental authorities and the private sector
- Absence of trust towards the financial and medical institutions
- Lack of insurance culture and health care culture
- Lack of money to get an insure policy voluntarily.

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