AMERICAN UNIVERSITY OF ARMENIA

ՀԱՅԱՍՏԱՆԻ ԱՄԵՐԻԿՅԱՆ ՀԱՄԱԼՍԱՐԱՆ

LL.M. Program

ԻՐԱՎԱԳԻՏՈՒԹՅԱՆ ՄԱԳԻՍՏՐՈՍԻ ԾՐԱԳԻՐ

TITLE

Health Insurance Implementation in Armenia: Issues and Perspectives of the Regulation

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NUMBER OF WORDS

11133

YEREVAN

2019

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List of Abbreviations

UN	United Nations
WHO	World Health Organization
UHC	Universal Health Coverage
SHA	State Health Agency
BBP	Basic Benefit Package

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"Health is a human right. No one should get sick and die just because they are poor, or because they cannot access the health services they need."

Dr. Tedros Adhanom Ghebreyesus
Director-General WHO

INTRODUCTION

The right to the highest attainable standard of health is a human right recognized in international human rights law.[1] The International Covenant on Economic, Social and Cultural Rights, Article 12 states, *"the States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"*. Moreover, the same Article recognizes the following: "*The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness"*. [2]

During the Soviet Union, the healthcare system in Armenia was highly centralized providing the population free healthcare aid, regardless of their social status. However, in 1991, when Armenia got independence, it faced economic, social and political problems, which entailed to the enormous tension in the healthcare system. Armenia was unable to fund the system, and the consequence was the application of the reforms[3]. Two major decisions were the formation of the State Health Agency and the Social Benefit Package. Although these new approaches were led to improve the wellbeing of people and act as financing mechanisms for primary healthcare treatment, out-of-pocket payment has been the main source of financing the system overall. The reason was and continues to be that those new policies were designed for a specific group of people.

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[1] The Right to Health, Fact Sheet No. 31, Office of the United Nations High Commissioner for Human Rights, World Health Organization, page 9, https://www.ohchr.org/Documents/Publications/Factsheet31.pdf (retrieved 11 February 2019)

[2] International Covenant on Economic, Social and Cultural Rights, Article 12, https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx (retrieved 11 February 2019)

[3] See, *Health care system in Armenia*, available at https://www.ap-companies.com/services/ekspatam/armenia/ (retrieved 11 February 2019)

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Since the independence of the country, 28 years have been passed, but still, the Armenian Government could not meet any constructive solution to the problem for reducing the private payments in the country. Even though the Constitution of Armenia enshrines the right to healthcare, where *"everyone shall, in accordance with law, have the right to healthcare".*[4] In Armenia, voluntary health insurance exists through the exercise of private insurance organizations. However, it does not cover the sensible part of the population due to its high premiums. Last changes that were made were to include private insurance companies for implementing the payments of those employees that are involved in the Social Benefit Package. Nonetheless, the money provided by for the package cannot fully satisfy the needs of people. On the other hand, the State Health Agency is acting more like a financial institution, who monitors the payment to medical institutions rather the one to tackle the real issues in healthcare and promote the effectiveness through necessary reforms.

In addition, conferences took place and declarations were made, which attached the issue of Healthcare. One of the significant conferences was the International Conference on Primary Healthcare, resulting in the Declaration of Alma-Ata[5]. The Declaration reaffirmed the important role of healthcare addressing *"the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly"*[6]. Furthermore, the Declaration puts the responsibility on the Governments *"for the health of their people, which can be fulfilled only by the provision of adequate health and social measures"*[7]. Forty years later, in October 2018, *Global Conference on Primary Healthcare* has been organized in Astana, Kazakhstan with the aim of universal health coverage and the Sustainable Development Goals. This time, Armenia also participated and together with other participating States and Governments made the new Declaration in pursuit of Health and affirmed its commitment to the multisectoral and sustainable healthcare. [8]

Nowadays, the new Government is working on the policy of implementation the compulsory health insurance in Armenia. In order to ensure extent healthcare access to its

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[4] Constitution of RA, 06 December 2015, Article 85, http://www.president.am/en/constitution-2015/ (retrieved 11 February 2019)
[5] Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, September, 1978, https://www.who.int/publications/almaata_declaration_en.pdf (retrieved 11 February 2019)
[6] Declaration of Alma-Ata, Article 7.2.
[7] Declaration of Alma-Ata, Article 5.
[8] "Armenia's acting healthcare minister visits Astana to attend Global Conference on Primary Health Care", www.armenpress.am, https://armenpress.am/eng/news/952049.html (retrieved 11 February 2019)

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citizens according to the international demands that Armenia committed to, mandatory health insurance will serve as the merely reasonable solution. [9] And this will amount to immense reforms in this system. Thus, the aim of this Paper is to analyze the issues and recommend what the regulation for compulsory health insurance in Armenia shall be consisted of. The freshness of the subject and its high importance for promoting better healthcare in Armenia served as incentives to write this Paper within the legal scope of the topic.

For the sake of the effectiveness of the Paper, it was important to cite the international practice, guidelines, and legislations together with the Armenian regulations in the applicable field. The Armenian Government decisions were examined,[10] as well as the legal acts of the Netherlands, Canada and Estonia were explored.[11]

Within the used literature, it is notable the work of Hussey and Anderson on *"A comparison of single-payer and multi-payer health insurance systems and options for reform"*. Many countries confront the choice between single-payer and multi-payer health insurance systems. This Article illustrates through comparison single-payer and multi-payer models *"in the areas of revenue collection, risk pooling, purchasing, and social solidarity"*. Both systems have their own advantages and the governments' priorities usually comply with either of these models.[12] It is noteworthy another Article by Petrou, Samoutis, and Lionis titled *"Single-payer or a multi-payer health system: a systemic literature review"*. The paper indicates the impact of the two aforementioned systems within the context of equity, efficiency, and quality of healthcare, budgeting health expenditure, and social solidarity. [13]

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[9] See, Nader Ghobi, *Right to Health or the Human Right of Access to Essential Healthcare,* Vol. 3, No. 6, June 2013, p. 532, available at https://www.academia.edu/7460706/Right_to_Health_or_the_Human_Right_of_Access_to_Essential_Healthcare (retrieved on 12 March 2019)

[10] Decision of the RA Government No. 1301-N, 15 November 2002, ՀՀ Կառավարության Որոշում «ՀՀ Առողջապահության նախարարության պետական առողջապահական գործակալության կանոնադրությունը և կառուցվածքը»; Decision of the RA Government No. 1691-N, 27 December 2012; Decision of the RA Government No. 375-N, 27 March, 2014; Decision of the RA Government No. 915-N, 27 July 2017.

[11] *Health Insurance Act(2006), the Long-Term Care Act(2007), the Social Support Act(2015)* and *the Public Health Act(2008)* in the Netherlands; *Canada Health Act(1985) and Federal-Provincial Fiscal Arrangements Act(1986)* in Canada; *Estonian Health Insurance Fund Act(2000), Health Insurance Act(2002) and Social Tax Act(2000)* of Estonia.

[12] P. Hussey, G. F Anderson, *"A comparison of single- and multi-payer health insurance systems and option for reform",* Health Policy, Volume 66, Issue 3, December 2003.

[13] P. Petrou, G. Samoutis, C. Lionis, "*Single-payer or a multipayer health system: a systemic literature review*" , Public health, Volume No. 163, WB Saunders (1 October 2018), available at https://www.med.unic.ac.cy/wp-content/uploads/samoutis-paper.pdf

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The present Master Paper consists of an introduction, three chapters, a conclusion, and bibliography. The Introduction will illustrate the overall characteristics of the health insurance issues for the implementation and regulation in Armenia. Since the topic has a wide range of aspect to discuss, the present paper will attach the main issues deriving from the legal perspectives. Chapter 1, titled "Historical Background. Alternatives to the Health Insurance System in Armenia: Regulations" is designated to study the background of the topic. It will attach the regulations and the decisions of the Government towards the implementation of healthcare as an alternative to the insurance. The chapter will reveal the existing gaps in the Armenian legislation which might be improved through the implementation of the health insurance. Chapter 2, called "Exercising Best International Practices: Comparative study", will study the international practice of OECD member states. Namely, the experience of the Netherlands as multiple-payer system holder, Canada, as single-payer system implementer and Estonia, as the post-soviet country adopted compulsory health insurance will be examined. Last, 3rd Chapter will present the recommendations to presupposing law that might be regulated in the future. The study of the problems and the presentation of the recommendations will be grounded on the detailed surveys and analysis of the sector. The Conclusion will briefly summarize the main revelations of the research paper. At the end bibliography consisted of all sources used for the thesis will complete the paper.

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CHAPTER I

HISTORICAL BACKGROUND

Alternatives to the Health Insurance System in Armenia
Regulations

Under Soviet domination, the healthcare system in Armenia was highly centralized giving the entire population free medical assistance, regardless of social status. However, in 1991, when Armenia got independence, it faced economic, social and political problems, which entailed to the overwhelming strain in the healthcare system. Armenia was unable to fund the system, and this problem led to the elaboration of reforms[14].

Starting from the late 1990s, Armenia has made considerable success/progress in the field of healthcare system reforms. This included the introduction of the first state Basic Benefit Package(hereinafter referred as BBP) in 1998, as well as the creation of the State Health Agency(hereinafter referred to as SHA), a single buyer of services, the separation of the purchaser of the services for medical assistance, healthcare services from the functions of their providers. The reforms were expressed through ensuring the autonomy of healthcare institutions as separate economic entities, and the inclusion of financing mechanisms in the field of primary healthcare. By 1997, private payment had become the main source of financing for the healthcare system. The Government's established program allowed certain free services for the targeted group of the population. The patients within that priority group were to receive a comprehensive package of free outpatient and inpatient services. However, the fundamental problem was access to the primary healthcare for a large number of the population, because of their inability to pay[15].

The Disadvantages of the State Health Agency

The State Health Agency, as an independent semi-governmental third-party purchaser, that pools and allocates healthcare resources, was established in 1998.[16]

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[14] See, Health care system in Armenia, https://www.ap-companies.com/services/ekspatam/armenia/ (retrieved on 10 January 2019)
[15] Ibid.
[16] See, Haroutune Armenian, Byron Crape and others, *Analysis of Public Health Services in Armenia,* 2009, p. 51 available at https://aua.am/chsr/UserFiles/File/PHA_Final%20English_2010(2).pdf (retrieved on 10 January 2019)

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According to the Statute of the State Health Agency of the RA Ministry of Health:

The State Health Agency of the Ministry of Health of the Republic of Armenia is a separate subdivision of the Ministry staff who, in the cases prescribed by law and in certain cases provided by the legislation of the Republic of Armenia, provides services in the field of health, acting on behalf of the Republic of Armenia.[17]

The Statute also prescribes the goals and problems of the Agency. These are:

a) arrangement of allocation of funds for actually performed works by the medical care providers in accordance with the agreements concluded within the framework of state-guaranteed free medical care and services;

b) ensuring efficient and targeted use of financial means provided by the state budget of the Republic of Armenia for the provision of medical assistance and services through the State Order envisaged by the state healthcare programs.[18]

It carries out the signing of contracts on medical service delivery, adoption of the reports and compensation, control of quality and quantity of delivered medical services, standards of financing and economy, participation in the development and implementation of standards in the manner prescribed by the RA legislation[19].

As a state agency, SHA does not have the incentives to make profits and to reduce expenses as the insurance companies have.

It was originally planned that SHA would have a governing council structure consisting of representatives from major beneficiaries (Ministry of Labor and Social Affairs, Ministry of Finance, Yerevan Municipality and local self-governing bodies, as well as NGOs) and its chairman would be the Minister of Health.[20] However, the SHA Board was originally formed with the participation of the Head of the Agency and its Deputies. The idea of the council was subsequently completely abolished, and since 2002, the SHA has been incorporated into the structure of the Ministry of Health. These deviations from the initial SHA concept have considerably limited its autonomy as an independent procurement agency.

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[17] Decision of the RA Government No. 1301-N, Appendix I, Statute of the State Health Agency of the RA Ministry of Health, §1, Article 1, 15 November 2002.
[18] Ibid, §2, Article 7.
[19] State Health Agency, Ministry of Health of RA, http://www.moh.am/#1/92 (retrieved on 10 January 2019)
[20] ՀՀ Կառավարության Որոշում ՀՀ Առողջապահության նախարարության պետական առողջապահական գործակալության կանոնադրությունը և կառուցվածքը, 4-ադ գլուխ, կետ 9, http://www.moh.am/uploads/1301n.pdf (retrieved on 10 January 2019)

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SHA does not practically use the possibility of concluding electoral contracts. This means that it can refuse to conclude contracts with a specific medical institution or any of later's department or service for example, as a result of poor quality or low efficiency. This is one of the most powerful tools that can be used by one buyer to promote efficient, high-quality services provided by the hospital, clinic or physician.

Today, SHA acts as a payer, focusing more on the payment process for medical institutions rather than assuming a more strategic role to address some of the healthcare problems.

In short, the State Health Agency does not have enough motivation to promote the effectiveness of providing healthcare. It does not have the necessary resources to meet the current demand for healthcare, to confront the intentions of medical institutions for market dominance and rent. Also, SHA does not have tools such as concluding electoral and quality-based contracts to support abovementioned efforts.

The Concept of the Basic Benefit Package: pros and cons

The Social Package is a set of measures to ensure the health, education and other issues of employees and/or their immediate family members working in the state bodies and state non-profit organizations in the fields of education, culture, science and social protection for the purpose of motivating employees and improving their work efficiency.[21]

The goals of the Package include the compliance with social workers' needs, motivation, and increase of productivity, increasing the attractiveness of public sector work and reduction of personnel flow in the state sector.

Followed, it is provided the comparative analysis of the BBP system based on the RA Government Regulations *No. 1691-N* and *No. 375-N*.

The Benefits of BBP

The social package is non-cash money transferred to the bank at the expense of the opened social package. The sum is cumulative. The Bank is opening and servicing the social package account

[21] Decision of the RA Government No. 1691-N, Appendix I, The Order of the Provision of the Social Package, §1, Article 2(1), 27 December 2012.

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free of charge, providing the employee with a social package account reference, paying a percentage of the positive balance on the account according to the signed contract.

BBP is available for the immediate family members, i.e. the spouse and up to 27-year-old children. It is possible to cash out the sum from the account according to the following circumstances:

- when the employee is no longer employed and he has the right to receive a pension;
- in case of inheritance, the assets of the Social Package Account shall be inherited in accordance with law;
- compensation for social payments made in accordance with Article 9 (10) of the Law of the Republic of Armenia "On Accumulative Pensions", through the balance on the Social Package Account as of January 1 of the current year, but not more than salary and business income from the previous year.

BBP provides services not only for the healthcare but also for the education fee, for leisure support in Armenia and in the Artsakh Republic and for the monthly repayment of the mortgage loan.

According to the Law, it is mandatory to pass once a year a compulsory preventive medical examination. The package of this examination includes ambulatory medical assistance and the medical services, like general practitioner physicians' counseling, mandatory measurement of pulse pressure and body mass determination, consultation of urologist (in case of absence of a surgeon) for men, consultation of gynecologist for women, physical examination of mammary glands for women, etc.[22] BBP covers several medical services provided by the secondary healthcare institutions-hospitals. The list of the hospital services is prescribed in the Government Decision No. 915-N.[23]

The Disadvantages of BBP

The Package is available only for a limited number of beneficiaries working in the fields specified by law, which are already aforementioned. This means that the rest of the population either may apply to the private insurance companies or through self-funding. The surveys have

[22] Decision of the RA Government No. 375-N, Appendix II, §4, Package of the free of charge compulsory medical preventive examination for the beneficiaries of social package guaranteed by the State, Article 9, 27 March, 2014.
[23] Decision of the RA Government No. 915-N, Appendix II, §3, Article 5, 27 July 2017.

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shown that around 85% of the population takes care of the medical expenses through self-funded measures, whereas the state-funded over 14% from the budget, which constitutes 1,3% of the Armenian GDP.[24] The monthly sum of the BBP for full-time employment is 6000 Armenian Drams.[25]

The list of the consumers does not include those included in the reserves, persons who have been working in the organization for less than six months in a given position, persons working in less than part-time employment, women during pregnancy and childbirth, as well as those who are on leave for childcare up to 3 years.

The right of a beneficiary to enjoy free and privileged medical care and services guaranteed by the state arises six months after the date of first employment of the beneficiary. The same time period exercises if one changes his or her employment place into another one.

During the calendar year (from January 1 to December 31) a beneficiary may receive a preventive medical examination free of charge within the social package only once a year. Moreover, if the beneficiary has passed the preventive medical examination in the second half of the year, the next one may be passed no sooner than six months later.[26]

BBP does not cover the surgery, supply of medicaments, the prosthetics of the extremities, maternity care, the diseases like congenital anomalies, sugar diabetes, connective tissue systemic diseases, etc.

The inclusion of private insurance companies for the implementation of BBP

From October 2017, the Government of Armenia has introduced the mechanism for implementing the Basic Benefit Package of Medical Services Beneficiaries (ie some public servants and other categories of workers) through private insurance companies[27]. Under this new mechanism, the Ministry of Health of RA unites the risks, while insurance companies operate as third-party administrators for the purpose of buying services. The third-party administrators pay to a number of healthcare providers selected by the Ministry of Health for their applications

[24] Panel discussion, *"Towards Universal Health Coverage: Introduction of Social Health Insurance in Armenia"*, organized by Turpenjian School of Public Health, AUA, available at https://newsroom.aua.am/2019/02/20/towards-universal-health-coverage-introduction-of-social-health-insurance-in-armenia/ (retrieved on 21 April 2019)

[25] See, official wevpage of the Ministry of Labor and Social affairs available at http://www.mlsa.am/?page_id=2835 (retrieved on 15 February 2019)

[26] Ibid, Article 5.3.

[27] Press Release of the Minister of Health of RA, 01.23.2018, retrieved 11 February 2019, <https://www.youtube.com/watch?v=BKgtxQHj0YI>

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provided and fulfill these payments through the methods and prices set by the Ministry of Health. By investing in the third party administrators system, the Government presupposed that competition among the insurance companies would increase the access to healthcare, and create incentives to ensure the productivity of the services. However, achieving those goals in a competitive market environment is not easy, as it requires a clear outline of the legally authorized roles and responsibilities.

The Government Decision *No. 915-N* specifies the amount of money available for each employee to be transferable to the private insurance companies according to the employee's workdays as beneficiary and the special formula.[28] The beneficiary is free to choose or change the insurance company based on the quality of the service provided by and other criteria. The Ministry of Health shall confirm the agreement on cooperation signed between the private insurance company and the healthcare organization. After this confirmation, the Ministry signs the contracts with the private insurance companies that are licensed to operate in Armenia. The Ministry of Health on a monthly basis does the funding of the insurance companies for delivering insurance services.

In case when the contract stipulates non-conditional and non-reimbursable amount for the medical care and maintenance services (including medicaments, medical supplies, etc) provided to the insured person, the representative or the insured person shall be obliged to the extent of that amount payable to the appropriate institution at its own expense. Moreover, the insurer on its own initiative may pay for those services, if the insured person did not pay the amount in accordance to the non-conditional and non-reimbursable amount stipulated in the contract to the relevant institution. Thus, the insured person is obliged to pay that amount back to the insurer in the next 30 calendar days after such claim is filed by the later.[29]

To conclude, the analysis found out that the State Health Agency is no longer effective because it does not promote healthcare progress among providers. It has fewer levers to control healthcare organizations through signing electoral contracts. Moreover, the activity of SHA is more financially focused rather than the quality of hospital-level services. And it does not represent the interest of healthcare receivers.

[28] Decision of the RA Government No. 915-N, Appendix I, §2, Article 14, 27 July, 2017.
[29] Government Decision No. 915-N, Appendix III, Article 5.6 and 5.7.

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It is worth mentioning that the Basic Benefit Package is an important opportunity for beneficiaries to enjoy not only healthcare services funded by the State but also leisure, education, etc. It is welcome that the Package is open for the immediate family members and children up to 27-year-old, inclusively, if consider the existence of social problems, basically the issue of unemployment among the younger generation. The list of diseases, medical examinations, and other healthcare services are quite broad and multisectoral. On the other hand, the list of beneficiaries is very limited and it does not include a perspective of extending it to the other beneficiaries of the other fields of employment. In addition, the amount provided by the State is incredibly small in order to cover some healthcare services that might be in need.

In the case of private insurance companies role as the third-party administrators, the Government presupposed that competition among the insurance companies would increase the access to healthcare, and create incentives to ensure the productivity of the services. However, achieving those goals in a competitive market environment is not easy, as it requires a clear outline of the legally authorized roles and responsibilities.

CHAPTER II

Exercising Best International Practices:

Comparative study

Within the scope of this Chapter, it will be analyzed the international practice through exercising the Organization for Economic Co-operation and Development (hereinafter, OECD) member countries. The OECD promotes policies, that will improve the economic and social well-being of people, namely examines and sets out international standards for taxes, looks at issues directly affecting daily life or social security of people.[30]The best practices and the regulations the member states made for compulsory health insurance will be taken into consideration. However, it is notable to state that the analysis is also based on two main methods applied by the OECD member states, which are "Multiple-Payer" and "Single-Payer" methods. For these reasons, the legal regulations in the Netherlands, Germany as "multiple-payer" countries and Canada, Estonia as "single-payer" countries will be studied.

[30] *The Organization for Economic Co-operation and Development (OECD), Our Mission,* available at their official webpage, http://www.oecd.org/about/ retrieved on 14 April 2019.

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As a preview, "Single-Payer" method is a healthcare financing system where one agency, which is usually a state agency or fund, collects, monitors and unites financial means and thus obtains health services for the entire population. Funds for this system can be formed from the total state revenues, allocations of employers and employees' health insurance premiums. "Single-payer" model combines all the consumers into one unified risk and has a greater power of monopsony when buying healthcare services. The system does not exclude the activity of private health insurance organizations. Whereas, in a "Multi-Payer" method number of private health insurance companies collect and unite financial resources and provide health services to the consumers. Due to the multi-payer system, the Government can enlarge the healthcare resource pool from other sources, if the Government is unable to collect the necessary amount of taxes specified for funding the system. The differences between these two systems are remarkable in terms of healthcare equity, risk pooling and negotiation, where the single-payer system performs better, as well as the provision of additional options to the patient, which is inherent to the multiple-payer system, and the costs.[31]

There are three types of co-existence of these two systems together in one country: complementary (Canada), supplementary (the Netherlands, Germany) and substituted (UK) methods.[32]

Health Insurance Regulation in the Netherlands

The healthcare system in the Netherlands is regulated through five basic acts as the pillars if the healthcare system in the country. These are the *Health Insurance Act, the Long-Term Care Act, the Social Support Act, the Public Health Act* and *the Youth Act.* The Dutch health insurance system integrates elements of public and private insurance.

The compulsory standard health insurance demands that every person who lives or works in the Netherlands as legally obliged has to take out standard health insurance to cover the cost

[31] P. Petrou, G. Samoutis, C. Lionis, "*Single-payer or a multipayer health system: a systemic literature review*" , Public health, Volume No. 163, WB Saunders (1 October 2018) p. 141. Available at https://www.med.unic.ac.cy/wp-content/uploads/samoutis-paper.pdf retrieved on 12 April 2019.
[32] P. Hussey, G. F Anderson, *"A compatison of single- and multi-payer health insurance systems and option for reform",* Health Policy, Volume 66, Issue 3, December 2003, pp 215-228.

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of, for example, consulting a general practitioner, hospital treatment and prescription medication. Additional health insurance is not compulsory.[33]

Main parties under the *Health Insurance Act* are private individuals (policyholders), health insurers (private insurance companies) and healthcare providers (hospitals). The central government sets a number of public requirements, which guarantee the social nature of health insurance under the *Health Insurance Act*:

- private individuals are required to purchase basic health insurance and are free to choose their own insurer;
- health insurers are required to accept these private individuals under their policy, irrespective of, for example, their aged or state of health;
- the premiums for a policy offered are equal for all policyholders, regardless of their health condition, age or background;
- they must guarantee that healthcare is available in the basic package for all their policyholders;
- the contents of the insured basic health insurance package are provided for under the law.[34]

That is something determined by healthcare providers, health insurers and policyholders. This structure ensures that healthcare providers have a great deal of freedom, while competition and market forces create incentives for high-quality and efficient care.[35] In implementing the Health Insurance Act, private health insurance companies play a key role in a system based on "regulated competition" and a number of specific public requirements.

The central government and municipalities are jointly responsible for implementing the *Public Health Act* which focuses primarily on keeping people healthy. The *Long-Term Care Act* (which focuses on other types of care) account for the bulk of the healthcare budget available in the Netherlands. This Act is a national act governing healthcare throughout the Netherlands. The *Social Support Act* and the *Youth Act* provide for other forms of care and support. The roughly

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[33] *Compulsory standard health insurance* reached by https://www.government.nl/topics/health-insurance/compulsory-standard-health-insurance

[34] *Healthcare in the Netherlands,* Ministry of Health, Welfare and Sport, November 2018, p. 7, https://www.government.nl/topics/health-insurance/documents/leaflets/2016/02/09/healthcare-in-the-netherlands

[35] Ibid.

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380 local authorities and the central government of the Netherlands are primarily responsible for enforcing these two acts. [36]

Basic health insurance package

The central government is advised on these issues by the independent authority responsible for the basic health insurance package, the National Healthcare Institute. The government, then, determines which types of care are included in the package and when this care should be provided. Namely, the package includes medical care provided by General Practitioners, medical specialists (consultant physicians) and obstetricians; hospitalization; medications; dental care up to age 18; nutritional/dietary care; medical aids; ambulance support/sedentary medical transport; physiotherapy for people with chronic illnesses, etc.[37]

The health insurers are free to organize who will provide the care and where it will be provided by following this openly specified package regulated by the central government. However, health insurers have a duty of care, that the guaranteed services are available to all their consumers.

In addition, policyholders have freedom to choose supplementary insurance, package, which may include dental care, alternative medicine, glasses or contact lenses, another generous cover for physiotherapy. It should be mentioned, that supplementary insurance is not regulated by the government, i.e. the private insurance companies are free to determine the policy and have their own rules.[38]

The competition among the health insurers is ensured through the option the policyholders have, that is they can change their health insurers every year for a better one. The same option works towards the healthcare providers too. Moreover, health insurers have right to change the providers based on their effectiveness and conclude a new contract with the other qualified and standardized healthcare provider. These rights given to consumers and private insurance organizations have a mere aim to provide and secure quality to the healthcare system.

[36] Ibid, p 3.
[37] Ibid, p 9.
[38] Ibid.

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Funding under the Health Insurance Act

There are two major financial flow: "nominal" premium and mandatory policy excess. All insured persons aged 18 and overpay a 'nominal' premium to their health insurer. These premiums average around EUR 1,300 a year. In addition, all individuals aged 18 and over also pay a mandatory policy excess of EUR 385,[39] one of the objectives of which is to increase cost awareness among the general public. For children and young people up to age 18, the government pays the costs of insurance from public funds.[40] The employers pay an employment-based, income-based premium into a central fund. Tax authorities determine income-dependent premiums for all other income categories (capital, self-employment, etc.), which are also paid into the central fund. Individual health insurers receive risk-adjusted capitation payments from the central fund. Low-income individuals receive premium subsidies. These premium subsidies are based on individual need and are paid for by tax money, i.e. by the government, and apply for people with low income, with possible scenario of less than 28.000 Euro as annual salary, being employed not the entire year or without an income, being unemployed the entire year.[41] There is envisaged an administrative fine, as everyone who lives or works in the Netherlands is required under Dutch Law to have health insurance from a Dutch healthcare insurer. If one living and working in the Netherlands does not have health insurance, that person must pay a fine in the amount of 386.49 Euro as designated for the year 2018.[42]

Summing up, the central government is responsible for the overall healthcare system and determines the quality requirements healthcare services must satisfy. These quality requirements are supervised by the *Dutch Healthcare Authority,* which makes rules so that good quality and affordable care is available to everyone and also regulates healthcare providers and health insurers; the *Netherlands Authority for Consumers and Market*s, which supervises competition in healthcare in the interest of patients and insured parties and the *Health and Youth Care Inspectorate,* which oversees and enforces the quality and safety of healthcare.[43]

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[39] The excess clause is different per year and per insurer. Here, the amount of money is considered for year of 2019.
[40] Madelon Kroneman, Wienke Boerma and others, *"Netherlands: Health system review",* Health System in Transition, Vol. 18, No. 2 (2016), p 79.
[41] Stefan Greb, Maral Manouguian and Jurgen Wasem, *Health Insurance Reform in the Netherlands,* CESifo DICE Report, January 2007, p. 1.
[42] See, *Health insurance (administrative fine)* available at https://www.cjib.nl/en/health-insurance-administrative-fine# retrieved on 15 April 2019.
[43] *Healthcare in the Netherlands*, op. cit., p. 12.

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Health Insurance Regulation in Canada

Health Insurance conditions and criteria for the provinces of Canada to comply with are regulated by the *Canada Health Act* (hereinafter referred to as Act).[44] The later sets out the primary object of the Canadian healthcare policy, which is to *"protect, promote and restore"* the physical and mental well-being of the residents and to *"facilitate reasonable access"* to health services without financial or other barriers.[45] Whereas the purpose of the Act is set *"to establish criteria and conditions for the insured health services and extended healthcare services"* provided under provincial law that must be met before a full cash contribution may be made.[46]

In the part of the interpretation of the Act, the definition of "*insured person"* means *"in relation to a province,* ***a resident of the province*** *[or territory of Canada] other than a) a member of the Canadian Forces, b) a person serving a term of imprisonment in a penitentiary as defined in Part I of the Correction and Conditions Release Act" or c) a resident of the province who has not completed such minimum period of residence or waiting period, not exceeding three months, as may be required by the province for eligibility for or entitlement to insured health services".*

Following, the Act determines the criteria that must be met by the provinces while applying a healthcare insurance plan. These criteria are described for a) public administration; b) comprehensiveness; c) universality; d) portability and e) accessibility.[47]

According to regulation, the government of each province shall appoint a non-profit public authority for administering and operating the health insurance plan that the province made. The public authority is responsible to the provincial government. It is envisaged to audit the public authority's accounts and financial transaction.[48]

The criteria of comprehensiveness for being satisfied is regulated as follows: "... *the healthcare insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other healthcare practitioners".*[49]

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[44] *Canada Health Act,* RSC 1985, c C-6, <http://canlii.ca/t/532qv> retrieved on 2019-04-13.
[45] *Ibid.* c 6, section 3.
[46] *Ibid*, section 4.
[47] *Ibid*, section 7.
[48] *Ibid*, section 8 (1).
[49] *Ibid*, section 9.

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The principle of universality ensures that provincial and territorial health insurance schemes cover everyone in the same manner and under the same terms and, together with the principle of accessibility, marks the system's commitment to preserving and promoting equity for all Canadians. [50]

The main contentment of the other criteria, portability, is that the health insurance plan shall include the ability for the insured persons to receive insured health services while being temporarily absent from the province. Most importantly, the plan must not impose any minimum period or waiting period, exceeding three months for resident residing outside the province. This criterion works when the resident of the province of Canada temporarily resides both in the other province of the country and out of Canada.[51]

The last criteria, the accessibility, shall be met when the healthcare insurance plan provides services on "*uniform terms and conditions"* without impeding *"either directly or indirectly the reasonable access to those services by insured persons"*. In addition, the payment must be *"in accordance to the tariff or system of payment authorized by the law of the province"*. Furthermore, the plan in accordance with the accessibility criteria must provide *"reasonable compensation for all insured health services"* and *"payment of amounts to hospitals in respect of the cost of insured health services"*.[52] In general, the reasonable compensation does not include the extra-billing[53] unless *"the province entered into an agreement with the medical practitioner or dentist of that province for negotiations, the settlement of the disputes relating to compensation"*.[54]

As Canada is a single-player mode country, the payment is made by the State. This is regulated separately by the *Federal-Provincial Fiscal Arrangements Act*, annexed *Canada Health Transfer and Canada Social Transfer Regulations* under which the provinces receive federal transfer payments.[55] The Canada Health Transfer consists of **(a)** a cash contribution[56];

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[50] Roy J. Romanow Q.C., "*Building on Values. The Future of Health Care in Canada"*, Commission on the Future of Health Care in Canada, Final Report, November 2002, p. 61.
[51] *Ibid* section 11 (1).
[52] *Canada Health Act,* op. cit., c. 6, s 12 (1).
[53] **Extra-billing** means the billing for an insured health service rendered to an insured person by a medical practitioner or dentist in an amount in addition to any amount paid for that service by the healthcare insurance plan, (*Canada Health Act,* c. 6 section 2)
[54] *Canada Health Act,* op. cit., c. 6, s 12 (2).
[55] *Federal-Provincial Fiscal Arrangements Act*, RSC 1985, c F-8, <http://canlii.ca/t/53909> retrieved on 13 April, 2019.
[56] **Cash contribution** means the cash contribution in respect of the Canada Health Transfer that may be provided to a province under sections 24.2 and 24.21 of the *Federal-Provincial Fiscal Arrangements Act.*

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(b) the portion of the total equalized tax transfer for all provinces that is determined by multiplying the total equalized tax transfer for all provinces by the quotient, rounded to the nearest hundredth, that is obtained by dividing an amount equal to the cash contribution specified in subparagraph (a)(i) by an amount equal to the aggregate of the cash contributions specified in subparagraphs (a)(i) and 24.4(1)(a)(i).[57]

Under the *Canada Health Act*, primary care doctors, specialists, hospitals and dental surgery are all covered by provincial insurance policies.[58] However, there are services not covered by the single-payer system. Thus, Canadian health insurance policy provides an option complementary insurance system through private insurance organizations. In this case, the beneficiaries have supplementary choice to buy extra benefits in the private insurance sector. Along these lines, private insurance can suit purchaser needs that are not met by the single-payer insurance plan. Nevertheless, the practice shows that higher-income individuals are the ones who acquire private coverage to meet these needs.[59]

In conclusion, Canadian regulation creates an obstacle for its citizens and the ones with residence permit to have access to private insurance as parallel services. The *Canada Health Act* lacks the regulation about the targeted home care services or drugs prescribed for long-term use. Most importantly, the coverage of services for diagnosis is not clearly formulated.

Health Insurance Regulation in Estonia

Within the frameworks of this paper, the case of Estonia is to be examined as an example of a post-soviet country who adopted mandatory health insurance instead of centralized healthcare management inherent to the Soviet Union system.

Estonia managed to create a single national scheme, the Estonian Insurance Fund (EHIF) in order to consolidate the regional health insurers. The basic activities, bodies, as well as the objectives, functions and legal status of the Fund, is regulated by the *Estonian Health Insurance Fund Act.*[60] The EFIF is an independent legal body with the supervisory board of ex officio members (Minister of the Ministry of Social Affairs, Minister of finance and chair of

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[57] *Federal-Provincial Fiscal Arrangements Act,* op. cit., Part V.1, 24.1 (1).
[58] See, Canadian Health Care, Public health Care Providers. Link is available at http://www.canadian-healthcare.org/page5.html retrieved on 13 April, 2019.
[59] P. Hussey, G. F Anderson, *supra,* p. 224.
[60] *Estonian Health Insurance Fund Act,* Rt I 2000, 57, 374, Article 1 (2001), available at https://www.riigiteataja.ee/en/eli/505012018001/consolide retrieved on 16 April, 2019.

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Parliamentary Committee of Social Affairs) and beneficiaries and employers nominated by the Government and representing organizations designated by the Government. Although it is autonomous, the decision concerning contribution rates, fee schedules for providers and benefit definitions are executed by the Government and the Parliament. The main responsibilities of the Fund include contracting healthcare providers, implementing payments for the healthcare services, reimbursement for pharmaceutical expenditures to the beneficiaries, as well as payments for temporary sick leaves and maternity benefits.[61] The assets of the Fund derive the *"part of the social tax prescribed for health insurance in the state budget"*, which amounts to 13% according to *Social Tax Act*[62] and part of the *"revenue from the social tax prescribed for health insurance benefits in the state budget which is higher than prescribed in the state budget"* [63], as well as from the *"income received from transactions and other legal acts performed pursuant to law and the statutes of the health insurance fund, donations, sums collected from other persons, interest and similar financial income, other income"*[64].

The Estonian solidarity-based and compulsory Health Insurance system is regulated by a separate Act, called *Health Insurance Act.*[65] The 2nd Article of this Act defines health insurance as *"a system for covering healthcare expenses incurred to finance the disease prevention and treatment of and purchase of medicinal products and medical devices for insured persons and to pay benefits for temporary incapacity for work and other benefits on the conditions and in accordance with the procedure provided for in this Act."* The Act illustrates the concept of the insurer, in this case, the EHIF, the insured person, the duration of insurance cover, which in cases specified by law terminates 1 or 2 months after the termination of the employment or the state's obligation to pay social tax for the person[66]. Moreover, the Act specifies the protection of the health insurance database, where the Health Insurance Fund, as the chief processor of the database has right to collect the information and release without knowledge and consent of the insured person.[67]

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[61] William D. Savedoff and Pablo Gottret, *Governing Mandatory Health Insurance; Learning from Experience,* The World Bank, 2008, p 103.
[62] *Social Tax Act,* RT I 2000, 102, 675, Article 10 (2) (2001), available at https://www.riigiteataja.ee/en/eli/514112013022/consolide retrieved on 16 April, 2019.
[63] *Estonian Health Insurance Fund Act,* op. cit., Article 35 (1).
[64] Ibid., Article 35 (2,3,4,5,6).
[65] *Health Insurance Act,* RT I 2002, 62, 377, Article 1.1 (2002), available at https://www.riigiteataja.ee/en/eli/520012014001/consolide retrieved on 19 April 2019.
[66] *Health Insurance Act,* op. cit., Article 6 and 7.
[67] Ibid, Article 18.

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Following to examination of the *Health Insurance Act of Estonia,* it is worth mentioning the chapter devoted to the health insurance benefit, where the law clearly and thoroughly describes what is a health insurance benefit:

"a high quality and timely health service, necessary medicinal product or medical device which is provided to an insured person under the conditions provided for in this Act by the health insurance fund or a person who has concluded a corresponding contract with the fund (benefit in kind), or a sum of money that the health insurance fund must pay to an insured person under the conditions provided for in this Act for the healthcare expenses incurred by the person or upon their temporary incapacity for work (pecuniary benefit)."[68]

The types of the benefit prescribed in Article 25 (2) of the same Act are health service benefits[69], medical devices, and products, benefit paid for temporary incapacity for work, the adult dental care, etc. It is noted in the same Article of the aforementioned regulation, that the beneficiary does not have right of recourse against EHIF regarding the money that the fund spent on the services, medical products, benefits for sickness, maternity, adoption, care or other kinds of benefit. The law itself envisages the possibility to cover health insurance benefits of an insured person in a foreign state.[70] The law specifies in its Article 30, that the list of health services covered by EHIF be determined by the Government of Estonia based on the suggestion of the Ministry of Social Affairs and the opinion of the supervisory board of EHIF on the proposal.

To conclude, the right to health insurance to participate in the labor market can create an incentive to reduce the informal labor market. Secondly, even when the dialogue with social subjects is underdeveloped, the tripartite governing body (through the supervisory board in Estonia) increases accountability of politicians, providers, and managers of the EHIF. If done transparently, this mechanism supports the development of sustainable health insurance system. Third, reliable contracts between the EHIF and suppliers, providing for clear responsibilities for both are an important tool for increasing productivity in quality of healthcare and accessibility. On the other hand, the *Health Insurance Act* regulates the concept of the second opinion, where

[68] Id., Article 25 (1).
[69] **Health service benefit – a** health service provided to prevent or treat a disease
[70] See, *Health Insurance Act*, op. cit., Articles 27 and 27^1., 50.

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the consumer has right to receive an independent opinion of another medical specialist in or outside Estonia by the means of the Fund.[71]

CHAPTER III

REGULATION OF "FUTURE" RA LAW ON COMPULSORY HEALTH INSURANCE

What the Law Shall Regulate

In this chapter, it will be illustrated the concept of Universal Health Coverage (hereinafter UHC) set by World Health Organization as a part of UN Sustainable Development Goals adopted in 2015. Joining in 1992 WHO as a member state, Armenia took commitments to act in accordance with the conventions of WHO and UN in general.[72] Bilateral cooperation led to the reforms discussed above. However, still, UHC standards lack in Armenia. The detailed explanation of UHC definition, objectives and what it includes will follow. UHC shall serve as a guide for Armenian future legal regulations towards the path of implementation health insurance system. Going forward, the chapter will present the main elements to be stipulated in the law. These are the concepts of the insured person, health insurer, health provider, as well as notions of the basic package, oversight regulation and consequences after the adoption of law on health insurance.

Concept of Universal Health Coverage

The World Health Organization describes the Universal Health Coverage as a mean *"that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care"*.[73] WHO former Director General, Dr. Margaret Chan, called UHC as *"the single most powerful concept that public health has to*

[71] Ibid., Article 40.
[72] See, Official webpage of UN WHO in Armenia, available at http://www.un.am/en/agency/WHO (retrieved on 12 March 2019)
[73] See, the Official Webpage of WHO, *Universal Health Coverage,* available at https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc) (retrieved on 12 March 2019)

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offer".[74] The Universal Health Coverage is based on the 1948 WHO Constitution, according to which health is a fundamental human right and commits to ensuring the highest attainable level of health for all.[75]

Within the auspices of UN Sustainable Development Goals 2015, the UHC is set as a target for the nations to achieve. It is of fundamental importance for low and middle-income countries to draft and carry out essential strategies for advancing progress towards UHC. The aim of UHC, among other things, is to protect people from any financial consequences that one may have for the payment of the healthcare services if paying in their own (out-of-pocket payment). Out-of-pocket payments are those made by people at the time of getting any type of service (preventive, curative, rehabilitative, palliative or long-term care) provided by any type of provider. They include cost-sharing (the part not covered by a third party like an insurer) and informal payments (for example, under-the-table payments), but they exclude insurance premiums. Out-of-pocket payments could be financed out of a household's income, including remittances, its savings, or by borrowing. They exclude any reimbursement by a third party, such as the government, a health insurance fund or a private insurance company.[76]

Thus, UHC will ensure people from the risk of suffering from poverty or losing their own property. However, UHC does not mean free coverage for all health interventions, as countries cannot provide all services free of charge on a sustainable basis. It means equity in access to health services for everyone, who needs services, and not only for the ones who can pay for. It means the quality of health services to be good enough to improve the health of beneficiaries. Finally, it means protection of the population against the financial-risk.[77] UHC includes all components of the health system: health service delivery systems, the health workforce, health facilities and communications networks, health technologies, information systems, quality assurance mechanisms, and governance and legislation. It is about a minimum package of health services and about ensuring a progressive expansion of coverage of health services and financial

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[74] See Official webpage of Center for Global Development, *"What will Universal Health Covreage Actually Cover?",* 20 February, 2013, available at https://www.cgdev.org/blog/what-will-universal-health-coverage-actually-cover (retrieved on 13 March 2019)

[75] See, *Constitution of the World Health Organization,* Preamble and Articlle 1, 7 April, 1948, available at www.who.int/governance/eb/who_constitution_en.pdf (retrieved by 13 March 2019)

[76] See, *Tracking Universal Health Coverage: 2017 Global Monitoring Report,* WHO and The World Bank, 2017, p. 25.

[77] See, Official webpage of WHO, *Health financing, "What is health financing for universal coverage",* available at https://www.who.int/health_financing/universal_coverage_definition/en/ (retrieved on 12 March 2019)

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protection. Most importantly, UHC signifies steps towards equity, development priorities, social inclusion, and cohesion.[78]

The way to reach the strengthened healthcare system guided by UHC is through the mandatory insurance contributions.[79] Thus, it will reduce people suffering from the risk of financial loss.

UHC is also key to achieving the World Bank Group's (WBG) twin goals of ending extreme poverty and increasing equity and shared prosperity, and as such it is the driving force behind all of the WBG's health and nutrition investments.[80]

In summary, legal frameworks for healthcare are not only a result of economic development but are an essential component of and contributor to such development.[81] States have responsibility to ensure right to health of their citizens and another type of residents through investing in health financing, health information systems, delivery of such systems, main medicines and technologies and, of course, human resources. This includes the idea of universal health coverage. To illustrate, states who still meet trouble in protecting their nationals and others for access to healthcare in correspondence to UHC shall act towards developing country-specific systems based on UHC as an achievement by 2030(SDG 3). According to WHO latest data, in 2015 out-of-pocket expenditure in Armenia concluded 81.6%. There is difference of 20% more compared to out-of-pocket expenditure in 2007.[82] In the same source, Canada achieved 14%, the Netherlands 12%, and Estonia 22%. These promising numbers show the effectiveness of UHC implemented through health insurance system for years.

Definition of "Health Insurance"

Compulsory health insurance works under obligatory public scheme, enforced by law, which is usually administered by public bodies.[83] Health insurance is a system for the financing of medical and surgical expenses by means of contributions or taxes paid into a common fund to

[78] See, *Universal Health Coverage,* op cit.
[79] See, Official webpage of UHC2030, *Coordination of health system strengthening,* available at https://www.uhc2030.org/what-we-do/coordination-of-health-system-strengthening/ (retrieved on 15 March 2019).
[80] See, Official webpage of the World Bank, *Universal Health Coverage,* available at https://www.worldbank.org/en/topic/universalhealthcoverage#1 (retrieved on 12 March 2019)
[81] *Advancing the Right to Health – the Vital Role of Law,* World Health Organization 2018, p 7.
[82] See, official website of WHO, *Global Observatory data repository,* available at http://apps.who.int/gho/data/node.main.GHEDOOPSCHESHA2011?lang=en (retrieved on 11 March 2019)
[83] See, C*ompulsory health insurance,* available at https://pallipedia.org/compulsory-health-insurance/ (retrieved on 10 March 2019)

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pay for all or part of health services specified in an insurance policy or the law.[84] Usually, an individual pays a fixed sum, premium, from his or her salary on a monthly basis or per year as a payroll tax. While voluntary health insurance (hereinafter VHI) schemes are those where the decision to join and the payment of a premium is voluntary. Together with out-of-pocket payments, VHI premiums are considered a private revenue source. VHI schemes need to be distinguished from publicly-funded health systems or schemes implemented through private insurance companies, such as in the Netherlands.[85]

The Law shall specifically underline in a provision the nature of the system as being compulsory and its type as social insurance or private. Social Health Insurance is inherent to single-payer systems, where the compensation is provided and monitored by the state institution. Whereas in the case of private insurance, as the word prompts itself, the health insurance system mainly is executed through private insurance companies, the activity of which is regulated by Government and Regulation.

It is up to the Armenian Government to make a decision which system to choose, multi-payer or single-payer. However, before making such a decision, the Government shall profoundly consider various criteria, conditions and international experience mostly related to the economic situation in the country in order for the system to be effective and with quality.

Main Parties involved in the Regulation

The notion of "Insured Person"

The law shall regulate who will be "insured" in the country. An insured person, or in other words, a beneficiary, is a person who receives healthcare services from the healthcare provider through health insurers. The main definition of the policyholder is *"a person or entity who owns an insurance policy and has the privilege to exercise the rights stated in the contract. This party is often, but not always, the insured, and may or may not be one of the policy's beneficiaries".*[86]

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[84] See, *Health Insurance*, Encyclopedia Britannica, available at https://www.britannica.com/topic/health-insurance (retrieved on 12 April 2019)

[85] See, *What is voluntary health insurance?,* official webpage of WHO, available at https://www.who.int/health_financing/topics/voluntary-health-insurance/what-it-is/en/ (retrieved on 13 March 2019)

[86] See, *Policyholder,* Insuranceopedia, available at https://www.insuranceopedia.com/definition/453/policyholder (retrieved on 10 March 2019)

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As the examination has shown, "insured persons" are the residents of the country. In the case of Armenia, people eligible for compulsory health insurance are citizens of RA[87], permanent and temporary residents, for example, refugees. Concerning foreign citizens arriving in Armenia, it should be regulated through bilateral and multilateral agreements between Armenia and foreign states regardless of the period they arrive. The reference to the meaning of foreign citizen shall be given to the *RA Law on Foreign Citizens*.[88]

According to the *RA Law on Diplomatic Service,* Article 45.1 (3):

"During the service in a diplomatic mission in a foreign state health insurance [of the diplomat], including that of his/her family members, shall be covered at the expense of the means provided for by the RA Law on State Budget and according to health insurance contracts".[89]

This provision shall be taken into consideration, when drafting the Law on Compulsory Health Insurance in Armenia, and make appropriate amendments in that provision. Notably, the amendments shall be considered regarding the means of expense provided for by the RA budget and health insurance contracts signed with foreign insurance companies functioning at the given state.

Besides considering the citizenship and residency of the person, the law shall determine who can be insured or who can ensure others as a family member. Following to say, that one employed person may apply to ensure his or her family members – unemployed spouse and the child or children. Correspondingly, it shall determine the age of the child be insured as a family member. According to the Social Benefit Package Regulation, the child may be included under this package until turning 27. This may be kept, upon the consideration of the Government and the employment status of the child turned 18.

The Government shall take obligation to insure pensioners and unemployed persons recognized as such by Armenian laws by the means determined by the legislation of RA. It might be possible for a son to add parents who are pensioners, to the healthcare insurance plan included himself.

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[87] *RA Law on the Citizenship of the Republic of Armenia*, 28 November 1995, available at https://www.refworld.org/pdfid/51b770884.pdf (retrieved on 10 March 2019)
[88] *RA Law on Foreign Citizens,* 2006, available at http://www.arlis.am/ (retrieved on 10 March 2019)
[89] *RA Law on Diplomatic Services,* 12 December 2001, Article 45.1 (3), available at https://www.arlis.am/DocumentView.aspx?DocID=121490 (retrieved on 10 March 2019)

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The status as beneficiaries of self-employed people, self-entrepreneurs and freelancers, and their family members shall be considered, as well.

The notion of "Healthcare Provider"

Healthcare provider is generally the individual or the institution, who provides healthcare services, including preventive and rehabilitative care, chronic and acute care to consumers, and who signed a contract for cooperation either with the private insurance company or with the state. When considering "hospital", it shall be clarified what namely the word means: whether primary healthcare institutions, in other words, ambulatory ones, are considered, too. Moreover, the law shall illustrate which types of hospitals are not considered, for example, hospitals for mentally disordered people. However, if considering the provider as an individual, the law shall articulate who is a person classified under "healthcare provider".

The other factor the state shall take into consideration regarding medical institutions is their private and state institution component. Usually, the state makes deals with state medical institutions. This may arise several problems, like long queues, less effective services and less competition among hospitals. This might happen if the state will accept the single-payer system.

The notion of "Health Insurer"

In the multiple-pay system, "health insurer" is deemed to be the private insurance organization, who signs the contract with the policyholder for delivering the insurance policy and with the hospitals with whom it will cooperate in future.

In the single-payer system, the insurer is mainly the state fund or another state non-profit organization, however not the Health Ministry, who provides the insurance policy to its consumers and signs contracts with the hospitals. As it was discussed above, there is a co-existence of both systems and in that case, both will be considered as "health insurers".

The Armenian Legislation provides the opportunity for private insurance companies to exercise health insurance in Armenia. However, the mere indication that exists concerning health insurance providers is the *RA Law on Insurance and Insurance Activities*.[90] Article 39.7 of the same Law states the following:

[90] See, *RA Law on Insurance and Insurance Activities*, Article 39, point 7, 30 September 2007, available at https://www.arlis.am/ (retrieved on 11 March 2019)

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"Company authorized to engage in life insurance may also be engaged in classes of insurance specified in paragraph 1 (accident insurance) and paragraph 2 (health insurance) of Paragraph 2 of Article 7 hereinabove, provided that they supplement its main activities and result from the service of life insurance contracts".

Certainly, the future Law on regulation of the Health Insurance in Armenia shall describe clearly and thoroughly the role of the private insurance companies and their rights and duties to comply with the Law.

Definitely, the law shall regulate the contracts signed between private insurance company and consumer and with the healthcare provider. The law has to assure it includes all provisions stipulated and is in accordance with the requirements placed in the law. This is about the reimbursement process, the basic coverage regulation, the payment procedure, etc. It is envisaged, that after the regulations will come into force, the insurance companies shall revise their healthcare provision contracts for the compliance to the new law.

Health Insurance Package

Currently, any basic coverage described by law is regarded as the Social Benefit Package, which was discussed in the 1st Chapter of this Paper.[91] Of course, this coverage does not meet Universal Health Coverage standards and criteria. It is mainly focused on preventive services, like examinations, consultations, and analyses. And most importantly it is for a limited group of people.

The future law shall provide the full list of the basic services, the healthcare provider shall implement and health insurer shall guarantee. The list shall comply with the UHC health indicators. As a basic mandatory package, it shall include initial consultations, examinations with general practitioners and specialized physicians and therapists, laboratory examinations inclusively; in-house treatment and hospitalization; nursing; medications and medical equipment; some dental services, for example, dental filling, removal of a tooth, etc. The package must consider surgical interference and ambulance aid. Most importantly, it shall cover chronic illnesses and the treatment, like physiotherapy, necessary for this kind of disease. Usually, basic coverage does not include cosmetology and cosmetic services, like surgery and other procedures, as well as plastic surgery.

[91] Decision of the RA Government No. 375-N, op.cit.

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Last but not least, as the world is progressing in digital technology and medicine evolves very fast together with medical apparatus, the Law shall consider its provision on medical equipment as living provision when necessary making additions to the types of medical devices covered.

Finally, the law shall keep an open window for private insurance companies to provide supplemental healthcare services to their consumers beyond the services of basic coverage.

Supervision

The law may be perfectly drafted with detailed explanations and descriptions, however, it may not be effective in application. The reason for the lack of success is the absence of supervision and enforcement measures determined by law. The Armenian Government shall create means to supervise the quality, safety and low-cost healthcare, monitor healthcare providers and health insurers (private insurance organizations). These means shall protect the interests of all parties, objectively.

If necessary, it shall determine fines for fraud or any other type of infringement, for example in the case of employer hiding its employee and do not registering him for health insurance.

Consequences after the new Regulation

The adoption of the new system will realize significant changes and amendments. One of them is the further activity of the State Health Agency that was discussed earlier. If the state takes steps towards mandatory health insurance through a single-payer system, then obviously SHA will no longer exist followed by the government decision. As it is known, SHA tools are poor to promote the effectiveness of providing healthcare in the country and it acts as a payer focused on payment process rather concentrating on the solution of healthcare related problems.

The creation of a new state non-profit Fund will replace SHA and more. The duties, like signing contracts with the medical institutions, or providing the payment will remain the same. However, it will have controlling tools over the hospitals as its duty of care to ensure the quality and effectiveness of healthcare for the sake of its beneficiaries. The separate regulation shall compose the governing body of the Fund to ensure its independence and objectivity in the activity.

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Another important adjustment will occur in the RA Tax Code. In order to finance the new system of healthcare insurance, the additional tax shall be deducted from the insured person's income. The tax might be called health insurance tax.

As a quick summary of the Chapter, all points discussed in this chapter constitute the main body of the future law. The chapter discussed the concept of health insurer, provider and policyholder as the main parties under the regulation. It considered what the basic package should include according to the law, how it shall be supervised and why. The analysis showed that imminent developments like the termination of SHA or new tax inclusion would appear. However, more detailed analysis in the field shall be done by the government before adopting the system and drafting the policy.

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CONCLUSION

The Paper discussed healthcare system existing in the Republic of Armenia since its independence. As it was concluded that the State Health Agency has insufficient motivation to promote the efficacy of healthcare provision. It does not have the necessary resources to meet the current requirements for healthcare, to confront the intentions of medical institutions for market dominance. Also, SHA does not have tools such as concluding electoral and quality-based contracts to support abovementioned efforts. Moreover, it acts as a payer focusing more on the payment process for medical institutions rather than assuming a strategic role to address some of the healthcare problems. The demand for health services in Armenia is much higher than what the state can compensate for.

If consider the other reform, the inclusion of the "Social Benefit Package" system in Armenia, it was discovered that among the benefits there are substantial issues that miss both in the system and its regulation. The package is dedicated not only to health but also to other services, like education, leisure, etc. Its nature is more preventive envisaged for examinations and analyses as mandatory once a year. The beneficiaries are those in the public sector working full time as permanent employees. Women of the sector do not benefit the package during pregnancy and childbirth, as well as being on leave for childcare up to 3 years. Also, it should be taken into consideration that the benefit amount is very little.

The Paper illustrated international practice through an examination of legislation in the Netherlands, Canada, and Estonia. Two methods in the healthcare system served as grounds for the research – single- and multi-payer models applied by OECD countries. The Netherlands served as the best practice for multi-payer model implementation, while Canada as single-payer. Although Estonian implementation of Social Health Insurance is considerably new and it is difficult to speak about its efficiency, it is a striking instance for the post-soviet country, like Armenia and Estonia.

Although the aim of this Paper is not considering the best option of these models, but to present the regulation regardless of the system to be applied, it should be noted that the single-payer method is more convenient for economically sustainable countries, where the economy grows without variations having strong grounds. On the other hand, for a small country, like Armenia, it is logical to have one risk-pooling institute and not spread risks among

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private insurance companies, where supervision will be hard to execute and demands more regulations and time, as well as the system, might meet corruption danger.[92] However, multiple-payer model provides opportunity for people to have more choice in health insurer and in their contracts. Moreover, exercising of private health insurance companies will promote economic welfare in the country as taxpayers.

Considering the regulation itself, it should be noted, that the universal health coverage adopted by WHO as one of SDGs shall be considered as the ground for the basic coverage. It shall be not only preventive but also curative, rehabilitative, palliative and designated for long-term care. The Third Chapter went through the concepts for the main body of the future law. The chapter discussed the concept of health insurer, healthcare provider and policyholder as primary parties under the regulation. It considered how compulsory health insurance shall be supervised and why. The analysis showed that imminent developments like the termination of SHA or new tax inclusion would appear. It is recommended to the Armenian Government to have more detailed analysis in the field before adopting the system and drafting the policy. In case the Government chooses single-payer model to apply in Armenia, it will be effective, among other things, to cooperate with both private and public medical institutions. Considerably, everything discussed in the last chapter shall be included in future regulation. It should prescribe supplementary insurance option, as well.

Finally, the implementation of mandatory health insurance will reduce out-of-pocket payment option and correspondingly the financial risk that citizens of Armenia usually meet. Much important, the Armenian Government has to learn from the mistakes that were made by the countries, which have an almost ideal picture at present. However, the process is long-lasting before reaching the desired results. It is important to make sustainable steps and be patient and motivated.

[92] This is the official approach of RA Ministry of Health. See at the Public discussion cited above.

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