COMMUNITY BASED HEALTH INSURANCE SCHEMES IN RURAL COMMUNITIES OF ARMENIA:

PERSPECTIVES FOR ENHANCEMENT

Master of Public Health Thesis Project Utilizing Problem Solving Framework

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EXECUTIVE SUMMARY

The severity of the socio-economic crisis that faced Armenia in the beginning of the nineties forced the country to make radical changes in the funding and organization of the health care system. The economic crisis hit mostly village health posts, which were poorly equipped, with low quality of health care services provided and basic drugs being unavailable for the population. The result was dramatically a decreased health status of the population and lack of access to health care services, especially in the rural areas of the country. As a result of problems (health sector financing gap, economic crisis, out of the pocket payments, low access in rural areas, etc), many preventable and avoidable diseases nowadays continue to increase and spread largely.

At the Primary Health Care (PHC) level, the Armenian government set free health care for several services and vulnerable population groups, but due to inadequate financing, the quantity and quality of health care is very limited or not available.

Many goals of the health care system depend on adequate financing. Today in the context of inadequate public expenditures in the health sector of Armenia, concerns over health status, equity and access to primary health care for the poor and the search for complementary financing solutions have risen.

The aim of this study is to explore the main problems present in the primary health care system of rural areas of Armenia, the major financing issues and the current and potential intervention strategies. Based on the discussion of relative advantages and disadvantages, technical and political feasibility and ease of implementation, following recommendations are developed regarding the options for new financing mechanisms of primary health care in Armenia: make legislative changes to facilitate the wider introduction of Community Based Health Insurance schemes, government have to contribute to the effectiveness and

sustainability of the Community Based Health Insurance schemes for rural population through technical support to strengthen management capacity of local schemes and facilitate links with formal financing and provider networks, create a new regional intersectoral consulting body "Community Based Health Insurance Regional Board", donors and other stakeholders need to be involved in the support of this schemes, to establish a national forum for discussion of Community Based Health Insurance. These actions will improve health status of population and access in the rural areas of Armenia.

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ACRONYMS

RA	**Republic of Armenia**
PRSP	**Poverty reduction Strategy Program**
MoH	**Ministry of Health**
PHC	**Primary Health Care**
FAP	**Feldsher Obstetrics center**
SHA	**State Health Agency**
BBP	**Basic Benefit Package**
CBHI	**Community Based Health Insurance**
RDF	**Revolving Drug Fund**
STC	**Support to Communities**
WHO	**World Health Organization**
WB	**World Bank**
GB	**Great Britain**
NGO	**Non Governmental Organization**

1. STATEMENT OF PROBLEM

1.1 Problem definition

The severity of the socio-economic crisis that faced Armenia in the beginning of the nineties forced the country to make radical changes in the funding and organization of the health care system. The economic crisis hit mostly village health posts, which were poorly equipped, with low quality of health care services provided and basic drugs being unavailable for the population. The result was dramatically a decreased health status of the population and lack of access to health care services, especially in the rural areas of the country.

The main problems in the Armenian health care sector are:

- Health sector financing gap
- Political uncertainty and lack of health policy perspectives
- Little protection against health care costs
- No government oversight of the informal health care sector
- Out of pocket payments as a major part of health services financing.

In 1996 the Ministry of health introduced a system of payments, whereby patients pay the full cost of treatment out of pocket directly to the providers. This reform was aimed to reduce under the table payments, which were previously accepted by the providers and patients and to promote user participation. These out of the pocket payments became a significant proportion of total expenditures, but it has had a negative impact on the access of health care services for poor people. It should be mentioned that according to the Poverty Reduction Strategy Program (PRSP) 50.9% of the Armenian population lives below the poverty line (1).

As a result of the above mentioned problems (health sector financing gap, economic crisis, out of the pocket payments, low access in rural areas, etc), many preventable and

avoidable diseases nowadays continue to increase and spread largely. According to the Ministry of Health Statistical Report (2004), an increase of general mortality rate from 5.86 per one thousand of population in 1985 to 6.20 – in 1990, and 8.10 – in 2004 has been documented (2).

The main causes of mortality are the same as in most developed countries, including first of all cardio-vascular disease (56-57% of general mortality), then malignancies, pulmonary disease, and accidental trauma/injuries and poisoning. There is an evident increase in the morbidity of main chronic diseases (tuberculosis, Diabetes mellitus and cardiovascular system diseases). In 1994 the incidence of tuberculosis was 19.5/100,000 population compared to 48.5 in 2004. For cardiovascular system diseases, the increase is highest for myocardial infraction (in 1995 54.3 compared to 87.2 in 2004) (2). In the rural areas of Armenia the health status is worse than that in urban areas (2).

Maternal mortality (26.7 in 2004) still remains higher than the WHO-accepted maximal rate of mortality (15 per 100.000 live-birth deliveries) (2).

Many goals of the health care system depend on adequate financing. Today in the context of inadequate public expenditures in the health sector of Armenia, concerns over health status, equity and access to primary health care for the poor and the search for complementary financing solutions have risen.

1.2 The Aim of the Study

The aim of this study is to explore the main problems present in the primary health care system of rural areas of Armenia, the major financing issues and the current and potential intervention strategies. Based on the discussion of relative advantages and disadvantages, technical and political feasibility and ease of implementation, a course of recommendations will be developed regarding the options for new financing mechanisms of primary health care in Armenia.

The main limitation of the data is absence of estimates of primary health care expenditures at the level of rural health care facilities.

2. MAGNITUDE OF THE PROBLEM IN ARMENIA

At the Primary Health Care (PHC) level, the Armenian government set free health care for several services and vulnerable population groups, but due to inadequate financing, the quantity and quality of health care is very limited or not available.

In the beginning of 2000, the health budget increased slightly each year, but access to health care services remains low for the people who are poor and live in the rural areas. In 1990 health care expenditures were 2.7% of GDP, which decreased to 1.3 % of the GDP in 1997. At that time, health care allocations were about 50% of the planned budget (3).

Current and projected macroeconomic data are presented below.

Table 1. Data on GDP, socio-economic status and health expenditure from 2002-2006

	2002	**2003**	**2004**	**2006**
GDP per capita	<800	834	904	> 1000
Number of poor. % of population	50.9	46.0	44.0	38.0
Number of very poor. % of population	16.0	15.0	15.0	13.0
Health expenditures, as % of GDP	1.2	1.4	1.5	1.9
State budget health expenditures. %	6.2	6.5	7.6	9.2

PHC share in health care budget. %	23.2	19.0	29.4	40.0

Source: Poverty Reduction Strategy Program, RA. 2002-2006.

According to the Ministry of Health, in 2004, 80% of PHC financial resources were spent to pay salaries, so the remaining 20% could not be enough for all other expenses including drug costs (4).

Poverty Reduction Strategy Program's analysis showed that utilization of primary health care services for the 20% of wealthy people in 1999 was 1.8 times higher than for the 20% of the poorest population (1).

In 2002, Armenia had 400 ambulatory facilities and policlinics (more then 300 in the marzes) and 600 Feldsher Obstetrics centers (FAPs). According to official statistics of the Ministry of Health, in 2002 the average number of ambulatory visits in the country was extremely low (**2.1** per person per year) compared with previous years (**7. 8** in 1990) and with the European Union (EU) average (**6.2**) (2).

Table 2.Outpatient contacts per person in 1990-2002 period

Year	Average number of contacts per year
1990	7.8
2000	2.4
2001	2.1
2002	2.1
EU average (1996)	6.2
NIS average (2001)	8.6

Source: Health statistics, Ministry of Health, 2004

Approximately **86%** of the **6.2** million outpatient visits in the country during the year 2002 were to primary care physicians (ambulatory doctors). Out of **6.2** million outpatient visits, **3.8** million were to primary care physicians working in the regions and districts (marzes) of Armenia (2). However, an evaluation of medical care accessibility in rural communities shows that the main reason for not applying for health care assistance for 65% of patients is the financial inaccessibility (5).

3. KEY DETERMINANTS

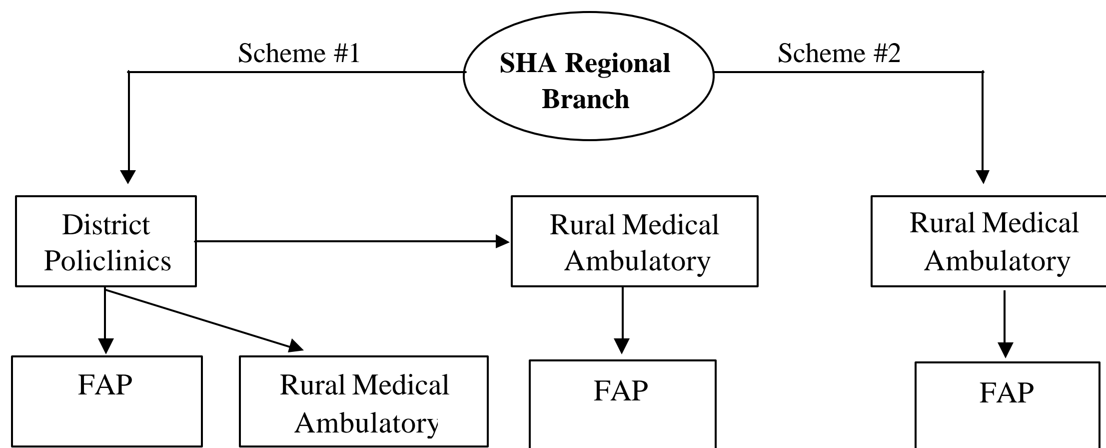
In many developing countries the under-performing economies with large informal sectors bring significant constraints for the government's resources. The result is that there are insufficient resources to spend on public services including health, and in this situation public health systems are unable to finance essential health care (6).

Low-income populations in the developing countries are mostly reliant on out-of-pocket expenditures to finance their access to health systems which combined with the inadequate public financing for health care has led to under-provision of high-priority services and health benefits. The following is a list of the major constraints to the delivery of priority health services in Armenia:

- The main constraint at the community and household level is distrust to health care system.
- The main constraints at the health services delivery level are inadequate drugs and medical supplies, weak technical guidance, program management and supervision, lack of equipment and infrastructure. This is further complicated because the rural PHC facilities do not achieve adequate financial flow. The rural ambulatories and health posts, in most of cases, are attached to the policlinic. The State Health Agency transfers

the funds for primary care to the polyclinic. These transfers include payments for services under the Basic Benefit Package of the state. Payments include salaries, drug cost, maintained cost, etc. Thus, the head doctor of the policlinic must decide how the funds will be distributed to the FAPs and ambulatories (including salary and other expenses). In most cases, the rural PHC facilities do not receive adequate support, which results in the lack of availability of drugs, unpaid salaries, etc. Below are presented two type of schemes of financial flows for community PHC level.

Existing financial flows for community level PHC.



- The main constraint at the health sector policy level is the health sector financing gap. There is a high proportion of out of pocket payments, lack of intersectoral action and partnership for health between government and civil society, absence of legislation on health insurance, inadequate regulation of pharmaceutical sectors, weak drug policies and lack of supply systems (7).

Almost all reported constraints created conditions where new mechanisms of financing have a role to play in the Armenian context. It is expected that the introduction of new financing mechanisms will eliminate many of the above shortcomings.

4. CURRENT AND POTENTIAL STRATEGIES FOR RURAL HEALTH CARE IMPROVEMENT

4.1Current strategies

One of the current actions undertaken by the government toward solving the problem is the creation of free services at the primary health care level and for health care of socially vulnerable groups. Adopted by the government in 2003, the Poverty Reduction Strategy Program stated the primary goal was to strengthen primary health care and provide a continuous increase of primary health care budget allocations (Table 1). Below are the planned budget expenditures for 2003 to 2015 years.

Table 3. Planned budget expenditures in the health care field

Indicators	*2003*	*2004*	*2005*	*2006*	*2009*	*2012*	*2015*
In AMD (billion)	21.0	24.9	30.8	35.5	52.7	73.3	101.1
From GDP, %	1.4	1.5	1.8	1.9	2.1	2.3	2.5
Change compared with previous year, %	31.2	18.6	23.5	15.4	12.4	11.5	11.2

Source: Poverty Reduction Strategy Program, RA, 2003

The primary health care services in Armenia are provided by paediatricians, district therapists and family physicians and the nurses (general and family) who are working in rural ambulatories, health centres or in polyclinics. Today in Armenia, implementation of family medicine is beginning and this new type of primary care is provided by recently trained family physicians and family nurses.

At present, the primary care services in Armenia are organised in two basic ways:

In rural areas, primary health care is provided in the ambulatories and rural health centres that are joint stock companies owned by the hamaynks, or attached to the marzs' polyclinics. Polyclinics are also joint stock companies that are owned by the marz authorities. The rural ambulatories and health centres where work physicians, nurses and midwives offer only a limited package of primary care services. The cases demanding narrow specialties consultation are served by the narrow specialties of the marz's polyclinics. At the health posts, nurses or midwives work under the organizational structure of the ambulatory or polyclinic. The health post nurses do important advisory, triage and referral functions. They treat those patients whom they have right stated by the Ministry of Health or they refer patients to higher organizational level of care. The nurses of the health posts are able to give patients some limited number of drugs without a physician's prescription (8).

In urban areas, primary care physicians and nurses work in the polyclinics, which are themselves joint stock companies and independent from the hospitals, although some Yerevan policlinics have recently been merged with medical institutions into larger medical pyramids. In Armenia there are several private primary health care institutions that provide certain primary care services.

State ordered medical care has defined a Basic Benefit Package of services, which is supposed to cover essential health care needs of entire population, ambulance services, hospital care for acute and social diseases and health needs of socially vulnerable groups of population (disabled people, children, orphans, etc.).

Primary care financing in Armenia has the following elements:

- A capitation fee is paid by the State Health Agency, which depends on the population size attached to that primary health care organization. The capitation fee is differentiated for the urban and rural population. Primary health care providers are paid based on the number of people they serve.

- Besides capitation fee, the State Health Agency pays fee-for-service for the following activities, which are also included in the state basic benefit package:
    - Narrow specialist services (in the field of cardiology, neurology, infectious diseases and endocrinology);
    - Emergency services; and
    - Laboratory services (for patients included in the vulnerable group).
- Population is required to pay out of pocket for the following services:
    - Home visits;
    - Narrow specialist services (not included in the state basic benefit package)
    - Laboratory services; and
    - Certain drugs (8, 9, 10).

The present method of payment for pharmaceuticals in primary care is quite complicated. There is a large group of diseases (diagnoses) for which the State will pay 100% of the cost for all citizens. Then there is a list of essential drugs that are paid by the State Health Agency for 100%, 70% or 50% (depending on the degree of vulnerability or disability) for persons belonging to vulnerable groups. Funds for these drugs have been made available via the State Health Agency, as part of the capitation fee since 1 January 2004 (10). In addition, there are some drugs provided by humanitarian assistance, distributed by six pharmacies in Yerevan and one pharmacy in each region (marz).

In Armenia public funds for medical services and drugs are not sufficient to provide all of them to the various groups of patients. Almost all patients from time to time have to pay for those drugs that, theoretically, are subsidized by the state.

4.2 Potential strategies

There are several potential financial strategies that could be implemented to improve the rural health care in Armenia. The first is Social health insurance. This is a form of compulsory universal health insurance coverage that is implemented under the social security type program and usually is financed by employer employee contributions to government or non profit insurance funds. Social insurance usually pools risks through social insurance financed from mandatory earmarked payroll taxes used for specific social programs (11). The main characteristic of the social health insurance is that it is compulsory, which means that everyone in the eligible group have to pay premiums (mandatory insurance payments made by employee and employer). Social insurance is organized generally under the Bismarkyan model. Social insurance assumed to be social type of financing, because it allows to collect all risks and distribute benefits among all population, for example, in this system, healthy person pays for ill, wealthy person pays for poor, worker pays for unemployed, etc (11).

A second strategy to improve rural health care is implementation of a Community based health insurance (CBHI), an alternative health financing mechanism. CBHI is a voluntary health insurance, organized in the level of the community, which allows the community to participate in the financing of health care. The concept of "community participation" plays a central role in policies and interventions seeking to reduce health inequalities and induce social representation and community power. (12). Community based health insurance schemes are known by different names in different countries. They are called mutual health organizations, or MHOs, in Anglophone West Africa, mutuelles de santé in Francophone West Africa, and igualas médicas in the Dominican Republic."(13). The common feature of all of the community based health insurance the schemes is the informal and voluntary nature of the schemes. Payment for membership is usually on a prepayment basis. Fund ownership and management can also be used to differentiate schemes (hospital

owned, community owned, NGO owned, government owned). Besides that schemes can be classified according to the types of services that they cover (providing drugs, primary health care services, hospital services, etc.) (12). Many CBHI schemes exist around the world: India, China, Vietnam, Bangladesh, Yemen, Rwanda, etc.

A type of second possible strategy was developed in 1995 under the Oxfam Great Britain Non Governmental Organization support. This initiative, "Support to Communities," was a Non Governmental Organization developed in rural communities (in 2 marzes) to manage their basic health care services through revolving drug funds. The Revolving Drug Fund (RDF) has been running in Vajotz Dzor and Sjunik. These marzes were chosen because of their high poverty and poor transport links. Before Oxfam supported schemes, access to Primary Health Care was through village health posts, each staffed by a nurse, who was poorly paid and had little ongoing education. The village posts were chosen because they were affordable, accessible to all in the village. Under the schemes the free provision of drugs for acute care is guaranteed for a monthly premium of 500 AMD. The posts were also sites for training of medical personnel and repairing of health posts. Basically, the community insurance promotes community participation in the management of Revolving Drug Funds (15). The community can decide to exempt 10% of poor families of the community to join the scheme without payment (5, 14).

5. POLICY AND PRIORITY SETTING

The Armenian government now interested in exploring the potential for alternative mechanisms and sources of health financing, especially at the community level. In many countries today the social protection is the major problem for rural communities:

"One of the world's urgent and vexing problems is how to finance and provide health care for the 1.3 billion poor in low and middle income countries, Many of world's poor still do not have access to effective and affordable drugs, surgery or other interventions because of weaknesses in the financing and delivery of care." (6)

The changing role of governments in countries undertaking reform of their health care systems was outlined in the 2000 World Health Report. This report urges governments to focus most of all on poverty and social exclusion issues (16).

Nowadays the strengthening of insurance function of the health care system is seen as a major way to reduce poverty. Health financing via social insurance is recognized as a powerful method to achieve universal coverage with financial protection against health care costs for all. The MoH of Armenia is considering the implementation of social insurance to replace the ten year old tax based financing mechanism. Although the government has established the State Health Agency as a future insurance fund, there are many constraints for compulsory health insurance implementation. One of the main difficulties is poor political will. The second one is high informal working sector, which will be a barrier for risk pooling. And finally there is no guarantee that after implementation of social insurance, the allocations of health care from the tax based budget will remain the same.

Many key determinants explain why the design of adequate health financing systems in developing countries, especially low income countries remains a subject for discussion. Many alternative financing mechanisms exist in the health care field, linking from the users' fees to social insurance. However, today developing countries are choosing a direct involvement of communities in health financing as a mechanism of transition period (17).

In the last few years many studies have been carried out on community-based health insurance. In most of studies, which are discussed below, the impact of CBHI schemes is

usually measured against several primary goals, such as the level of resources mobilized, the extent to which access and utilization of health services has increased the degree of financial protection provided by scheme membership, and in terms of equity or social inclusion (17).

5.1 General Trends Worldwide / Community based health insurance

A review of 258 CBHI schemes by the International Labour Office concluded that there was no evidence relating to the impact that CBHI have on health status (18). However Hsiao suggests that the Cooperative Medical System schemes in China, which were a voluntary community-based health insurance, had a significant impact on the health status of scheme members, because the infant mortality in rural areas was reduced from 200/1000 live births (1949) to 47/1000 (1973-1975), and life expectancy almost doubled, from 35 to 65 years (19).

Although the evidence on the impact of CBHI schemes on health status was not strong, many researchers reported that these schemes increase access to health care services. Schneider and Diop presented that the implementation of CBHI in Rwanda had increased access to health care; members have four times more access to health care than non-members (20). These authors concluded also that the introduction of CBHI in Rwanda had improved the efficient use of resources (including drugs and staff of district health facilities). Household data analysis shows that community financing improves access of rural communities to needed heath care and provides financial protection against the cost of illness (21).

The utilization of health care services is also important measurement for these schemes. In Rwanda household surveys found that the utilisation of preventative health services for women and children was four times higher for members than non-members (22).

There is significant evidence that CBHI schemes have a positive contribution to raising revenue. Jakab and Krishnan concluded that community financing mechanisms can mobilize significant resources for health care in low -income areas (23). Bennett et al. analyzed 82 schemes, which promoted risk sharing of the costs of health care for people outside the formal employment sector and concluded that the average cost-recovery of the schemes was only 30%, and all schemes depended on continuing external subsidies in order to remain viable (24).

Many studies showed that community-based health insurance schemes reduce the out-of-pocket expenditure of their members, increase their utilization of health care services and bring to the financial protection. Jakab et al reviewed 43 papers on CBHI schemes and found that *"Where household survey data have been analyzed, a consistent observation was that community-based health financing has been effective in reaching more low-income populations who would otherwise have no financial protection against the cost of illness"*. (23). However, as Bennett et al. observed, in most of cases the poorest are frequently excluded and are not provided with financial protection (22).

Schneider and Diop analysed the CBHI schemes in Rwanda and found that all people independent of income level had an equal opportunity to join the schemes (20).

5.2 Community based health insurance in Armenia

Two evaluations of the Armenian Revolving Drug Fund were done: "Evaluation of the Revolving Drug Fund component of the community based Primary Health Care program of Oxfam, Armenia" in 2000, and "A report on the Revolving Drug Fund schemes originated by Oxfam Great Britain in Armenia, Azerbaijan and Georgia" in 2002. These evaluations have concluded that the scheme has a number of positive benefits:

- The scheme increases access to Primary Health Care
- Members do not delay treatment compared with the non-members
- Members receive most of their primary care consultations and drugs free of charge.
- Families from villages with a CBHI have lower expenses for primary health care services (5, 14).

An economic analysis of schemes also indicated that schemes recover about 5% of total cost of the health post operations and 80 % of drug expenses. The two studies showed that participation rates in the schemes fluctuated from 10 to 90 %, and the average participation rate was about 35 %. The last evaluation demonstrated that the utilization of health care facilities by community varies largely for members and non-members (Primary Health Care services used by Revolving Drug Fund non-members is 26.2% and Revolving Drug Fund members 36.5%) (14).

Some quality improvements attributable to the scheme were noted in the CBHI: improvements in the supply of drugs in the health posts was increased, the medical personnel are more motivated because they have the drugs to treat patients more effectively, the medical personnel receive a salary, the community is now more interested in the welfare of the health posts and the health boards (consists of CBHI members) are playing an important supervisory role. In many cases the formation of health boards, whose membership is drawn from the community, has given the community more direct involvement in the decision-making process.

Most of weaknesses identified in communities were related to:

- Financial barriers for the poor when they pay their contributions
- Adverse selection actively working

- Pooling and real risk sharing is a problem when participating members are small in number
- Monopoly power of providers negotiating scope and price of services
- Management training is limited
- Low quality of care and poor control over quality assurance
- Less-organized schemes are cut off from formal sector networks (5, 14).

Based on the results of these two studies, it is concluded that the schemes are useful models for the provision of primary health care in rural areas of Armenia, but there is a need to make some specific improvements (5, 14).

5.3 Community based health insurance as a strategy

Community Based Health Insurance is seen as one mechanism that can contribute to such strategies, particularly in settings were a high proportion of total health expenditure is financed by out-of-pocket payments (25). As the WHO has stated: "even small pools or pools for segments of the population are better than pure out-of-pocket financing for all" (26).

Community-based health insurance is a mechanism that allows for the pooling of resources to cover the costs of future, unpredictable health-related events. Community Based Health Insurance schemes are becoming common in low income countries. However, CBHI schemes nowadays are recognized as an intermediate step from reliance on out-of-pocket financing towards achieving universal insurance coverage through some mix of tax-based financing, social health insurance and private health insurance (27).

The main goal for expanding existing community insurance schemes and integrating them into national systems is to improve access to health care, increase financial protection, and raise additional revenue. The evidence reviewed above suggests that community health insurance can contribute to achieving these objectives (28).

To support Community Based Health Insurance schemes, governments should take a leading role in donor coordination, appropriate policy development and planning. This is necessary to ensure the effective use of public and private resources.

Bennett et al presented the dangers in failing to consider the relationship between CBHI schemes and the broader health care system. Bennett has further explored the issue that how CBHI schemes interact with the broader health financing system, and highlights the importance of measuring not only the impact of CBHI schemes (ability to raise funds, and provide financial protection for their members, equity etc.) but also the impact such schemes have on the broader health financing system. From a policy perspective, she suggests that it is important to coordinate government managed risk pools and CBHI-based risk pools. (24).

Ranson and Bennett offer a useful framework that explores the potential strategies that governments could adopt if they wish to support the development, sustainability and impact of CBHI. Below is presented strategies to overcome problems (29, 30).

Table 4. Some Strategies for Overcoming the Problems

Stewardship	Creating an enabling environment	Resource transfers
• Developing a policy framework that includes specification of the role for CBHI (the population covered, the benefits package and the level at which the benefit package is to be delivered). It must define the responsibilities of different actors • Regulating CBHI: legislating for the benefits package to specify what services are to be delivered (prevention, management of specified chronic diseases, specific services e.g. reproductive health); setting minimum standards of quality for the services provided; stipulating payment mechanisms that incorporate incentives for efficient provision of care; making membership compulsory and mandating that insurers provide universal coverage (this	• Improving governance, especially with regard to corruption. • Developing technical capacity in the areas of policy formulation, financial management, monitoring and evaluation, health information systems etc. • Legal recognition of CBHI initiatives • Social animation; developing an appropriate public relations and communication strategy.	• Direct transfers: governments can make direct financial transfers to CBHI scheme budgets. They can also provide technical and managerial support and training for the scheme staff. • Indirect transfers are a common mechanism for subsidising CBHI schemes, particularly where government owns health care providers and covers, for example, provider staff salaries. • "Tied transfers": this is a form of subsidy linked to particular services (e.g. immunisation) infrastructure or goods (e.g. drugs, medical equipment etc.) • Re-insurance

deals with the problems of moral hazard and adverse selection) • Mandating certain activities or features e.g. compulsory contributions • Monitoring and regulating insurance • Monitoring and regulating health care • Data collection, analysis and information sharing: information relating to disease prevalence, treatment quality, and cost are vital for evidence based management of service provision and for adapting both premiums and benefits packages		

Currently in Armenia, the government is not adequately fulfilling all of these roles to contribute to the development of CBHI schemes. If the government is committed to supporting the further development of Community Based Health Insurance in Armenia, it needs to strengthen its stewardship function, enact legislation to facilitate the operation of CBHI schemes and expand financial support for Community Based Health Insurance.

6. SPECIFIC RECOMMENDATIONS

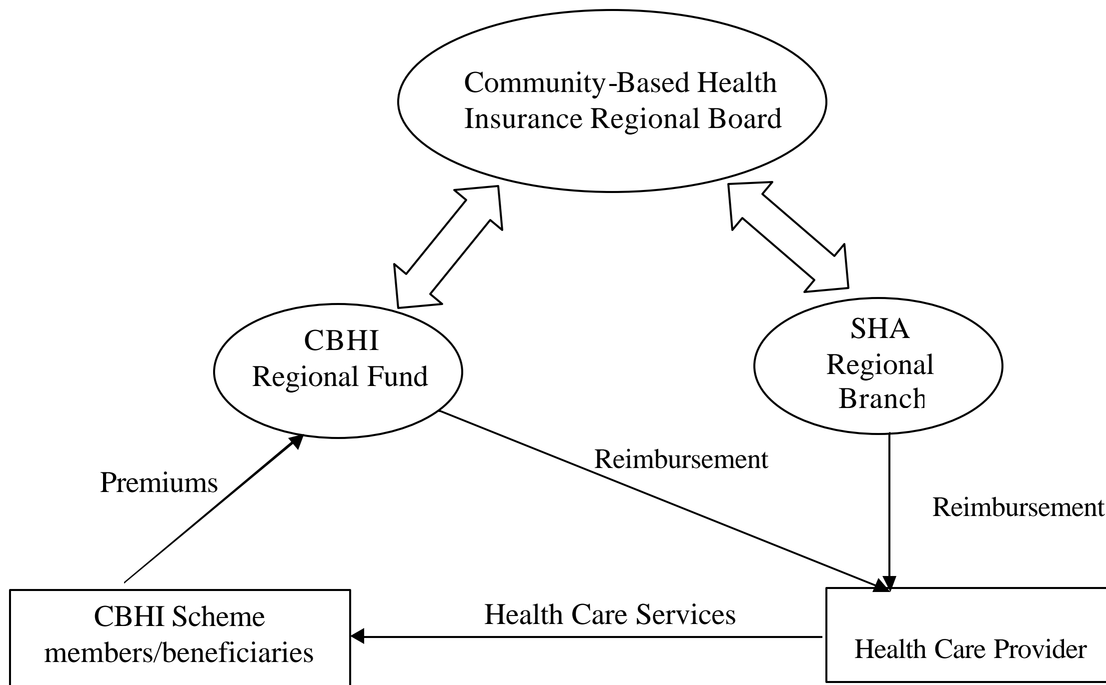
Based on discussed strategies, it is recommended:

1. Legislative changes are needed in Armenia to facilitate the wider introduction of Community Based Health Insurance schemes. These are relevant to the law "On Public Health", drafted by the Ministry of Health and recently presented to the national parliament's Standing Committee on Social, Health and Environmental Affairs for further parliamentary discussions and debate. Adoption of this law will provide a formal legislative and regulatory framework for further development of the national health care system; it is this

vital that this law is supportive of the longer-term development of Community Based Health Insurance.

2. Government have to incorporate the objectives of the CBHI within the national health policy framework, such as national primary health care plans, policy reduction strategy plans and develop an appropriate policy framework for the introduction of Community Based Health Insurance in Armenia.
3. The government could contribute to the effectiveness and sustainability of the Community Based Health Insurance schemes for rural population through technical support to strengthen management capacity of local schemes and facilitate links with formal financing and provider networks. For example, when the SHA is contracting rural primary health care institutions through the district policlinics, the SHA should ensure that dedicated salary allocations, and resources for drugs and medical supplies are detailed in the contractual arrangements to ensure adequate funding for rural ambulatories and FAPs.
4. If the government wishes to support the development, sustainability and impact of Community Based Health Insurance, it has to provide technical assistance to different CBHI schemes such as: increase medical equipment supply, revise essential drug list, provide training to Primary health Care administrators to increase the understanding and advocacy of Community Based Health Insurance, disseminate best practices of CBHI in Armenia, continue strengthening of Primary Health Care in Armenia.
5. It is recommended to create a new body 'Community Based Health Insurance Regional Board', which would act as a regional level intersectoral consulting, supervising and coordinating entity, and which could serve to fill the information, communication, and administrative gap between state-provided

and Non Governmental Organizations -provided financial funds and other relevant resources.



6. If government efforts to support Community Based Health Insurance schemes are to become more successful, donors and other stakeholders need to consider how they can work through state-established systems and channels and continue expanding existing community insurance schemes. Such an approach would strengthen these systems and increase the impact aid, as well as strengthening planning, monitoring and accountability mechanisms. Overall such an approach would contribute to increasing the overall efficiency of the health system.
7. It is clear from the Armenian experience that Non Governmental Organizations have a central role to play in setting up and sustaining

Community Based Health Insurance schemes. Their involvement is crucial to the success of the schemes and to ensuring that the schemes continue to focus on meeting the needs of the poorest and most disadvantaged (31). This role should be regarded as complementary to the role of national governments and donors.

7. IMPLEMENTATION AND EVALUATION

Many of the recommended actions will need strong government and marz authority commitment, support by non-governmental organizations and active involvement of communities and rural practitioners.

CBHI schemes are considered a complement, not a substitute for strong government involvement in health care financing. It also can be regarded as an alternative approach to introduce the health insurance system in the country. However, no single financing mechanism, including this one, is likely to provide a universal solution for health care financing.

The effects of the proposed interventions can be seen after a long period. The indicators for monitoring of the recommended course of actions may include accessibility of health care services, availability of drugs in rural health facilities, patient satisfaction, health care service utilization at the Primary Health Care level, etc. The health status of the population as a main outcome will be improved and measured after much longer period.

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