Health Insurance Component of the Social Package: a Qualitative Assessment

Master of Public Health Integrating Experience Project

Utilizing Professional Publication Framework

by

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LIST OF ABBREVIATIONS

GoA Government of Armenia

FGD Focus Group Discussion

IDI In-Depth Interview

BBP Basic Benefit Package

OCSC Obstetric Care State Certificate

CHSC Child Health State Certificate

SP Social Package

NHIC National Health Insurance Company

GDP Gross Domestic Product

MSHI Mandatory Social Health Insurance Fund

SWOT Strengths, Weaknesses, Opportunities, and Threats

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ABSTRACT

Background: Armenia implemented several major health care reforms in the last 20 years. The main reform efforts aimed to establish a balance between hospital and primary care and to make those services accessible and reduce informal payments. During the past decade, the Ministry of Health of the Republic of Armenia and international organizations implemented a number of projects to improve the performance of the Armenian healthcare system. The Government of Armenia introduced the Social Package (SP) in January 2012, for public employees of educational, cultural institutions, and civil servants in Armenia which covered about 120,000 people. Mandatory health insurance was one of the components of the package, giving each beneficiary avoucher with a value of 132,000 AMD out of which 52,000 AMD must be dedicated to obtaining basic health insurance package from private insurance companies. There are no evaluation studies for this program.

Objectives: This study aimed to evaluate the health insurance component of the Social Package program for evidence based decision and policy making in Armenia. The specific objectives of the study included exploring attitudes, practices, and experiences in terms of how the health insurance component (HIC) of the SP program influenced access to healthcare services, out-of-pocket payments, and overall satisfaction of different stakeholder groups with the mandatory and voluntary parts of the HIC of the Social Package.

Methods: The research team used a qualitative study design with semi-structured in-depth interviews and focus group discussions to address the research questions. The directed content analysis using the SWOT approach helped to emphasize the strengths, weaknesses, opportunities and threats of the health insurance component of the Social Package program. The study took place in Yerevan (the capital city) and Shirak marz (Gyumri city) to understand the challenges of implementing the HIC of the SP program. Five groups of participants took part in the study: policy makers/experts, healthcare providers, insurance company officers, SP beneficiaries and non-beneficiaries. The study included 75 participants (65 female and 10 male).

Results: All participants had a positive opinion about the HIC of the SP program; it improved affordability and utilization of inpatient surgical care for its beneficiaries. The participants highlighted the following weaknesses of HIC of the SP program: limited coverage and long list of exclusions; reported episodes of informal payments, particularly in marzes; limited understanding of the HIC among some stakeholder groups; and informal pressures to choose a specific insurance company or health provider. The participants suggested the following opportunities to improve the HIC of the SP program: improving management of financial and human recourses in insurance companies and health facilites, expanding coverage of services and number of people, and strengthening monitoring of the program . The following threats to sustainability of the program were mentioned: unequal opportunities to use the HIC in marzes due to poor quality of services and lack of specialists, lack of treatment and diagnostic guidelines, inappropriate allocation of financial resources for primary and hospital care, very high administrative expenses, and unnecessary use of hospital services.

Conclusion: The implementation of the health insurance component of the SP was a step forward in reducing informal payments for healthcare services in Armenia and improving utilization of

hospital care. However, the HIC of the SP program introduced motivations for unnecessary hospitalizations leading to inefficiencies in the health system and increased health expenditures for the country. The current study makes recommendations to make the health component of the SP program more effective, efficient, and equitable: reconsider organization of HIC of the SP program moving away from the current multi-payer one through a non-profit public agency; redesign the basic health package of the SP program to motivate utilization of preventive and primary care; strengthen the capacity of a strategic purchaser establishing mechanisms for continuous monitoring and evaluation of financial flows; consider establishment of mandatory health insurance (single-payer) as a complementary source of financing health care system; improve facility level financial management practices to increase transparency and effectiveness; develop standard treatment and diagnosis guidelines;continuously work with the general public to increase awareness of the health insurance component of the SP Program.

1. INTRODUCTION

1.1. Background

The World Health Organization's (WHO) health systems' framework suggests that the three main goals of health systems are health, responsiveness and fairness in financing (Murray & Frenk, 2000). The financial security of the population in terms of getting necessary medical services depends on the level of risk protection that health care system provides (Xu, Aguilar, Carrin, & Evans, 2005). There are three main domains to analyze financial risk protection and evaluate progress in financing of health systems: who is covered, what services are covered, and what proportion of cost is covered (WHO, 2010). Financing of the health care system along with Payment, Organization, Regulation and Behavior is one of the "control knobs" that determine the performance outcomes of the health system (including financial risk protection) and can be used to change them (Roberts, Hsiao, Berman, & Reich, 2004).

After the collapse of the Soviet Union countries faced economic crisis and catastrophic decline in prepaid revenues for financing their health systems (Balabanova, Roberts, Richardson, McKee, & McKee, 2012). Despite the same starting condition in those countries, they ended up in different circumstances in the process of transition. There are variations in health systems' performance between countries, even those with similar income (Murray & Frenk, 2000). Many reforms have been implemented in the former Soviet countries, but lack of financial protection remains an issue in many of them (Balabanova, et al., 2012).

Public sector expenditure on health as a percent of Gross Domestic Product (GDP) was 5.5% in Moldova, 3.4% in Russia, and 1.8% in Georgia in 2011 (Balabanova, et al., 2012). The level of out-of pocket spending remains high; for example, in 2008 in Georgia it was 66.3%, in Moldova 48.4% and in Russia 28.4%. In 2010, the proportion of those who mentioned financial

barriers for not seeking health care was 69.7% in Georgia, 28.6% in Moldova and 4.6% in Russia (Balabanova, et al., 2012)

The idea of universal health coverage is one way to overcome lack of financial protection. Universal health coverage means that everyone in a society can afford basic health care services in sufficient quality and without having catastrophic expenditures (Savedoff, Ferranti, Smith, & Fan, 2012). Gains form expanded health coverage depend on many factors, such as institutional framework, governance arrangements and there is no unique best way for reforming health financing to get universal health coverage (Moreno-Serra & Smith, 2012). Besides thinking about funding sources, policy makers need to pay attention to pooling arrangements and purchasing methods (Kutzin, 2012).

Reforms in financial mechanisms could help to reach the policy goal of universal coverage; single-payer and multi-payer models of health insurance system are two different options to consider (Hussey & Anderson, 2003). In the first case usually one organization is responsible for all four functions of health insurance system: revenue collection, risk pooling, purchasing and social solidarity (Kutzin, 2001). In the second case several organizations carry out those functions (Hussey & Anderson, 2003). In Kyrgyzstan and Moldova, for example, several reforms were made to shift the health system from fragmented to more integrated single-payer system (Kutzin, Jakab, & Shishkin, 2009).

In Moldova the reform was implemented in 2004. A new fund, the National Health Insurance Company (NHIC), became responsible for pooling and purchasing of health care (Kutzin, Jakab, et al., 2009). However, the level of out-of-pocket payments did not decline (Richardson, Roberts, Sava, Menon, & McKee, 2011).

In 2006-2009, Kyrgyzstan introduced a single payer system at the national level. They pooled the health budget and mandatory health insurance contributions into one fund which allowed to eliminate pool fragmentation and coverage duplication (Kutzin, Ibraimova, Jakabc, & O'Dougherty, 2009). From 2000 to 2009 the level of out-of-pocket payments as the share of total health expenditure declined from 53% to 43% (Ibraimova, Akkazieva, Ibraimov, Manzhieva, & Rechel, 2011).

In contrast to Kyrgyzstan and Moldova, Georgia moved away from Mandatory Social Health Insurance to a multi-payer system in 2004, and in 2007 the level of out-of-pocket payments was 70.9% of the total health expenditure while the public spending was 18.4% (Chanturidze, Ugulava, Durán, Ensor, & Richardson, 2009). Evidence suggests that the multi-payer system in Georgia did not improve the quality of health services and access to care for the poor (Bauhoff, Hotchkiss, & Smith, 2011).

These examples show that pooling all the financial sources into one agency allows to minimize evidence of risk selection and to increase the purchasing power (Hussey & Anderson, 2003).

1.2. Situation in Armenia

Armenia, as a former Soviet Union country, is in the transitional stage of development; it suffered from economic crisis after independence in 1991. The process of changes impacted all spheres including the health system (Hakobyan, Nazaretyan, & Makarova, 2006; Harutyunyan, Demirchyan, Petrosyan, & Thompson, 2010) . The system shifted from a centralized Semashko model to a fragmented one and out-of-pocket payments became the main sours of financing (Hakobyan, et al., 2006). The main reform efforts aimed to establish a balance between hospital

and primary care (improve allocative efficiency), make those services accessible and reduce informal payments (WHO, 2009). The process of privatization of health care facilities led to substantial weakening of the system in terms of quality control and management instead of reducing informal payments (WHO, 2009).

The sources of health system financing in Armenia include state budget, out-of-pocket payments, donor/NGO contribution, and insurance financing, although the last one is only 0.3% of the total spending (WHO, 2009). Public expenditure on health was 0.8% of GDP and 2000 and 1.8% in 2009. According to the Medium-Term State Expenditure Framework, it was planned to spend 1.7% of GDP in 2011 and 1.4% in 2012 (GoA, 2011b). However, in 2010-2012, the actual expenditure remained at 1.8% of GDP. Health expenditures from public sources as a percent of GDP continues to remain among the lowest in the WHO European Region (Feeley, 2009).

According to the National Health Accounts out-of-pocket payments were about 52.4% and public expenditure 39.2% of total health expenditures in Armenia in 2009 and 55.4% and 36.4% respectively in 2010 (NHA, 2010; WHO, 2009, 2010). Despite significant improvements documented over the last decade, access to basic care remains challenging in Armenia because of lack of public financing of the health system. For example, the percent of those who didn't seek health care when needed because of financial barriers in the last 4 weeks among adults was 77.5% in 2001 and 27.1% in 2010 (Balabanova, McKey, Pomerleau, Rose, & Haerpfer, 2004; Balabanova, et al., 2012). In 2008, 17% of Armenian households had catastrophic health expenditures, using the extreme poverty line (Aydinyan & Feeley, 2010).

Provided evidence shows that the Armenian health system does not yet perform well in terms of financial risk protection of its population and because of significant OOP payments many people have to spend a significant portion of their income on health.

During the past decade, the Ministry of Health and international organizations implemented a number of projects to improve the performance of the Armenian health care system (MoH, 2010). Those programs include the introduction of the Basic Benefit Package (BBP, 1996), Obstetric Care State Certificate (OCSC, 2008), Child Health State Certificate (CHSC, 2011), official co-payment policy (2011) and Social Package (2012) (Crape et al., 2011; GoA, 2011b; Mladovsky et al., 2012; MoH, 2010).

For vulnerable groups, including disabled, orphans under 18 years old, war veterans and families of those who died in the war, children 0-7 years of age and children under 18 with one parent, the Government of Armenia implements the Basic Benefit Package, which allows getting free health care at primary and secondary level facilities. It also covers the treatment of such diseases as Tuberculosis (TB) and HIV/AIDS (MoH, 2012). The State Health Agency reimburses hospitals and polyclinics for services provided within the scope of the BBP.

In 2008, the Government of Armenian introduced the Obstetric Care State Certificate (OCSC) program to assure all women receive free and quality obstetric and post-natal care in maternity hospitals and eliminate informal payments (Truzyan, Grigoryan, Avetisyan , Crape , & Petrosyan 2010). In 2011, the Child Health State Certificate (CHSC) program was implemented to cover the actual cost of in-patient health services for children less than seven years of age, to decrease informal payments and to improve access of children to hospital care (Crape, et al., 2011). Independent evaluations demonstrated that both programs were successful in meeting the policy goals (Truzyan, et al., 2010). The Government introduced the official co-payments policy

in February 2011. It covered a range of services included in the BBP, such as emergency care, gynecological services, and starting 2012 oncologic care and treatment for sexually transmitted infections; the main idea was to formalize the unofficial payments and increase government revenues (Mladovsky, et al., 2012).

Voluntary private health insurance was implemented in Armenia to increase risk-pooling and financial protection, improve access to necessary care and to use limited public recourses more effectively (Sekhri, Kutzin, & Tsaturyan, 2007). It had been covering mainly employees of international organizations working in Armenia. The coverage of health services provided by private health insurance companies has had overlaps with the BBP (Sekhri, et al., 2007).

In January 2012, the Armenian Government introduced the Social Package (SP) – social benefits for 132,000AMD - for public employees of educational, cultural institutions, civil servants aiming to cover 120,000 employees (GoA, 2011a)The main goals of the Social Package were stated as:

1. To meet the employees' social needs
2. To increase the motivation and productivity of employees
3. To increase the attractiveness of government employment
4. To reduce the flow of qualified workforce from government agencies to private sector.

Mandatory health insurance has been one of the components of the SP, giving each beneficiary an opportunity to obtain basic health insurance package for 52,000AMD from a private health insurance company. It also has a voluntary part: the participant can enlarge the amount of money spent on health insurance for either buying more generous health services package or include one family member in the coverage. There are no clearly stated objectives for the health insurance component of the SP (GoA, 2011a). The health related policy objectives of

this program could be similar to policy objectives of introducing private health insurance: to improve access to care, financial protection, equity in financing, quality of care, and to reduce informal payments and increase administrative efficiency (Sekhri, et al., 2007).

The mandatory basic health package covers a number of medical services mainly related to hospital treatment, including neurosurgical, cardiac and vascular surgeries. Moreover, it covers several diagnostic tests and preventive therapeutic measures within the limit of 3,000AMD per year (GoA, 2011a), which overlaps with the Basic Benefit Package. The cap on insurance company spending is 3.8 million AMD per person per year. The duration of the program was not specified in the Government decision (GoA, 2011a). The basic mandatory health insurance component of the Social Package has a long list of exceptions from coverage such as ambulatory treatment, chronic diseases, autoimmune diseases, dental services, psychological problems and others (GoA, 2011a).

1.3. Objectives of the study

The Social Package program has not been formally evaluated yet. The purpose of this study was to evaluate the health insurance component (HIC) of the Social Package program for evidence based decision and policy making in Armenia. The study investigated whether the health insurance component of the Social Package met its policy objectives from the perspectives of different stakeholders, such as beneficiaries, health professionals, health insurance companies and policy makers. It identified strengths, weaknesses, opportunities, and threats of the health insurance component of the SP and made recommendations to policy makers for improvements.

The specific research objective of the study included:

- Explore attitudes, practices, and experiences of different stakeholder groups in terms of access to care, out-of-pocket payments, and overall satisfaction within the health insurance component of the Social Package Program.
- Explore differences in the experience of different stakeholder groups with the mandatory and voluntary parts of the health insurance component of the Social Package Program.
- Explore differences in the experience of different stakeholder groups with the health insurance component of the Social Package Program in Yerevan and Gyumri cities.
- Explore differences in the experience of SP beneficiaries and non-beneficiaries in terms of access to health services or out-of-pocket payments.

2. METHODS

2.1. Study design

To address the specific objectives, a qualitative cross-sectional directed content analysis design and methodology were employed (Hsieh & Shannon, 2007). The research team conducted semi-structured in-depth interviews and focus group discussions with different stakeholder groups and applied the SWOT (strengths, weaknesses, opportunities, and threats) analysis to address the research objectives (Bensoussan & Babette, 2008).

2.2. Maitanance of rigor

To maintain the rigor of the study, the study team used the following strategies: stratified the participants by residency area to make findings more transferable to other regions of

Armenia; invited different stakeholder groups to participate in the study - using different data sources helped to achieve triangulation and increased trustworthiness of the findings; and data collection continued until reaching saturation (Pope & Mays, 1995). Moreover, the moderator used iterrative questioning technique during data collection and writes a detailed memo on the overall athmosphere, participants' behavior during the interview or focus group discussion, reflections on challenging or new questions, and other important observationsimmediately after each interview. The study had frequent debriefing sessons between the student investigator and the advising team to share experiences and perceptions and to recognize personal biases and preferences (Andrew, 2004; Sandelowski, 1986).

2.3. Study participants

The study team used purposive sampling with a snow-ball strategy to recruit potential participants from Yerevan (the capital city) and Gyumri (the second big city in the country located far from the capital). The main stakeholder groups involved in the study included policy makers, health insurance company officers, health providers that worked with insurance companies, beneficiaries of the Social Package and those who did not qualify to be beneficiaries. The student investigator approached public school teachers from Yerevan and Gyumri to recruit SP beneficiaries and private school teachers to recruit non-beneficiaries with similar characteristics. The study participants were categorized into five groups 1) SP beneficiary, 2) SP non-beneficiary, 3) health care provider, 4) insurance company officer, and 5) policy maker.

2.4. Study Instruments

The study team developed semi-structured in-depth interview guides for interviewing policy makers, health insurance company officers and health care providers and focus group discussion guides for the beneficiary and non-beneficiary teachers. Semi-structured approach to data collection was employed both during in-depth interviews and focus group discussions in order to provide an opportunity to express broader insights during the dialogue (Webb & Doman, 2009). The study team adapted the guides for specific considerations with each group of stakeholders and designed to maximize the value of the collected data to meet the study objectives. All guides were developed in English and then translated into Armenian (Appendix 1). All the interviews and discussions were conducted and transcribed in Armenian to be able to capture explicit and implicit meanings expressed in the Armenian language, as well as culturally specific expressions and concepts (Suh et al 2009). After the meetings the participants completed a demographic questionnaire.

2.5. Data analysis

After data collection and transcription, the student investigator analyzed the in-depth interview and FGD transcripts using a coding system proposed by Bradley and colleagues to address the research objectives (Bradley, Curry, & Devers, 2006) and applying SWOT analysis (Bensoussan & Babette, 2008). Research team used the directed content analysis approach (Hickey & Kipping, 1996). The directed content analysis was completed using Bradley and colleagues' coding rubric and enabled interpretation of the findings in the context of health services delivery (Bradley, et al., 2006). Transcripts were reviewed for words and phrases which described the Social Package and were related to the research questions of the study. Then codes

were categorized according to the objectives of the study: a) attitudes, practices, and experiences; b) access to care, out-of-pocket payments, and overall satisfaction; c) mandatory and voluntary parts of the health insurance component; and d) the experience of SP beneficiaries and non-beneficiaries. The codes of the same categories were constantly compared between different stakeholder groups and between participants from Yerevan and Gyumri. The categories were classified into higher order themes that were recurrent and unifying concepts. The themes were abstracted and classified according to the SWOT analysis to emphasize the strengths, weaknesses, opportunities, and threats to the health insurance component of the Social Package program (Bensoussan & Babette, 2008). Strengths, weaknesses, opportunities, and threats constituted the taxonomy that helped to describe the multifaceted and complex HIC of the SP program (Bradley, et al., 2006).

2.6. Ethical considerations

The Institutional Review Board of the American University of Armenia approved the study protocol. The moderators made audio-recordings only with permission of all participants. The transcripts did not contain names, positions of respondents or any other identifying information (Appendix 2). There were no adverse events during the field work.

3. RESULTS

The fieldwork took place in February-April 2013. The total number of participants was 75 - 43 in Yerevan and 32 in Gyumri. Tables 1 to 4 present demographic data about the participants. They participated in ten focus group discussions, two dyadic interviews and two in-

depth interviews. The mean duration of focus group discussions and interviews were 46 and 40 minutes respectively.

Direct quotes were taken from focus group discussionsand interviews and provided in boxes. The individual informant numbering within each category of participants was provided in the boxes to demonstrate triangulation of ideas among different stakeholder groups. The individual informant identifiers (e.g., SP beneficiary 3.1.A.2) specify the category of participants who provided the quote (e.g., SP beneficiary), the subheading of the report (e.g., 3.1.A.2) and the sequential number of the given category of participant who provided the quote for the given box (e.g., 2.). If the same participant provided more than one quote within a single box, these quotes are provided under the same identifier. A single informant who provided quotes in more than one box has different identifiers for each box. After each identifier the geographic area is indicated (Yerevan versus Gyumri).

3.1. Strengths of the HIC of the SP program

3.1. A Addressing social problems of government employees

The program [Social Package] *has several goals. First of all it was the first attempt to implement a non-monetary remuneration system in Armenia. … The Government has decided that the health care component must be compulsory given many issues in the health system of our country.*

Policy maker 3.1.A.1
Yerevan

The program was directed to improve our health and social conditions; moreover, we were able to pay tuition for our children.

SP beneficiary 3.1.A.1
Yerevan

I was impressed to hear about the program and even didn't believe that our Government could pay attention to the teachers, and then I realized that it was real and I was happy.

SP beneficiary 3.1.A.2
Gyumri

I included my husband in my package [voluntary part of health insurance]. *Thanks god*

there was no need to use it, but it was a good opportunity and I used it.

SP beneficiary 3.1.A.3
Yerevan

According to the study participants the purpose of the Social Package was to give a motivation for government workers to stay in the government system. The health care part was compulsory because it was considered as the most important one by policy makers. Beneficiaries appreciated the fact that the Government decided to pay attention to their problems.

A few participants of the study in Yerevan mentioned about using the voluntary part of the health insurance component for their family members.

3.1. B Improved access and utilization of inpatient health care services

I think that utilization of health care dramatically improved for those who were covered by the Social Package. I am sure that many of them see a doctor and get help. If they did not have insurance they wouldn't have that opportunity.

Policy maker
3.1.B.1

We have about 120,000 cases covered under the Social package. For those who have no serious health problems the program allows having a preventive medical examination once a year and revealing a problem in early stages.

Policy maker
3.1.B.2
Yerevan

The coverage of the program is broad enough and many users were able to undergo very expensive surgeries.

Insurance company officer 3.1.B.1
Yerevan

One of our teachers had a surgery; it was a great help for her.

SP beneficiary 3.1.B.1
Gyumri

I was ill and they [the insurance company] *covered all my treatments and they called me periodically and were interested in my quick recovery. I was impressed.*

SP beneficiary 3.1.B.2
Yerevan

We had many surgeries under this program. Although we were not paid adequately, our patients benefited.

Health provider 3.1.B.1
Gyumri

It was the opportunity to see a doctor for those who couldn't afford it before the program. We really needed it and we were happy.

SP beneficiary 3.1.A.3
Gyumri

The program was created for those who have limited access to health care; it gives them the opportunity to use health services.

Health provider 3.1.A.2
Yerevan

All participants agreed that the HIC of the Social Package improved affordability and utilization of health care services for the beneficiaries. Different stakeholders stated that the HIC of the Social Package improved the utilization of inpatient health care services, especially in case of surgical treatment. Providers indicated that beneficiaries visited health providers more often and the number of surgeries increased as a result of the Social Program implementation. In Gyumri, only a few participants mentioned about improved access; however, covering surgical treatment was mentioned more often as a benefit from the program.

3.1. C Financial protection of beneficiaries

I think that for those families, who use the Package it has a positive impact especially if we talk about expensive services. For sure, those who have insurance are more protected from catastrophic health expenditures than those who do not have.

Policy maker 3.1.C.1
Yerevan

If it [out-of-pocket payments] *still exists, it is minimal for the Social Package, because insurance companies want to have satisfied clients and they will do their best to protect them from out-of-pocket payments.*

Policy maker 3.1.C.2
Yerevan

It [the Social Package] *was a step forward towards the compulsory health insurance in Armenia and those who have serious health problems get the opportunity to solve them absolutely free of charge.*

Insurance company officer 3.1.C.1
Yerevan

Last year, my husband had a heart problem and I realized that I would like to be involved in it [Social Package], *because the cost of the surgery was a financial burden to my family and I have heard that the Social Package covers similar cases.*

SP non-beneficiary 3.1.C.1
Yerevan

Reportedly the HIC of the SP program had a positive impact on the process of eliminating catastrophic health expenditures for the beneficiaries. It also led to decreasing out–of-pocket payments in health care facilities; many beneficiaries of the program from Yerevan reported that they received free-of-charge medical services, especially surgical treatment, without informal payments. None of the beneficiaries from Gyumri mentioned that they were protected from out-of-pocket payments. Those who were not beneficiaries of the SP program wanted to have a SP, because they were not protected from OOP health expenditures.

3.1. D Compensation for Health Providers

Part of the money that was allocated to the health care system within the Social Package was for sure transferred to cover salaries of health care providers and it improved their work conditions. Even if that money was spent on new equipment for the hospital it would also indirectly improve the work of providers.

Policy maker 3.1.C.1
Yerevan

I wonder if the system of insurance will develop in Armenia, because when the patient has insurance you have no financial issues to discuss with him/her, you just do your work.

Health provider 3.1.C.1
Yerevan

The most important benefit for us is that we are free from financial relations with

patients. You know how unpleasant it is for doctors to discuss the payment with them [patients]. *I hope that in the future everyone will have health insurance.*
Health provider 3.1.C.2
Gyumri

Health providers in both Yerevan and Gyumri indicated that the HIC of the SP helped them to be free from payment related discussions with patients.

3.1. E Expansion of voluntary private health insurance

Besides the financial benefits they [insurance companies] *improve their professional capacity in the health care sphere. They had to deal with many clients, find appropriate health care facilities and they had to improve their services. It was a capacity building for them.*
Policy maker 3.1.D.1
Yerevan

We have clients who learned about [health] *insurance because of the Social Package and they expressed willingness to buy* [health] *insurance for their family. We benefited from the* [SP] *program* [in terms of increasing the number of people who buy private health insurance].
Insurance company officer 3.1.D.1
Gyumri

We start trusting insurance companies more than before.
SP beneficiary3.1.D.1
Yerevan

Policy makers and most insurance company officers in Yerevan and Gyumri stated that the HIC of the Social Package led to development and expansion of voluntary private health insurance in Armenia. This finding was triangulated by some SP beneficiaries.

3.2. Weaknesses of the HIC of the SP program

3.2. A. Limited coverage of health care services and risk selection

The initial [basic health insurance] *package was designed with some reservations. It was done to protect insurance companies from unexpected expenditures. Because of that the basic health package had very careful definitions to limit the number of cases when insurance companies had to reimburse the health costs. …*

Policy maker 3.2.A.1
Yerevan

The package deals with in-patient care and covers only those services that lead to hospitalization. Almost all outpatient care services stay out of the scope of the program.

Insurance company officer 3.2.A.1
Yerevan

I read the contract very carefully, and from the ten pages seven were about exclusions [conditions not covered by the SP]. *The most important diseases were excluded.*

SP beneficiary 3.2.A.1
Yerevan

I was not able to use this package, because I had a heart problem and bought drugs for 15,000 AMD every month. When I asked the insurance company about compensation they said that I would take this treatment my whole life and they were not able to pay for it. It seemed that they cover only flu, which we could treat by home-made jam.

SP beneficiary 3.2.A.2
Yerevan

I have an impression that the goal of this program is to make profit; if they include all chronic diseases in the list of exclusions it means that it is only for healthy people.

SP beneficiary 3.2.A.3
Yerevan

If the patient had a chronic condition they [the insurance company] *would not cover it, but we have had a lot of those cases. For example, we had an emergency patient with pre-stroke condition and we weren't able to help him because his insurance refused to cover the case. He had to go to a different hospital and pay for the treatment.*

Health provider 3.2.A.1
Yerevan

They [insurance companies] *write the text of the contracts in a way to be able avoiding reimbursement for the used health services.*

SP non beneficiary 3.2.B.1
Yerevan

They [insurance companies] *deliberately hide the information* [the exclusion criteria], *because it is not helpful for them to have informed clients*.

SP beneficiary 3.2.B.4
Gyumri

Usually patients have no information [about their rights]; *only those who have someone in an insurance company know about their rights, and they know how to present their* [health] *problems to be covered.*

Health provider 3.2.B.2
Yerevan

Different stakeholders reported that the coverage of the SP was very limited. The list of exclusions was set to serve as a risk selection mechanism for the insurance companies.

The SP beneficiaries felt that insurance companies were not willing to openly discuss the list of exclusions. Moreover, some SP beneficiaries mentioned that health insurance companies were able to avoid paying for certain health services because beneficiaries did not fully understand their rights within the health insurance component of the SP Program.

3.2. B Lack of understanding about health insurance packages

We have issues especially among beneficiaries, majority of them do not even understand what is insurance. They don't know who to apply to for addressing their problems, how much money they can receive as compensation. ... The situation is worse in the marzes compared to Yerevan.

Policy maker 3.2.B.1
Yerevan

The main issue for us is the lack of information. There are some health problems, for example, genetic or chronic diseases, which are in the list of exclusions and it is an international policy for insurance companies, but our population has no idea about it and they expect that all their health problems will be covered.

Insurance company officer 3.2.B.1
Yerevan

I have participated in presentations about the program twice. They [insurance companies] *told a lot about the advantages, but nothing about exclusions, because the list is very long.*

SP beneficiary 3.2.B.1
Yerevan

I was not able to use the health care part of the Social package because I have no idea how to use it. I had a surgery and paid the full price.

SP beneficiary 3.2.B.2
Gyumri

When we have questions they [insurance companies] *say that we should call Yerevan office and talk to them. But it is very expensive for us to talk for several minutes by cell phone every time.*

SP beneficiary 3.2.B.3
Gyumri

I have no information about the program and I don't want to have it, because this is not my responsibility. If my patients have some questions we have a specialist in our hospital who explains them all the issues [related to health insurance].

Health provider 3.2.B.1
Yerevan

We provide them [patients] *information on how to use a program* [Social Package]*; for example, before starting the treatment we ask them to contact their insurance company and get permission to avoid problems.*

Health provider 3.2.B.2
Gyumri

All stakeholders reported about lack of information about and understanding of health insurance component of the Social Package program. Policy makers and health insurance company officers reported about their efforts to inform the beneficiaries about the health insurance component, but there was still lack of understanding among beneficiaries and providers, especially in Gyumri. Healthcare providers also complained about lack of information on health insurance among beneficiaries leading to more work for the providers when dealing with insurance companies.

3.2. C Pressures for choosing insurance or health providers

The private insurance companies were chosen as health insurance providers because there was no alternative in the public sector… Within the scope of the Social Package beneficiaries have the opportunity to choose the insurance company.

Policy maker 3.2.C.1
Yerevan

I know that in many schools teachers were forced to choose a specific insurance company.

SP non beneficiary 3.2.C.1
Yerevan

It is like during the Soviet years; our choice [of insurance company] *is voluntary but*

mandatory.

SP beneficiary 3.2.C.1
Yerevan

They [insurance companies] *force us to buy a more expensive health insurance package, but for me it was better to pay my son's tuition. They emphasize the health component more since they have their own interests in mind.*

SP beneficiary 3.2.C.2
Yerevan

We signed what they gave us without even reading.

SP beneficiary 3.2.C.3
Gyumri

We never limit their [beneficiaries] *choice of health care facilities, because it is a health issue and it would be an additional responsibility for us. In this case they* [beneficiaries] *can't complain about the quality of health services, it was their choice.*

Insurance company officer 3.2.C.1
Yerevan

In the insurance company they say that I have to go to a particular hospital, but I have my doctors whom I trust, why I should change them?

SP beneficiary 3.2.C.4
Yerevan

For dental services they [the insurance company] *forced me to go to their clinic, but I did not want, because I know that the quality* [of health services] *was low there*.

SP beneficiary 3.2.C.5
Gyumri

According to policy makers and health insurance company officers, the beneficiaries were free to choose insurance companies and health care providers. However, the SP beneficiaries reported the opposite. The SP beneficiaries repeatedly reported about being informally forced to choose a specific health insurance company. The beneficiaries in Gyumri were discussing this issue more openly than their peers from Yerevan. Moreover, some beneficiaries from Gyumri did not even know that they could choose. Moreover, some SP beneficiaries from Yerevan and Gyumri reported that insurance companies restricted the list of health facilities where the beneficiaries could receive health services.

3.2. D Informal out-of-pocket payments

I can't exclude this issue [informal payments] *but I think that it reduced to minimal. The main reason for that* [informal payments] *has been insufficient financing for hospital services. If the heads of hospitals would allocate money so that every doctor would receive appropriate salary the risk for out-of-pocket payments will be minimized.*

Policy maker 3.2.D.1
Yerevan

For Social Package it is minimal because the insurance companies have the goal to have many satisfied clients and they will do their best to protect them from additional payments.

Policy maker 3.2.D.2
Yerevan

I cannot 100% guarantee that we do not have it [informal payment]*, because we all know our reality, but it is gradually going down.*

Insurance company officer 3.2.D.1
Yerevan

They [the insurance company] *paid only 200,000 AMD for my surgery related to forearm fracture; I had to pay out-of-pocket the remaining 100,000 AMD. They* [the insurance company] *said that they had a cap.*

SP beneficiary 3.2.D.1
Yerevan

Our director was hospitalized, and the insurance company paid only 80,000 AMD. But he [the school director] *had to make such a big additional payment that 80,000 AMD seemed nothing.*

SP beneficiary 3.2.D.2
Gyumri

Many participants reported that informal payments for the healthcare services covered under the SP package reduced; however, there were reported episodes of informal payments. Particularly, SP beneficiaries from Gyumri reported about making informal out-of-pocket payments to health providers and insurance companies.

3.2. E Administrative difficulties

The mechanisms of payment [for services covered under the SP health package] *are*

unclear in each stage…

Policy maker 3.2.E.1
Yerevan

The Government and hospitals set their prices for healthcare services and we have difficulties with that. They [hospitals] *try to work with us with high prices, this process is not regulated.*

Insurance company officer 3.2.E.1
Yerevan

Sometime doctors make arrangements with patients, they record a different diagnosis to get more money from us, and all these happen because of unregulated prices.

Insurance company officer 3.2.E.2
Gyumri

The doctor prescribes the medication, I should buy it, keep the receipt, than I should show it to the insurance company and wait for seven months until they [the insurance company] *make a decision to cover the medication cost or not. You should call them* [the insurance company] *thirty times to get an answer.*

SP beneficiary 3.2.E.1
Yerevan

One of our teachers had a problem with her eyes and after four visits [to the insurance company] *she just torn her insurance card. She was annoyed.*

SP beneficiary 3.2.E.2
Yerevan

I was feeling very bad when I went to the hospital, where I had to wait about two hours until the insurance company approved my hospitalization.

SP beneficiary 3.2.E.3
Yerevan

It seems that they [the Government] *wanted to make our life easier but those of us who used the* [health insurance] *package were disappointed because they are disorganized. People prefer to pay out-of-pocket for the treatment they receive and solve their problems.*

SP beneficiary 3.2.E.4
Gyumri

Now we have three pricelists: for patients covered by the BBP, by insurance companies and those who pay out-of-pocket. It makes our work very difficult.

Health provider 3.2.E.1
Yerevan

We have to wait very long before they [insurance companies] *will give an answer, it takes several hours. Moreover, for each additional procedure we should contact them again and wait for approval*.

Health provider 3.2.E.2
Yerevan

I have to give the certificate to the patient, whom s/he presents to the insurance company, then the insurance company provides her/him another document to be taken back to the hospital and this is an endless process which complicates our work.

Health provider 3.2.E.3
Yerevan

I can say that they [insurance companies] *delay our payments and we have no idea how much money we will eventually get for each particular case.*

Health provider 3.2.E.4
Gyumri

I had a case when a patient came to me with acute cardio-respiratory deficiency on Sunday. We weren't able to contact the insurance company and had to provide care to the patient. The insurance didn't cover that case and the doctor had to pay for the care by himself.

Health provider 3.2.E.5
Yerevan

Health care providers and SP beneficiaries faced difficulties when dealing with health insurance companies. According to the majority of healthcare providers, unregulated prices for health care services were leading to administrative difficulties. The majority of healthcare providers emphasized high amount of paperwork for insured patients, they also reported about delayed and reduced payments from health insurance companies for the provided healthcare services to SP beneficiaries. SP beneficiaries from Yerevan and Gyumri complained about lots of bureaucracy and delays in getting appropriate care because of ineffective administrative procedures set by health insurance companies.

3.2. F Low quality of services

The insured patient shouldn't feel any difference in the quality of provided services compared to uninsured ones. He should know that insurance company is responsible for that [quality of services].

Policy maker 3.2.F.1
Yerevan

We have regulations [to assure the quality of provided care] *and we have a goal to improve them. For example, we call our clients and ask whether they are satisfied with the quality of provided services.*

Insurance company officer 3.2.F.1.
Yerevan

I have heard that the attitude of doctors to the patients is very bad if they have Social Package health coverage.

SP non-beneficiary 3.2.F.1
Yerevan

I know that in some cases doctors avoid having patients with insurance. They say that they have no idea whether their work would be compensated or not; I am afraid that it will affect the quality of their work.

SP beneficiary 3.2.F.1
Gyumri

I have never felt as humiliated, as when dealing with the health insurance company. The attitude is very slighting, especially in Gyumri.

SP beneficiary 3.2.F.2
Gyumri

The quality of our work suffers because before this program we had 20 minutes for each patient, but now we are not able to spend more than 10 minutes per patient.

Health provider 3.2.F.1
Yerevan

I had a patient with pneumonia and he had to come to see me at list once a week, but officer of an insurance company called me and said that I have to limit the number of visits. But in that case the quality of my treatment suffers.

Health provider 3.2.F.2
Yerevan

They [insurance companies] *delay our payments but they should know that it would affect the quality of our work. If doctors see that their work remains unpaid they will migrate from Armenia or change their performance.*

Health provider 3.2.F.3
Gyumri

They [patients] *lose their opportunities to have high quality services. When I see that the patient has insurance I avoid dealing with him/her, I refer him/her to another doctor because I have no idea whether my work would be paid or not.*

Health provider 3.2.F.4
Gyumri

I would like to add that insurance companies try to dictate us how to work with patients, how to state the diagnosis or what treatment to provide them or they force us to send patients to Yerevan, but they should know that it has negative impact on the quality of our work.

Health provider 3.2.F.5
Gyumri

Almost all stakeholders, except SP beneficiaries from Yerevan, were concerned about deteriorating quality of services. Different stakeholders stated that the main reason for low quality of services was unwillingness of providers to deal with insured patients because of unclear mechanisms of payments and heavy paperwork.

3.2. G Unnecessary utilization of health care services

I can assume that we do not have this issue [unnecessary utilization of health care services] *in the scopes of the Social Package, because insurance companies should have policy to control it.*

Policy maker 3.2.G.1
Yerevan

We have no special mechanisms to regulate unnecessary utilization of health care services; it is regulated by [SP] *program's list of exclusions. We have cases, when providers prescribe many unnecessary diagnostic tests if the patient has insurance. Then our experts suggest that only one test out of ten was meaningful and we pay only for that one.*

Insurance company officer 3.2.G.1
Yerevan

We don't take steps in that direction [to control unnecessary utilization]*; the package itself has a long list of exclusions to regulate that issue.*

Insurance company officer 3.2.G.2
Gyumri

I approached them [insurance company] *with a spine problem; they referred me to the X medical center in Yerevan. I went there they performed a lot of diagnostic tests but didn't come up with a diagnosis. Moreover, they insisted that I stayed in the hospital so that the insurance company would pay for those services. I can't afford to stay in the hospital in Yerevan for weeks.*

SP beneficiary 3.2.G.1
Gyumri

I was hospitalized with pneumonia, after the discharge I paid 600,000AMD [for the hospitalization]*… I was in the hospital and their* [insurance company] *representative came and saw me there. I paid that money and did not receive any penny* [from the insurance company]. *I am educated enough to tell them if they do not resolve this issue I will go to the court.*

SP beneficiaty 3.2.G.2
Yerevan

The patients demand that we prescribe them all tests which are covered by insurance; they think that we avoid doing that because we don't want to spend more money on their treatment.

Health provider 3.2.G.1
Yerevan

The number of unnecessary visits of patients with SP increases; for example, someone can come and just have a talk with us about their problems and we have to spend our time.

Health provider 3.2.G.2
Yerevan

One of my patients told that she wanted to do all analysis covered by her package for her child; but there are some types of tests which are not used in pediatric practice. I explained her but she insisted and I had to do that.

Health provider 3.2.G.3
Yerevan

The number of patients is not more than before the [SP] *program, since there is no compensation for ambulatory care and nobody would come without a reason for surgery.*

Health provider 3.2.G.4
Gyumri

Nobody will come for surgery without a reason; people even have no idea how to use it [health insurance]. *You finish the course of treatment and only after that they* [patients] *tell you about having insurance. But what can we do in that case?*

Health provider 3.2.G.5
Gyumri

The number of unnecessary visits has increased after implementing the SP.

Health provider 3.2.F.6
Yerevan

When they [insurance companies] *present the package every time they emphasize buying more health insurance but not the other opportunities. A few people will use the health insurance and money will stay in insurance companies, but for example the money for tuition would be spent for sure.*

SP beneficiary 3.2.A.3
Yerevan

The study found some contradictions concerning unnecessary utilization of healthcare services by the insured patients. Policy makers stated that unnecessary utilization of healthcare

services should be controlled by insurance companies. However, insurance company officers stated that they had no special policy to control moral hazard and relied on the list of exclusions and their experts' opinions. Healthcare providers from Yerevan believed that unnecessary utilization of healthcare services among SP beneficiaries was a problem. However, the healthcare providers from Gyumri stated the opposite: they did not face this problem since SP beneficiaries in Gyumri had very limited understanding of how they could use health services covered by their health insurance package.

3.3. Opportunities for the HIC of the SP program

3.3. A Suggestions about better management of financial and human recourses

The resources provided by the Government must be used effectively. They should reach to the target population and not be accumulated in different levels such as insurance companies. I think that it would be better not to choose as a provider [of insurance] *private insurance companies but a governmental agency, which would oversee the provision of healthcare services and control the quality of provided health care services.*

Policy maker 3.3.A.1
Yerevan

We [insurance companies] *should not think about making a profit, we should think about ways to organize the program better.*

Insurance company officer 3.3.A.1
Yerevan

The paper work must be eliminated and they should pay us much more salary, at list10 times more, because we shouldn't think about money, we just should take care of our patients.

Health provider 3.3.A.1
Yerevan

If they [Government] *wants to have high quality services they should pay us more money, but it is in the far future for us.*

Health provider 3.3.A.2
Gyumri

It would be better if they [health care facilities] *had special staff to deal with patients with insurance.*

Policy maker 3.3.A.2
Yerevan

Each insurance company should have its own hospital and in that case we will be responsible for quality of healthcare services.

Insurance company officer 3.3.A.2
Gyumri

We have to keep all receipts and prescriptions, wait for a long time, but it would be much better if the doctor sent all documents via email and they [an insurance company] *would make a decision.*

SP beneficiary 3.3.A.1
Yerevan

It would be better if every insurance company had representatives in hospitals; they could solve all problems with coverage. I know that some hospitals in Yerevan have such experience.

Health provider 3.3.A.3
Gyumri

They [insurance companies] *should provide strict definitions for each case. It would be better if doctors were involved in the process of the SP program development; we could give valuable advice.*

Health provider 3.3.A.4
Gyumri

I should know for sure how much money I will have for treating each patient with a specific disease. The doctors' work should be paid. The system is not perfect yet.

Health provider 3.3.A.5
Yerevan

The heads of hospitals receive additional financial resources, which they have to manage, but it should be regulated by policy of the program. If they are able to create a mechanism of payment to doctors in a way that doctors have additional financing from each insured patient, the risk of it [informal payments] *will be minimized.*

Policy maker 3.3.A.1
Yerevan

The main suggestion of policy makers regarding better management of financial resources and improved efficiency of the program included stricter regulation of money flow within the program and shifting the implementation of health insurance component from private commercial insurance companies to a government owned agency. Health provider participants suggested introducing fixed fee for each provided service.

Different stakeholders from Yerevan and Gyumri suggested that it would be helpful to have a person in hospitals to deal with insured patients, provide them appropriate information, and solve financial issues or have health facilities for each insurance company.

3.3. B Suggestions about health insurance coverage

The coverage of the program should be larger. It is desirable to have the main health problems of insured persons covered, and they should clearly know which services are covered by the package. The program should have specific definitions and minimal list of exclusions.

Policy maker 3.3.B.1
Yerevan

If we want to increase the affordability of health care we should try to expand the financing of this field. … We should make the [health] *insurance mandatory also for private employers and involve as much population as possible.*

Policy maker 3.3.E.2
Yerevan

The insurance should involve more people. It would be better both for us and for the population.

Insurance company officer 3.3.B.1
Gyumri

In case of teachers, I think they shouldn't take into account whether we are part time or full time employees; it [health insurance package] *should be the same for everybody.*

SP beneficiary 3.3.B.1
Yerevan

They should enlarge the coverage of the program to involve more people and, why not, doctors.

Health providers 3.3.B.1
Gyumri

All study participants emphasized that the coverage of the health insurance program should be expanded in two directions: covering more people and more health services. Some of them suggested considering implementation of mandatory health insurance to increase the number of covered population and expand the package of health services.

3.3. C Suggestions about monitoring and evaluation of the program

We need to have stronger monitoring mechanisms for the program. The insurance companies are under the control of the Central Bank, the health part of the program is controlled by the Ministry of Health, and we need to summarize all this information to be able to understand what is going on.

Policy maker 3.3.C.1
Yerevan

The program should be controlled by the Government, the number of insurance companies should increase because the biggest are owned by very reach persons ["oligarkh"] *and they know how to make money from that.*

SP beneficiary 3.3.C.1
Yerevan

The monitoring of the program is out of our responsibilities, but for sure monitoring will help to make improvements in the program in the future.

Health provider 3.3.C.1
Gyumri

Policy makers, providers, and SP beneficiaries emphasized the importance of monitoring and evaluation of the HIC component of the SP program especially by the Government.

3.3. D Sustainability of the program

There are predisposing factors for that [sustainability] *and one of them is that it is the second year that our Government allocates money for the program and I assume that they will have the recourses for that in the future.*

Policy maker 3.3.D.1
Yerevan

Yes we have predisposing factors for sustainability, because we have positive changes compared to the previous year.

Insurance company officer 3.3.D.1
Yerevan

It would be better if the program was continuous. We hope that in the future we will have more opportunities to use it.

SP beneficiary 3.3.D.1
Gyumri

Many participants believed that the health insurance component of the SP program would be sustainable.

3.4 Threats to the HIC of the SP program

3.4. A Health insurance component of the SP in marzes

They use the Social package in marzes as well but the issue is to what extent. To my knowledge, 90% of the compensations were paid in Yerevan. Moreover, there are differences in the quality of services, and if the person had a choice, s/he would prefer to come to Yerevan. ... We need to have skilled personnel and also we have to regulate the flow of doctors from marzes to Yerevan. All these problems may lead to less effectiveness of healthcare system performance.

Policy maker 3.4.A.1
Yerevan

I don't think that financing is the only problem of health care system in Armenia. We have many other problems; for example, lack of quality [of care], *lack of health providers in marzes, geographic accessibility and other issues.*

Policy maker 3.4.A.2
Yerevan

When we ask them [local insurance company] *some questions they say that we have to call Yerevan, but it is not cheap, they didn't provide cell phone numbers. .... It would be better if all our problems were addressed by local insurance officers.*

SP beneficiary 3.4.A.1
Gyumri

I would prefer not being referred to Yerevan but having competent specialists here in Gyumri.

SP beneficiary 3.4.A.2
Gyumri

They [insurance company] *didn't provide any cell phone numbers, but we have to talk to them for hours from our personal phones. I don't understand why I should do that?*

Health provider 3.4.A.1
Gyumri

Policy makers raised a concern that the SP beneficiaries in marzes did not have similar opportunity for using heath insurance component of the SP as in Yerevan. SP beneficiaries and health providers from Gyumri reported that they faced difficulties using SP related health

insurance because of low quality services provided by insurance companies and the financial burden of calling insurance company offices in Yerevan.

3.4. B Allocative and Technical Efficiency of the HIC of the SP program

Motivation for Utilizing More Expensive Inpatient Care

The package deals with in-patient care and cover only those services that lead to hospitalization.

Insurance company officer 3.2.A.2
Yerevan

They performed a lot of diagnostic tests but didn't come up with a diagnosis. Moreover, they insisted that I stayed in the hospital so that the insurance company would pay for those services. I can't afford to stay in the hospital in Yerevan for weeks.

SP beneficiary 3.2.G.1
Gyumri

I was hospitalized with pneumonia, after the discharge I paid 600,000AMD [for the hospitalization]*... I was in the hospital and their* [insurance company] *representative came and saw me there. I paid that money and did not receive any penny* [from the insurance company].

SP beneficiaty 3.2.G.2
Yerevan

Financial Resources and Health Insurance Companies

At this moment I think that most of the resources allocated for the Social Package are still concentrated in the insurance companies; I do not have statistical data that would make me think differently.

Policy maker 3.4.B.1
Yerevan

They [insurance] *create such mechanism that it seems that they want to help us but the main purpose is making profit. For sure it will make difficult for us to use the program effectively.*

SP beneficiary 3.4.B.1
Yerevan

Higher Administrative Expenses

Each insurance company should have its own hospital and in that case we will be responsible for quality of healthcare services.

Insurance company officer 3.3.A.3
Gyumri

We may have our representatives in each hospital but we do not have sufficient resources for that.

Insurance company officer 3.4.B.1
Yerevan

It would be better if every insurance company had representatives in hospitals... I know that some hospitals in Yerevan have such experience.

Health provider 3.3.C.2
Gyumri

When they [insurance companies] *present the package every time they emphasize buying more health insurance but not the other opportunities*.

SP beneficiary 3.2.A.3
Yerevan

Most of the study participants were concerned about allocative and technical inefficiencies of the HIC of the SP program. Policy makers and some beneficiaries were concerned that most of the financial resources allocated by the Government remained with insurance companies and were not spent on buying health care services.

The HIC of the SP program created motivation for unnecessary utilization of more expensive hospital care leading to significant inefficiencies in the health system.

Moreover, health insurance company officers beilived that it was necessary to spend significant resources to have their own hospitals or their own representatives in each health facility. This would also be a significant threat to the efficiency of the program and significant increase in administrative costs related to the work of private insurance companies.

3.4. C Higher Prices for Health Care Services

Health care facilities work with insurance companies with higher prices. Moreover, when insurance companies pay for provided services we lose the control on how that money was allocated within the hospital.

Policy maker 3.4.C.1
Yerevan

Now we have three pricelists: for patients covered by the BBP, by insurance companies and those who pay out-of-pocket. It makes our work very difficult.

Health provider 3.2.E.1

Yerevan

Many participants mentioned that health care providers had a separate price list for insurance companies; the prices were much higher for insurance companies. This could lead to artifishally increased prices for certain health services.

3.4. D Lack of Treatment and Diagnostic Guidelines

We understand that it is difficult for insurance companies to work with the program because we have no protocols for diagnosis and treatments in Armenia, and they [insurance companies] *have concerns that we will try to get more money from them.*

Health provider 3.4.C.3
Gyumri

Health insurance officers and providers mentioned absence of diagnostic and treatment protocols as a problem that could lead to additional inefficiencies in the HIC of the SP program.

3.4. E Provider Payment Issues

I am very disappointed because our salary still is not more than 100,000 AMD and I have to spend more time with ensured patients to explain them their rights, but I don't want to do that.

Health provider 3.4.B.1
Yerevan

When the health care provider is not paid enough it can lead to motivation to ask for informal payments from patients.

Policy maker 3.4.B.2
Yerevan

Some participants highlighted the threat that health providers would take informal payments from patients because of inadequate salaries.

4. Summary of the Main Findings

The qualitative stakeholder analysis identified the following main findings:

Strenghts:

- Additional social aid for the covered population
- Improvements in access and utilization of health care services among beneficiaries, especially for in-patient surgical care
- Improvement in financial protection for beneficiaries
- Expansion of voluntary private health insurance packages

Weaknesses:

- Limited coverage of health services
- Lack of understanding about health insurance packages
- Informal pressures for choosing insurance companies and/or health providers
- Informal out-of-pocket payments
- Unnecessary utilization of inpatient care and no motivation for preventive and primary care

Opportunities:

- Improve management of financial and human resources
- Expand coverage in terms of more health services Build a basis for mandatory health insurance
- Monitor and evaluate the program

Threats:

- Unequal opportunities for using SP in Yerevan and marzes
- Allocative and technical inefficiencies of HIC of the SP including inappropriate allocation of financial resources, higher administrative expenses, and unnecessary utilization of more expensive inpatient care
- Higher prices for health care services

- Lack of treatment and diagnostic guidelines
- Provider payment issues.

5. DISCUSSION

The current inquiry was designed to understand whether the health insurance component of the Social Package meets its policy objectives from the perspectives of different stakeholders. It identified strong and weak aspects, opportunities and threats to the program and made suggestions to policy makers for improvements. All the stakeholder groups expressed positive opinion about the implementation of the health insurance component. Similar to other low- and middle-income countries, the implementation of a HIC of the SP improved utilization of health care services (inpatient surgical services) and financial protection related to those services among beneficiaries in Yerevan and Gyumri (Kutzin, 2012; Spaan et al., 2012). However, existing studies demonstrate that even if the goal of newly implemented health reform is to inlarge the coverage of health care services introducing health insurance for the formal workforce it leads to more inequity: the SP benefits its members at the expense of the rest of the population excluding high-risk or poor people (Hsiao, 1995; Kutzin, 2012).

Voluntary health insurance market has been very small in Armenia (NHA, 2010) and implementation of the HIC of the SP program facilitatied development of voluntary health insurance market in Armenia.

Insufficient public awareness could be one of the obstacles to development of health insurance network and it can be the reason for insufficient usage (Sekhri, et al., 2007). The current study also found that the SP beneficiaries from marzes could not use health services covered by their health insurance package because of very limited understanding of the HIC.

Existing studies suggest the need for health programs to protect the users from unnecessary exclusions to address the issue of such an important market failure as risk selection (Sekhri, et al., 2007). The study demonstrated that the HIC of the SP program did not protect its beneficiaries from issue of risk selection. The risk selection mechanism was applied at the level of health conditions and not individuals – the long list of exclusions of non-communicable and preexisting conditions made sure that health insurance companies did not cover bad health risks. Health insurance company officers considered the list of exclusions as a mechanism for controlling unnecessary use of health care services, whily the list of exclusions was a major barrier to necessary use of services.

The basic health package almost exclusively covered inpatient care related services creating major barriers to utilization of preventive and chieper outpatient services for the beneficiaries and strong motivation for providers to hospitalize beneficiaries even for conditions that could receive outaptietn treatment within the scope of the program. This can be a major threat to efficiency, effectiveness, and equity in the Amrenian health care system shifting the focus of the health care system from preventive and primary care to much more expensive hospital care (Simoens, Steven, Giuffrida, & Antonio, 2004; Starfield, 2012).

The current study suggested that the implementing the HIC of the SP program did not meet the policy objective of improving the quality of care for the covered services. Despite the fact that health facilities have been charging the highest prices when services were covered by insurance companies, health providers did not receive appropriate compensation and were not interested in servicing patients that had health insurance coverage. The problem with appropriate provider compensation and lack of translarancy inside health facilities regarding provider payments had been consistently reported a major threat to sustainability for recent successful

health reforms in Armenia (Crape, et al., 2011; Truzyan, et al., 2010). Moreover, studies from other countries also demonstrated that physicians avoid serving or spend less time with patients with insurance programs offering low compensation to providers (Decker, 2009); this can compromise the quality of provided.

The study results suggested issues with patient satisfaction with insurance companies or health providers because of the following reasons: 1) were pushed to choose a specific company or provider; 2) faced administrative difficulties to receive compensation from insurance companies; 3) were refused coverage because of lack of understanding or the long list of exclusions; 4) were asked to pay informal payments; and 5) had to travel from marzes to Yerevan for accessing specialists. Patient satisfaction is one of the important proxies for judging about the program success and its deterioration may lead to program failure (Donabedian, 1988). For example, in Georgia, administrative difficulties were one of the major reasons for the beneficiaries to avoid using the Medical Insurance for the Poor (Bauhoff, et al., 2011).

The current study suggested that the implementing the HIC of the SP program did not meet another very important policy objective of improving administrative efficiency. The finding of this study suggested that majority of financial resources allocated by the Government for health stayed with health insurance companies as profit and adminidtrative expenses. According to the Central Bank of Armenia, in 2011, 70.7% of the financial resources collected as health insurance premiums by private health insurance companies were spent on buying health care services; this number dropped to about 25.0% in 2012 with the introduction of the HIC of the SP program through private for-profit health insurance companies (CBA, 2012) administrative costs and profit totaled 75% of premium revenue. The international experience suggests that administrative expenses of 25% are already considered as very high (Hsiao, 1995).

The HIC of the SP program has been organized through private commercial insurance companies moveing away from a single-payer sysyem to a multi-payer system through private for-profit insurance companies. International experience has demonstrated that health financing reforms that created new forms of fragmentation failed to address important policy objectives of improving efficiency and equity (Kutzin, Jakab, & Cashin, 2010).

The study participants made suggestions for improving the HIC of the SP program: 1) improve management of financial and human resources by health insurance companies and health facilities; 2) strengthen monitoring and evaluation of the HIC of the SP program; 3) expaned the coverage in terms of more health sarvices and including more beneficiary groups; and 4) consider introducing mandatory social health insurance as a complementary source of funding for the health care system.

5.1 Strengths

This study was the first attempt to evaluate the health insurance component of the SP in the early stages of its implementation through a qualitative assessment of the program.

5.2 Limitations

Not all marzes were included in this study; moreover, from the group of 120,000 multi-professional beneficiary groups only teachers were interviewed as beneficiaries and non-beneficiaries of the SP program.

6. RECOMMENDATIONS

The following recommendations are suggested based on the findings of the study and international experience:

- Eliminate existing forms of fragmentation
  - Reconsider organization of HIC of the SP program moving away from the current multi-payer arrangement to a single-payer one through a not-for-profit public agency
- Strengthen primary care orientation of the health care system
  - Redesign the basic health package of the SP program to motivate utilization of preventive and primary care (particularly focusing on no-communicable diseases) and decrease unnecessary hospitalization
- Strengthen the capacity of a strategic purchaser establishing mechanisms for continuous monitoring and evaluation of financial flows and quality of care
- Consider establishment of mandatory health insurance (single-payer) as a complementary source of financing health care system
  - Mandatory and public (pre-paid) financing is a necessary condition for reaching the policy objective of universal health coverage
- Improve facility level financial management practices to increase transparency and effectiveness
- Develop standard treatment and diagnosis guidelines for every level of care
- Implement electronic health records for effective management of financial resources in the system and monitoring of quality of care

- Continuously work with the general public to increase awareness of the health insurance component of the SP Program

The next step in evaluating the HIC of the SP Program should include a nationwide quantitative study.

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TABLES

Table 1: Demographic characteristics of teacher participants

	Number of participants	**Age** (mean, range in years)	**Work experience** (mean, range in years)
Yerevan	26	47.1 (27-60)	22.4 (4-40)
Gyumri	20	49.6 (35-63)	25.8 (13-41)

Table 2: Health problems reported by teacher participants

Health problems	**Yerevan (%)**	**Gyumri (%)**
Heart disease	12%	15%
Hypertension	24%	40%
Diabetes	12%	15%
Rheumatoid decease	5%	15%
Lung disease	5%	5%
Kidney disease	20%	15%
Neurological disease	5%	5%
Gastro-intestine disease	5%	15%
Liver decease	8%	5%

Table 3: Demographic characteristics of health provider participants

	Number	Age (mean, range in years)	Work experience (mean, range in years)	Work experience with insured patients (mean, range in years
Yerevan	8	42.5 (27-45)	16.4 (3-18)	3.0 (2-4)
Gyumri	10	40.8 (31-51)	11.6 (9-20)	2.6 (2-3)

Table 4: Demographic characteristics of health insurance company officer participants

	Number	Age (mean, range in years)	Work experience (mean, range in years)
Yerevan	7	30.4 (27-41)	2.7 (0.6-4)
Gyumri	2	29.5 (24-35)	2.5 (2-3)

APPENDIX 1: Examples of focus group discussion and in-depth interview guides (in English and Armenian)

Health Insurance Component of the Social Package: a Qualitative Assessment

Focus group discussion guide
Teachers involved in SP

Place
Date
Time
Moderator
Recorder

Introduction of topic

1. In your opinion, what were the main reasons for implementation of SP?

2. When and how have you been informed about the SP implementation?

3. What was the general attitude of teachers towards the implementation of the program? Were there any disagreements? If any, why?

4. What do you know about SP? **Probe**: a) who is covered b) which services are covered? Is there anything that is not clear to you, what specifically?

5. Tell me please how you use different parts of the SP? Probe: did you involve any member of your family?

6. What are the strengths and weaknesses of the program from the perspectives of a)covered teachers,b) health providers c) Hospital administration d) Insurance companies e) Government?

7. What do you think about the Package of services covered by the SP (mandatory and voluntary parts)? How could it be improved and why?

8. What expectations did you have regarding SP? **Probe:** What do you mean when you say . .
9. Was there any expectation that did not come true? **Probe**: Why do you think . . .

10. Tell me please how did you decide from which company to buy your health insurance? Probe: did anybody suggest/influence you to choose the particular company and why?

11. Did you or members of your family (if they are involved in insurance) use any medical services after involving in SP? Please specify what services?

12. How would you assess the quality of health care services covered under the SP package? Probe: were the doctors competent? Did they help you? If not, what specifically dissatisfies you in the health care services provision?

13. How does the insurance company cover/reimburse the health care services in the SP package? (if No) **Probe:** how did they explain it to you? Is everything clear for you? Do you face difficulties/challenges in the payment of health care services under the SP? What specifically?

14. To what extent the SP impacted you to seek health care- **Probe***:* Did you start applying for the health care more frequently than before? Could you please remember, was there any situation when you needed health care but couldn't afford it before being covered by the SP? After being covered by the SP?

15. Did you pay for the health care services covered under the SP package? If yes, was it a "thank you" payment or the providers asked you to pay unofficially? How frequently? For what services particularly?

16. Comparing the implementation of SP at the beginning and after a year of functioning, could you describe any changes?

17. Do you have interesting stories related to the SP, would you please tell about? Probe: Was there any interesting situation in which the health service was covered or refused by insurance company within SP? Among your relatives, friends?

18. Is there anything that we did not discuss and you would like to add?

Thanks for your participation!

Սոցիալական Փաթեթի (ՍՓ) բժշկական ապահովագրության ծառայության որակական գնահատում

Խմբային քննարկման ուղղեցույց
ՍՓ –ում ընդգրկված ուսուցիչներ

Տեղ
Ամսաթիվ
Ժամ
Վարող
Արձանագրող

Թեմայի ներկայացում

1. Ձեր կարծիքով որո՞նք էին ՍՓ-ի ներդրման հիմնական նպատակները:

2. Ե՞րբ և ինչպե՞ս եք Դուք տեղեկացվել ՍՓ-ի ներդրման մասին և ՍՓ փաթեթում ընդգրկվելու հնարավորության մասին: Խնդրեմ հակիրճ ներկայացրեք: :

3. Ինչպիսի՞ն էր ուսուցիչների հիմնական վերաբերմունքը ՍՓ-ի ներդրման վերաբերյալ: Ինչու՞:

4. Խնդրում եմ պատմեք ի՞նչ գիտեք ՍՓ-ի մասին: **Փորձ՝** ո՞վ է ընդգրկված; ի՞նչ ծառայություններ են ընդգրկված ; կա՞ արդյոք ինչ -որ բան ՍՓ վերաբերյալ, որ Ձեզ պարզ չէ; հատկապես ի՞նչ:

5. Խնդրում եմ պատմեք ինչպե՞ս եք դուք օգտվել ՍՓ-ի մեջ ընդգրկված տարբեր ծառայություններից: **Փորձ՝** ընդգրկե՞լ եք արդյոք Ձեր ընտանիքի անդամներից որևէ մեկին այդ փաթեթում: Ի՞նչ ծառայություններից եք օգտվել:

6. Այս ծրագրի արդյունքում ի՞նչ են շահում և ի՞նչ են կորցնում՝ 1.ապահովագրվողները; 2. բուժաշխատողները; 3. բուժհաստատությանների ղեկավարուքյունը, 4. ապահովագրական ընկերությունները5. պետությունը:

7. Ի՞նչ եք կարծում ՍՓ-ում ընդգրկված ծառայությունների փաթեթի մասին (պարտադիր և կամավոր): Ինչպե՞ս կարելի է այն բարելավել ; ինչու՞:
8. Ի՞նչ սպասումներ ունեք ՍՓ-ից : **Փորձ** `ի՞նչ նկատի ունեիք, երբ ասացիք…

9. Կաի՞ն արդյոք սպասումներ, որոնք չիրականացան: **Փորձ**`ի՞նչ եք կարծում ինչո՞ւ:

10. Խնդրում եմ պատմեք ինչպե՞ս եք որոշել, որ ապահովագրական ընկերությունից ստանալ Ձեր առողջության ապահովագրությունը: **Փորձ**՝ առաջարկել/ազդե՞լ է արդյոք որևէ մեկը Ձեր որոշման վրա , ինչու:

11. ՍՓ-ում ընդգրկվելուց հետո, Դուք կամ Ձեր ընտանիքի անդամներից որևէ մեկը, եթե նա ընդգրկված է ՍՓ-ում, օգտվե՞լ եք որևէ առողջապահական ծառայությունից : Խնդրում եմ մանրամասնեք հատկապես որ ծառայություններից եք օգտվել:

12. Ինչպե՞ս կգնահատեք ՍՓ-ում ընդգրկված ծառայությունների որակը:**Փորձ**՝ արդյոք բժիշկները ունեին բավականաչափ մասնագիտական հմտություններ: Նրանք օգնեցի՞ն Ձեզ: Եթե ոչ, ինչը՞ հատկապես Ձեզ չի գոհացրել բուժծառայությունների մատուցման ընթացքում կամ Ի՞նչ դժվարությունների եք հանդիպել այդ ընթացքում, պատմեք:

13. Ինչպե՞ս է ապահովագրական ընկերութունը փոխհատուցել ՍՓ-ում ընգրկված առողջապահական ծառայությունների արժեքը: Եթե չի փոխհատուցել՝ փորձ՝ ինչպես նրանք բացատրեցին այդ հանգամանքը: Արդյոք ամենինչ պա՞րզ էր Ձեզ համար: Ունեցե՞լ եք արդյոք դժվարություններ ՍՓ-ում ընգրկված բուժծառայությունների համար վճարելու հարցում: Խնդրում եմ մանրամասնեք:

14. Ինչպե՞ս է ազդել ՍՓ-ն Ձեզ վրա բուժօգնության դիմելու հարցում : **Փորձ**՝ ՍՓ ընդգրկվելուց հետո Դուք սկսեցի՞ք ավելի հաճախ դիմել բուժօգնության քան նախկինում: Կարող եք հիշել այնպիսի իրավիճակ, երբ դուք կարիք եք ունեցել բժիշկի դիմելու և չեք դիմել նախքան ՍՓ-ում ընդգրկվելը: Իսկ ընդգրկվելուց հետո՞:

15. Երբևէ՞ վճարել եք ՍՓ-ում ընդգրկված բուժծառայությունների համար: Եթե այո , արդյոք դա բժիշկի կողմից պարտադրված «մաղարի՞չ» էր: Որքա՞ն հաճախ են նման դեպքեր հանդիպել Ձեզ հետ: Հատկապես ո՞ր ծառայությունների դիմաց:

16. Եթե համեմատենք ծրագրի ներդրումը մեկ տարի առաջ և հիմա, ի՞նչ փոփոխություններ կարող եք նկարագրել ծրագրում; Խնդրում եմ մանրամասնեք:

17. Եթե կա որևէ հետաքրքիր պատմություն ՍՓ-ի հետ կապված, խնդրում եմ պատմեք: **Փորձ**՝ Եղե՞լ է արդյոք որևէ հետաքրքիր իրավիճակ, երբ ապահովագրական ընկերութունը փոխհատուցել է կամ չի փոխհատուցել ՍՓ-ում ընգրկված բուժծառայությունների արժեքը Ձեր, կամ Ձեր հարազատների և ընկերների շրջանում:

18. Կա արդյո՞ք որևէ բան, որի մասին մենք չխոսեցինք,բայց դուք կցանկանայիք ավելացնել:
Շնորհակալություն մասնակցության համար:

Health Insurance Component of the Social Package: a Qualitative Assessment

In-depth interview guide
Policy makers

Place
Date
Time
Moderator
Recorder

1. What were the main reasons for implementing SP in Armenia? What stakeholder groups participated in the decision making process (government officials, international organizations, insurance companies etc.)? Why private insurance companies were chosen to provide SP to the beneficiaries?

2. What are the benefits and loses of the program from the perspective of a) population b) physicians c) health care facilities d) insurance companies e)RA government?

3. How comprehensive is the SP to cover all the health care needs of the enrolled population? What are the strengths and limitations of the package offered in 2012, what should be added or removed from the package and why?

4. How well 1. Insured population/SP beneficiaries 3. health providers 2. Insurance companies are informed about their rights, responsibilities and opportunities within the framework of the SP? What obstacles do these groups often face during the SP implementation (both in Yerevan and marzes) and what can be done better?

5. What is the payment mechanism for 1. insurance companies 2. medical personnel by the program? Probe: are they informed about those mechanisms?

6. Based on your experience what works well in the program, and what are the gaps or unpredicted challenges that appear during the daily functioning of the program (both in Yerevan and marzes)? What can be done better?

   Probe 1*:* Comparing the implementation of SP in the beginning and after one year of functioning, could you mention any changes, what specifically?

   Probe 2: To what extent implementation of SP improved access to health care services?

7. What impact, if any, had the implementation of SP on utilization of 1) primary care services and 2) hospital services? **Probe:** Does SP program lead to unnecessary utilization of health care services? What type of services? What can be done to control this issue?

8. What do you think about the Package of services covered by the SP (mandatory and voluntary parts)? How could it be improved and why?

9. What impact, if any, had the implementation of SP on access and affordability of health care services? **Probe:** to what extent did the SP help to reduce households' catastrophic health care expenditure? How?

10. In your opinion, do unofficial payments to health providers or facilities still happen in Armenia for services which are covered by SP? **Probe**: What are the reasons for that? What is being done to prevent that? What else could be done?

11. What monitoring and evaluation mechanisms do you have for successful control of the implementation of the SP? **Probe**: what are the responsible bodies/organization for the program monitoring (both on Yerevan and marz levels)? What is included in the monitoring plan? Do you monitor the providers, facilities, or insurance companies? What can be done to improve the monitoring and control of SP program?

12. In your opinion is SP program sustainable? Why? If no, how could it become sustainable? How could the coverage of the enrolled population be improved? What factors need to be considered in this case? What should be the next step?

13. In your opinion in general how can the SP program be improved? Do you have specific suggestion to improve access to health care services in Armenia?

14. Is there anything that we did not discuss and you would like to add?

Thanks for your participation!

Սոցիալական Փաթեթի (ՍՓ) բժշկական ապահովագրության ծառայության որակական գնահատում

Անհատական հարցազրույցի ուղեցույց
Քաղաքականություն մշակողներ

Տեղ
Ամսաթիվ
Ժամ
Վարող
Արձանագրող

Թեմայի ներկայացում

1. Որո՞նք էին Հայաստանում ՍՓ-ի ներդրման հիմնական նպատակները: Ի՞նչ շահագրգիռ կողմեր են մասնակցել ՍՓ վերաբերյալ որոշումներ կայացնելու ընթացքում (կառավարության աշխատակիցներ, միջազգային կազմակերպություններ, արահովագրական ընկերություններ և այլն): Ինչո՞ւ որպես ՍՓ-ի շրջանակներում ծառայություններ մատուցիղ օղակ ընտրվեցին մասնավոր ապահովագրական ընկերությունները:

2. ՍՓ ծրագրի արդյունքում ի՞նչ են շահում և ի՞նչ են կորցնում՝ 1.ապահովագրված անձինք; 2. բուժաշխատողները; 3. բուժհաստատությանների ղեկավարուքյունը, 4. ապահովագրական ընկերությունները 5. պետությունը:

3. Ինչքանո՞վ է ՍՓ-ը բազմակողմանի և ամբողջական ընդգրկված բնակչության առողջապահական կարիքները հոգալու համար: Որո՞նք են 2012 թվականին առաջարկված ՍՓ ծրագրի առավելուրյունները և թերությունները; ի՞նչ պիտի ավելացվի կամ կրճատվի ծրագրից և ինչու՞:

4. Որքանո՞վ են ապահովագրվածները/ՍՓ ունեցող անձինք, բուժաշխատողները, ապահովագրական ընկերությունները տեղեկացված ՍՓ-ի շրջանակներում իրենց իրավունքների, պարտականությունների, ինչպես նաև հնարավորությունների մասին: Ի՞նչ խոչընդոտների են հանդիպում այս խմբերը ՍՓ-ի ներդրման ընթացքում (Երևանում և մարզերում) , Ի՞նչ և ինչպե՞ս կարելի է ավելի լավ կազմակերպել գործընթացը:

5. Ինչպե՞ս է իրկանացվում բուժաշխատողների, ապահովագրական ընկերությունների վճարումը ՍՓ շրջանակներում:**Փորձ**՝ որքանո:վ են նրանք

տեղեկացված են վճարման մեխանիզմների մասին, ի՞նչ բացեր կան վճարման գործընթացում: Ինչպե՞ս կարելի է բարելավել վճարման գործընթացը:

6. Ձեր փորձից ելնելով՝ ի՞նչն է ամենից լավ գործում ՍՓ ծրագրում և ի՞նչ բացթողումներ կամ անսպասելի դժվարություններ են հանդիպում ծրագրի ամենօրյա գործընթացում (Երևանում և մարզերում) և ի՞նչը կարելի է ավելի բարելավել:

Փորձ 1՝ Եթե համեմատենք ՍՓ ներդման սկզբում և հիմա, ի՞նճ փոփոխություններ կարող եք նկարագրել ծրագրում; խնդրում եմ մանրամասնեք:

Փորձ 2՝ Ինչքանո՞վ է ՍՓ-ն նպաստել բուժծառայությունների մատչելիության բարելավմանը:

7. Ի՞նչ ազդեցություն է ունեցել ՍՓ-ը բուժծառայությունների սպառման վրա պոլիկլինիկաներում և հիվանդանոցներում: **Փորձ**՝արդյոք ՍՓ-ը հանգեցրե՞լ է բուժծառայությունների անհարկի սպառմանը: Հատկապես ո՞ր ծառայությունների շրջանակներում: Ինչպես կարելի է վերահսկել այդ խնդիրը:

8. Ի՞նչ եք կարծում ՍՓ-ի շրջանակներում ընդգրկված ծառայությունների մասին (պարտադիր և կամավոր մասեր): Ինչպե՞ս կարելի է դրանք բարելավել:

9. Ի՞նչ ազդեցություն է ունեցել ՍՓ- բուժծառայություններից օգտվելու հնարավորության և մատչելիության վրա: Փորձ՝ ինչքանո՞վ է և ինչպե՞ս է ՍՓ-ն նպաստել նվազեցնելու ընտանիքների աղետալի բժշկական ծախսերը:

10. Ձեր կարծիքով Հայաստանի բուժհաստատություններում դեռևս հանդիպու՞մ են ոչ պաշտոնական վճարումների դեպքեր ՍՓ-ի շրջանակներում ընդգրկված ծառայությունների դիմաց (Երևանում/մարզերում) և որքա՞ն հաճախ, հատկապես ո՞ր ծառայությունների դիմաց,: **Փորձ**՝ որո՞նք են դրա պատճառները: Ի՞նչ է արվում այդ երևույթը կասեցնելու համար: Էլ ի՞նչ կարելի է ձեռնարկել:

11. Մոնիտորինգի և գնահատման ի՞նչ մեխանիզմներ ունեք ՍՓ-ի ներդրման հսկողության համար: **Փորձ**՝ ո՞ր մարմիններն են պատասխանատու մոնիտորինգի համար (Երևանում և մարզերում): Ի՞նչ է ընդգրկված մոնիտորինգի ծրագրում: Արդյոք դուք հսկու՞մ եք ծառայություններ մատուցողներին, հիմնարկներին, ապահովագրական ընկերություններին և ինչպե՞ս: Ի՞նչ կարելի է անել ծրագրի մոնիտորիգը բարելավելու նպատակով:

12. Ձեր կարծիքով ՍՓ-ը շարունակական կլինի՞: Ինչու՞: Եթե ոչ, ի՞նչ կարելի է անել այն շարունակական դարձնելու համար: Ինչպե՞ս կարելի է բարելավել բնակչության ընդգրկվածությունը ծրագրի մեջ: Ի՞նչ գործոններ պետք է հաշվի առնել այդ դեպքում; Ո՞րը պիտի լինի հաջորդ քայլը:

13. Ձեր կարծիքով ինչպե՞ս կարելի է ավելի բարելավելՍՓ-ը: Որևէ առաջարկ ունե՞ք Հայաստանում բուժծառայությունների մատչելիությունը բարելավելու համար:

14. Կա արդյո՞ք որևէ բան, որի մասին մենք չխոսեցինք,բայց կցանկանայիք ավելացնել:

Շնորհակալություն մասնակցության համար:

APPPENDIX 2: Examples of consent forms (in Armenian and English)

American University of Armenia
Institutional Review Board #1/Committee On Human Research

Consent form for teachers who involved in SP

Hello, my name is _Armine Tumasyan. I am a physician and student of the Master of Public Health program at the American University of Armenia. We are doing a project to explore the Social Package program and make suggestions to policy makers for improvements. I am inviting you to participate in an interview for this project because you are a citizen of Armenia and speak Armenian, you are a teacher who is covered by the SP and we would like to know about your experience when using the SP Services. Participating only involves this interview today. It should take no longer than 45 to 60 minutes to complete. Your name will not appear in any presentation of the project. What you say will contribute to this project but what you say will be put together with what is said by other participants. You will be one of approximately 15 to 20 people who participate in this project. Quotes from what you say may be used in reporting the final project findings but will not be related to your name or any other personal and identifiable information. I would like to audio-record the interview not to lose any information and take notes throughout the interview. Would you allow to audio-record our conversation? My notes and the recording will be stored without any information that will identify you and they will be destroyed at the end of the entire project.

Your participation in this study is voluntary. There will not be any negative consequences if you decline to take part in this project. You may refuse to answer some of the questions or can stop the interview at any time.

There is no financial compensation or other personal benefits from participating in the study and there are no known risks to you resulting from your participation in the study.

If you have any questions regarding this study you can call the Principal Investigator Dr. Varduhi Petrosyan at (37410) 51 25 92. If you feel you have not been treated fairly or think you have been hurt by joining the study you should contact Dr. Hripsime Martirosyan, the Human Subject Protection Administrator of the American University of Armenia (37410) 51 25 61.

Do you agree to participate?

Thank you.

If yes, shall we continue?

Հայաստանի ամերիկյան համալսարան
Հանրային առողջապահության բաժին
Գիտահետազոտական էթիկայի թիվ 1 հանձնաժողով
Իրազեկ համաձայնության ձև
Սոցիալական փաթեթում ընդգրկված ուսուցիչներ

Բարև Ձեզ, իմ անունը Արմինե Թումասյան է: Ես բժիշկ եմ և սովորում եմ Հայաստանի Ամերիկյան Համալսարանում Հանրային առողջապահության բաժնում: Մեր բաժինն իրականացնում է հետազոտություն, որի նպատակն է գնահատել Սոցիալական Փաթեթը և առաջարկություններ անել ծրագրի հեղինակներին այն կատարելագործելու համար: Դուք հրավիրված եք մասնակցել այս հարցազրույցին/քննարկմանը, քանի որ Հայաստանի հանրապետության քաղաքացի եք, խոսում եք հայերեն , դուք փաթեթում ընդգրկված ուսուցիչ եք և դուք անձ եք, որը կարող է կարևոր տվյալներ տրամադրել թեմայի վերաբերյալ: Ձեր մասնակցությունը սահմանափակվում է միայն ներկայիս հարցազրույցով, որը կտևի ոչ ավել քան 45-60 րոպե: Ձեր անունը կամ պաշտոնը չի նշվի ոչ մի զեկույցում կամ ներկայացման մեջ: Դուք լինելու եք այն 15-20 մասնակիցներից մեկը, ովքեր մասնակցելու են այս հետազոտությանը: Ձեր կողմից տրամադրված տեղեկատվությունն օգտագործվելու է միայն այս հետազոտության շրջանակներում, և միայն ընդհանրացված տվյալներն են ներկայացվելու զեկույցում:: Ձեր հարցազրույցից վերցված մեջբերումները կարող են օգտագործվել հետազոտության վերջնական արդյունքները պարունակող զեկույցում՝ չնշելով Ձեր անունը կամ անձնական այլ տվյալներ: Ձեր թույլտվությամբ ես կձայնագրեմ հարցազրույցը և նշումներ կվերցնեմ ընթացքում ոչ մի տեղեկատվություն բաց չթողնելու նպատակով: : Իմ նշումներն ու ձայնագրությունը կպահպանվեն առանց Ձեր անունը կամ անձնական այլ տեղեկատվություններ նշելու և կոչնչացվեն հետազոտոթյան ավարտին:

Ձեր մասնակցությունն այս հետազոտությանը կամավոր է: Ձեզ ոչինչ չի սպառնում, եթե Դուք հրաժարվեք մասնակցել այս հետազոտությանը: Դուք կարող եք հրաժարվել պատասխանել ցանկացած հարցի կամ ցանկացած պահի ընդհատել հարցազրույցը: Դուք չեք ստանալու որևէ պարգևատրում հետազոտությանը մասնակցելու դեպքում: Դուք ոչ մի ռիսկի չեք դիմում մասնակցելով այս հետազոտությանը: Ձեր անկեղծ պատասխանները կօգնեն հասկանալ ինչ է նշանակում տարեց լինել Հայաստանում և տարբեր տարիքի անձանց կարծիքով ո՞րն է տարեց համարվելու սահմանը:
Այս հետազոտության վերաբերյալ հարցեր ունենալու դեպքում կարող եք զանգահարել հետազոտության համակարգողին՝ Վարդուհի Պետրոսյանին (37410) 51 25 92 հեռախոսահամարով: Եթե Դուք կարծում եք, որ Ձեզ լավ չեն վերաբերվել կամ այս հետազոտությանը մասնակցելու դեպքում Ձեզ վնաս է հասցվել, կարող եք զանգահարել Հայաստանի ամերիկյան համալսարանի Էթիկայի հանձնաժողովի քարտուղար՝ Հռիփսիմե Մարտիրոսյանին (37410) 51 25 61 հեռախոսահամարով:
Համաձա՞յն եք մասնակցել : Շնորհակալություն:

Կարո՞ղ ենք շարունակել:

American University of Armenia
Institutional Review Board #1/Committee On Human Research

Consent form for policy makers

Hello, my name is _Armine Tumasyan. I am a physician and student of the Master of Public Health program at the American University of Armenia. We are doing a project to explore the Social Package program and make suggestions to policy makers for improvements. I am inviting you to participate in an interview for this project because you are a citizen of Armenia and speak Armenian, and you are involved in policy and decision making related to the SP project. Participating only involves this interview today. It should take no longer than 45 to 60 minutes to complete. Your name will not appear in any presentation of the project. What you say will contribute to this project but what you say will be put together with what is said by other participants. You will be one of approximately 15 to 20 people who participate in this project. Quotes from what you say may be used in reporting the final project findings but will not be related to your name or any other personal and identifiable information. I would like to audio-record the interview not to lose any information and take notes throughout the interview. Would you allow to audio-record our conversation? My notes and the recording will be stored without any information that will identify you and they will be destroyed at the end of the entire project.

Your participation in this study is voluntary. There will not be any negative consequences if you decline to take part in this project. You may refuse to answer some of the questions or can stop the interview at any time.

There is no financial compensation or other personal benefits from participating in the study and there are no known risks to you resulting from your participation in the study.

If you have any questions regarding this study you can call the Principal Investigator Dr. Varduhi Petrosyan at (37410) 51 25 92. If you feel you have not been treated fairly or think you have been hurt by joining the study you should contact Dr. Hripsime Martirosyan, the Human Subject Protection Administrator of the American University of Armenia (37410) 51 25 61.

Do you agree to participate?

Thank you.

If yes, shall we continue?

Հայաստանի ամերիկյան համալսարան
Հանրային առողջապահության բաժին
Գիտահետազոտական էթիկայի թիվ 1 հանձնաժողով
Իրազեկ համաձայնության ձև
Ծրագրի մշակողներ

Բարև Ձեզ, իմ անունը Արմինե Թումասյան է: Ես բժիշկ եմ և սովորում եմ Հայաստանի Ամերիկյան Համալսարանում Հանրային առողջապահության բաժնում: Մեր բաժինն իրականացնում է հետազոտություն, որի նպատակն է գնահատել Սոցիալական Փաթեթը և առաջարկություններ անել ծրագրի հեղինակներին այն կատարելագործելու համար: Դուք հրավիրված եք մասնակցել այս հարցազրույցին/քննարկմանը, քանի որ Հայաստանի հանրապետության քաղաքացի եք, խոսում եք հայերեն , մասնակցել եք ծրագրի ստեղծման գործընթացին և դուք անձ եք, որը կարող է կարևոր տվյալներ տրամադրել թեմայի վերաբերյալ: Ձեր մասնակցությունը սահմանափակվում է միայն ներկայիս հարցազրույցով, որը կտնի ոչ ավել քան 45-60 րոպե: Ձեր անունը կամ պաշտոնը չի նշվի ոչ մի զեկույցում կամ ներկայացման մեջ: Դուք լինելու եք այն 15-20 մասնակիցներից մեկը, ովքեր մասնակցելու են այս հետազոտությանը: Ձեր կողմից տրամադրված տեղեկատվությունն օգտագործվելու է միայն այս հետազոտության շրջանակներում, և միայն ընդհանրացված տվյալներն են ներկայացվելու զեկույցում: Ձեր հարցազրույցից վերցված մեջբերումները կարող են օգտագործվել հետազոտության վերջնական արդյունքները պարունակող զեկույցում՝ չնշելով Ձեր անունը կամ անձնական այլ տվյալներ: Ձեր թույլտվությամբ ես կձայնագրեմ հարցազրույցը և նշումներ կվերցնեմ ընթացքում ոչ մի տեղեկատվություն բաց չթողնելու նպատակով: : Իմ նշումներն ու ձայնագրությունը կպահպանվեն առանց Ձեր անունը կամ անձնական այլ տեղեկատվություններ նշելու և կոչնչացվեն հետազոտթյան ավարտին:

Ձեր մասնակցությունն այս հետազոտությանը կամավոր է: Ձեզ ոչինչ չի սպառնում, եթե Դուք հրաժարվեք մասնակցել այս հետազոտությանը: Դուք կարող եք հրաժարվել պատասխանել ցանկացած հարցի կամ ցանկացած պահի ընդհատել հարցազրույցը: Դուք չեք ստանալու որևէ պարգևատրում հետազոտությանը մասնակցելու դեպքում: Դուք ոչ մի ռիսկի չեք դիմում մասնակցելով այս հետազոտությանը: Ձեր անկեղծ պատասխանները կօգնեն հասկանալ ինչ է նշանակում տարեց լինել Հայաստանում և տարբեր տարիքի անձանց կարծիքով ո՞րն է տարեց համարվելու սահմանը.
Այս հետազոտության վերաբերյալ հարցեր ունենալու դեպքում կարող եք զանգահարել հետազոտության համակարգողին՝ Վարդուհի Պետրոսյանին (37410) 51 25 92 հեռախոսահամարով: Եթե Դուք կարծում եք, որ Ձեզ լավ չեն վերաբերվել կամ այս հետազոտությանը մասնակցելու դեպքում Ձեզ վնաս է հասցվել, կարող եք զանգահարել Հայաստանի ամերիկյան համալսարանի Էթիկայի հանձնաժողովի քարտուղար՝ Հռիփսիմե Մարտիրոսյանին (37410) 51 25 61 հեռախոսահամարով:
Համաձա՞յն եք մասնակցել : Շնորհակալություն: Կարո՞ղ ենք շարունակել: