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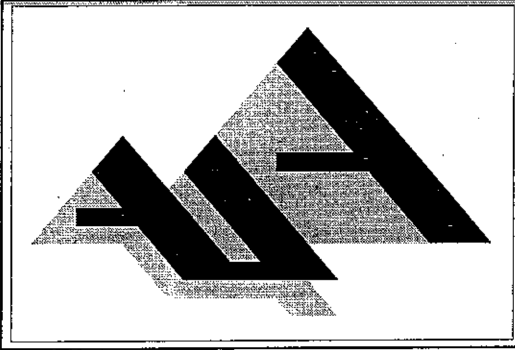

THE SPEAKER

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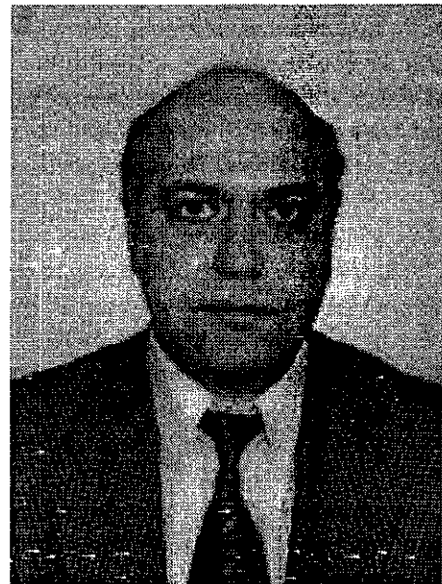
DEVELOPMENT STRATEGY OF HEALTH CARE IN ARMENIA

HAYK NIKOGHOSYAN
Minister of Health of Armenia



Health Care appears to be in an extremely difficult, blocked situation. In recent years, a number of serious problems have accumulated in the system. The first problem is that administrative decentralization has progressed simultaneously with a significant weakening of the mechanisms of functional management and health care quality control. This has happened in a situation where, parallel to decentralization, the strengthening of functional management could have been predicted.

A large gap has opened up between different areas of health care. We have never had such a huge difference in the quality of health care between the capital and the outlying regions.

The number of health care institutions, as well as their administrative status, needs to be regulated and clarified. Unfortunately, no concept has yet been adopted for privatization in the field. A classic system of public health and health care has not yet been formed in Armenia. Public health is still not looked upon properly: as a basic human right and a state function. The public, unfortunately, still does not recognize its responsibilities and its right to choose a healthy life. There is no health care information and statistics system in Armenia that would comply with modern requirements. The priority of a primary care system has still not been given enough importance, and this is a question that was discussed in soviet times as much as it is now.

The number of hospital beds is excessive and does not conform to the real needs and capacities of Armenia and the system. The decreased accessibility to health care has become a serious problem. As a result, and despite the increasing rate of disease, the number of people who apply for health care in a timely manner, has decreased. The accessibility of health care in general is at an extremely low level. The currently functioning system of free health care is, unfortunately, mostly illusionary, and the public and health personnel do not have confidence in it. We still do not have a system that would satisfy the state, the public, and medical personnel. Logic has been distorted — if two of the sides were to be dissatisfied, at least the remaining side should have found it acceptable. We currently have a system that has, unfortunately, accumulated problems in all possible directions, especially in hospitals.

Nor have the reforms in the system of medical education been accomplished: we train too many professionals. Their distribution, according to specializations and areas, is inadequate. Yerevan has two-thirds of the doctors in Armenia, but only one-third of the population of the country lives there. This is the distribution of professionals; this is our human resource policy – if it can be referred to as a policy at all.

Serious problems have arisen in the fields of drugs and technology policies. The accessibility to primary drugs is not ensured. The lack of regulation of prices and purchases has caused significant limitations on the accessibility of drugs to the public and medical institutions. International health programs and humanitarian aid are poorly systemized. They are unrelated to the real problems in Armenia — an

inadequate distribution both in medical institutions and amongst the public.

The Ministry of Health and the Government are fully conscious of the seriousness of this situation. They have set a task to implement a qualitative change in our approaches. We will program the development of the health system to balance social and market values, on the one hand, and, very importantly - to systemize the interests of the public, on the other. If we were to describe and briefly formulate the directions of the development of health care for the next few years, we could say that the program is aimed at turning away from the unfavorable tendencies of the last few years. It also aims at a maximal enforcement (with the available resources and potential) of the constitutional norm regarding citizens' rights to the maintenance of good health. This norm has, in fact, been violated. It is necessary to increase sharply real accessibility to free health care, and to commence the formation of a public health care system. Unfortunately, we must admit that an elitist health care system has developed instead of public health care. Public health care as a category has been pushed to a second or third priority. We currently feel the need for change in the concepts surrounding this issue.

The plan for the development in 2000 and the following years is based upon internationally accepted basic values and development principles. We will declare openly that we will follow international criteria and concepts in the fields of health and public health care. We will set out these principles in the program. These principles are health and the preservation of health as a basic human right, as an objective in granting equal possibilities for health care in the public, as well as public cooperation and inter-agency strategies and responsibilities, the cooperation of various individuals and institutions in acts targeted to the preservation of health. Finally, we must clearly emphasize that health care and health are integral objectives and the responsibility of the public. The state is obliged to adopt its overall responsibility in this, refraining from putting the burden only upon the health care system, because the latter can answer only a small number of problems related to health. Consequently, the inter-agency strategy and the inter-sectoral approaches will be the cornerstones for the coming years.

We are planning that the health care program for the coming years will have five main components. The first is the public health system. The second is the health care system. This is the closest and, unfortunately, the least affordable for the public. The third is the drug and technology policy. The fourth is medical education, science, and human resource potential. Finally, the fifth is the systemization of international projects.

The field of public health will start as an inter-agency sphere that predefines a general responsibility for the state and the public, as far as health care is concerned. As for the preservation of health, its segments are not only in the system of health care. Its classic mode of implementation is the hygiene and anti-epidemic service. An information system of not just classic public health, but also health care, will build up around this service. In 2000, we plan to clarify the structure, organization, and legal forms of the system, including the merging of redundant and weak areas. In order to improve the financial situation of the service, it is planned to start organizing extra-budgetary activities. Their absence in recent years has weakened the system and prepared for a shift to new principles for the financing of the system, that is, the per-capita principle. Public health should be able to adequately distribute finances because it is mostly targeted to the public. It must take into consideration the number of people who are being served in the area. This is the approach and the internationally accepted order.

A fundamentally new step is being planned: the creation, along state borders, of anti-epidemic units and teams to ensure epidemiological and sanitary security on the borders of Armenia. It is also planned to develop and adopt a package of secondary legislation linked to the law on ensuring epidemiological security. This law was passed in 1992. The new package is still in the drafting process.

An important area of the public health system will be the development of a health care information system. It will target improved health care management, and monitor indicators defining important health care projects and public health. A clarification and adoption of a health care indicator system is planned for 2000. In addition, a new national health care statistics system will be adopted, and staff will be trained. Documents used - such as accounting and reporting forms - will be improved. Health care statistics have never been in such a poor state as now. It is not only incomplete; it simply does not reflect the real indicators of health care. On the one hand, privatization and the existence of a private sector have played a role here: this sector has not provided reports in the nationally accepted manner. On the other hand, the mechanisms of publicly - financed health care, together with their financial and medical standards, caused certain problems with respect to statistics. Health care financing was linked to various forms of documents. The various forms of health care, because of a number of financial reasons, started to move further and further away from their theoretical and real status. State-financed health care began to distort statistics. Thus, 80% of in-care treatment fall in the emergency category, if we trust the statistics we have. Diagnoses consist mainly of those diseases that are included in the list to be financed by the state. We are sure that, if this list changes, the types of diseases will change accordingly.

HAYK NIKOGHOSYAN was born on April 19, 1955, in Yerevan. In 1978, he graduated from the Yerevan State Medical University with a specialization in medical care. In the period from 1978-1981, he was a post-graduate student at the Moscow Oncology Institute. From 1981-87, he was head of the Republic Diagnostic Center at Republic Hospital. From 1992-94, he was the Chairman of the Board and Executive Director of the "Diagnostika" Medical Association.

In 1998, he was appointed Minister of Health of Armenia. He does not belong to any political parties; he is married and has three children.

On one hand, the incomplete system of collecting statistical data, and on the other hand, distortions related to entirely different factors, have caused the current state of the statistics system. Simply put, it cannot be trusted.

As an important step for the development of public health and health care, an inter-agency national health care council will be created in 2000. The top political authorities in the country will head it. For the first time ever, the coordination of health care policy will be raised to the level of political management, to include all the ministries and other government agencies, which in one way or another are related to health care: education, environmental protection, agriculture, urban construction, defense, etc. In 2000, we must emphasize that health is a common objective for the state and the public. In this sense, the year 2000 will be a turning point.

Greater changes are planned in the health care system of the ambulatory-polyclinic or, so-called primary health care; and the hospital level. The main target of the ambulatory-polyclinic system will be the gradual development and installation of family medicine. In the next ten to fifteen years, family medicine should become predominant - to be the foundation of the ambulatory-polyclinic system. Family doctors will significantly differ from the present classic local physician not only by his/her knowledge, but also by being much closer to the public and families, and by enjoying more of their confidence. Parallel to the development of the family medicine system, the ambulatory-polyclinic system will reform – slowly but surely. Its primary focus will get closer to the public and become more integrated. The narrowly specialized circle of the ambulatory-polyclinic system, which did not establish itself properly in the last few years, will slowly integrate with the narrowly specialized circles of hospital services. This integration can mostly be of a functional character, but in some cases, it may be oriented towards area administration. Family doctors must take on greater responsibilities and leave much less work for specialists. The latter, in their turn, should be more closely linked to the hospital circle and be able to combine their work in the hospital and ambulatory circles. In this sense, a very important step is being planned: the ambulatory-polyclinic care will start receiving a significant amount of assistance in the communities. Besides state financing, there will be a great deal of support from the communities. We think that polyclinic care is closer, more visible, and more comprehensible for the public. Consequently, the participation of the people and the communities at this level can be much more significant and realistic. Gradually, the role of financial and other support from the communities in the preservation of the polyclinic system will increase. Meanwhile, state financing will definitely not decrease. The polyclinic system must at last shift for good to a per-capita financing principle. We have started to lay its foundation this year. It will appear in the budget for the next two years and will be technologically equipped. In the next three years, we are going to implement a large project, particularly in the regions. All regional polyclinics will have modern equipment.

The regions will have never witnessed such a medical, financial, and technological invasion, as they will see in the next three years. The process will start in December. All polyclinics in the regional centers will have modern equipment. They will be provided with transportation. An important step will be taken: village ambulatory centers which, as independent units, have been separated from central polyclinics (causing a distortion in the link between the village and its region), will be mostly re-united under regional central polyclinics. The latter will again be in charge of the population of the whole region, including the people living in villages. We have never before had such a split of village health care as we have now. If you go to villages, you will see a picture that is inexorably getting worse. For several years, regional polyclinics have not been aware of what is happening in the villages – let alone any methodical, narrowly specialized help or analytical work. Indeed, village doctors have been abandoned.

We still do not have a system that would satisfy the state, the public, and medical personnel.

The biggest changes, however, are planned in the hospital system where the decrease of health care accessibility is more visible. This is the most expensive level that, unfortunately, is the least accessible to the public. The state declares that there will be a turn towards the gradual restoration of free in-patient care. This will be mainly implemented by turning down the principle of limiting free in-patient health care according to disease, health care, and social group. In the past three years, the trend has been to focus on certain social groups, diseases, and types of health care. These are the only ones included in government funded health care. The others are excluded. The second trend has been towards gradually decreasing the size of the list of these groups. A significant percentage of the public that was not included, either in the list of social groups, or in the list of diseases, has officially been denied the right to free health care. We have included 250000 people in the group of the socially unprotected. We forget that in Armenia there are at least five times 250000 people who are officially not on the lists of the socially vulnerable, but are unable to receive any health care in the paid sector. We have also limited the types of diseases and health care; as if assuming that people themselves chose their disease! Are they to choose only the diseases that are on the list of free health care? It is true that the budget is small and that there must be limits. Nevertheless, these should not be at the expense of people, but at the expense of hospital institutions. They will have a general profile for health care. In Armenia, about thirty exclusively free hospitals will be chosen. Eight or nine will be in Yerevan; the remainder will be in the regions. These hospitals will work as state institutions and receive an adequate amount of financing from the budget to provide free health care. Payment for health care would not be allowed in these hospitals. No hospital will be closed. The existing ones will continue to work with the same financing of 1999. Unfortunately, there are rumors nowadays that the new health care strategy is planning to close hospitals and to trigger unemployment among doctors. No hospitals will be closed and there will be no massive unemployment at all. All hospitals will preserve their status and financing as of this year. Some of them will simply be set aside to deal with parts of the government plan that they did not perform in the past, and which will be performed by no other hospital. We declare that we will implement the constitutional norm of individuals. The norm guarantees that they have free hospital care. The only limitation will be in the number of hospitals where this

kind of care will be available. We would be happy to have it in all the hospitals of Armenia. Unfortunately, this is impossible. This does not mean, however, that we will give people no chance at all for free health care. We must accept that it is preferable to have this health care given at a location five kilometers away from where they live, or in a neighboring district, rather than to have no such possibility at all. This is a step that, in a few years' time, will give back the individual's right for in-patient health care.

What will the other hospitals be doing? They will be doing what they are doing currently in the regions, with no changes. However, there will be one hospital in each region that, aside from this kind of treatment, will perform many other functions that the others do not perform. It will take in all the other groups that are not included in the lists of groups treated free of charge. The same thing will take place in Yerevan. Those hospitals in Yerevan that are not included in the list of exclusively free hospitals will continue to be financed by the state at the same level as 1999. They will receive state funding, mainly in narrowly specialized health care. Any hospital is obliged to accept urgent cases. There will be no limitations to this.

As for the rumors about unemployment, they are completely unfounded for one reason only. A head physician who will try to create massive unemployment though at the same level of financing as this year will have to explain why he has not made the same staff reductions this year. Cases of unfounded firings, as well as other large-scale acts will be prohibited if they do not conform to the proportional reduction in funding provided by the state. Such reductions, however, are not planned by us.

This is going to lead to a concentration and more efficient utilization of state funds. It will also restore people's rights to free health care. It is also going to promote the development of principles of open competition. This comparison, as our estimates show, will result in a re-evaluation of prices in both the free and, particularly, the paid sectors.

There will be a shift to the internationally accepted "global budget" financing principle. Financing will not be "per capita", as this currently results in an enormously huge number of reports and unjustified large debts. Hospitals are in a situation in which they are motivated to report more patients in their reports than they have actually treated. They have been told that the more patients they report to have treated, the more money they will receive. The government, however, knows from the start that this money will not be made available. The rules of the game that the state is playing with the medical institutions are unfair. Moreover, the unpaid amounts are fixed as revenues, later reported as profit, with the attendant profit tax. Because of this, financing used by the government, the government has accumulated a debt of 1.7 billion drums in 1997 to the medical institutions of Armenia. It was never able to pay this. Trying to improve the mechanisms by which it would be able to avoid accumulating more debts, the government made the situation even worse and accumulated a debt of 2.3 billion drams in 1998! This year, attempting to finally overcome this trend and avoid accumulating further debts, the financing mechanism had a yet worse effect. The current accumulated debt is four billion drums. The total adds up to eight billion. The most ridiculous thing is that these four billion drums have been recorded as profit, and the system has to return 1.3 billion to the state as profit tax! Thus, the system has to return (to the state) one-third of an amount it has not received. This is the financing system currently in place.

We should add to this the humiliating conditions under which doctors and medical workers find themselves. Practically, the hospital system suspects that it is wasting state funds; even if it does not exaggerate the numbers reported and does not deal in disproportionate reporting. Even simple medical disputes and mistakes turn into financial liabilities because there is money behind every patient and every diagnosis. Doctors, especially hospital doctors, have never been in such a humiliating situation in which they have to prove to an army of people who are lower than them, both in terms of intellect and professionalism, that they have acted correctly.

The public, unfortunately, still does not recognize its responsibilities and its right to choose a healthy life.

With the shift to a global budget in which the amount payable to each hospital is fixed (and there is a specific order within that amount), these types of problems will no longer exist. What is more important is that global budget financing is used in all countries with budget financing like ours. We tried to do something that no other country has done: while gathering the means around a budgetary principle, we distributed them based on insurance principles. This never happens. It is based on either insurance, or a budget. It does not work if it is mixed – it ends up looking as in our case.

This principle of the separation of free and paid health care allows us to reach, through small and logical steps, the solution to the hospital system optimization problem which Armenia is currently facing. This, in other circumstances, could have resulted in the very painful process of the direct closure of some hospitals. As Minister, I have dealt with this problem for a year; we have attempted to block the implementation of the program that the Ministry and the system were given late last year. This program simply posited the closure of some hospitals. This task was stated very clearly, and it was given the name of "optimization". We think that optimization is what we are going to do now. We are going to ensure a certain volume and quality of guaranteed health care for the public. We will also let the other part of the system work its own way and define its quality and volumes.

The Ministry will also use the powerful advantage of licensing in order to regulate this whole process. The program of hospital health care development will also include licensing, the official installation of the first package of health care standards and, more importantly, the improvement of the relationship between ambulatory-polyclinic and stationary-hospital institutions. It is necessary to fill the gap between these areas.

We are planning to do the preparatory work necessary to create a health insurance system soon. Insurance is a special issue. We have already been talking about this for ten years. In practice, nothing has been done. Armenia wishes to pass a law on medical insurance. It realizes the necessity of stating that it is currently not ready for this, as well as the need to define the date at which we may start. The date from which the installation of a state

medical insurance system will begin will be stated in the law so that no one can violate it. If we do not state the first step in the law, we will continue to say that it is still too early to start.

We also had hopes in relation to voluntary insurance. Unfortunately, this did not work in Armenia, although I think that it would have if the state had somehow promoted it. It would have worked if a privileged tax field was established for those taxpayers who had made a voluntary insurance payment, as well as for those hospitals that give priority to treating voluntarily-insured patients. In our strategy, we state that, before installing state insurance, and later, parallel to the installation process, the state should promote voluntary insurance. A segment of the population in Armenia can and ought to have voluntary insurance.

The state will also have a clear drug policy. This will be mainly targeted at increasing access, security, and efficient use of drugs. In the system of free in-patient care, Armenia will use a system of centralized state wholesale purchases to significantly decrease prices, as well as to increase security and quality. For well-known reasons, not everyone likes this, but the government will use its money in the most efficient way. International experience has shown that, after a shift to a system of centralized purchases, the expenses that the government makes for drug purchases decrease by at least 30%. As in any civilized country, the state should approve a list of basic drugs. State purchases will be made mainly within the framework of the list of basic drugs. This will also decrease spending on drugs, at the same time increasing guarantees, quality, and variety. The combination of these two will result in an estimated 40% – 45% decrease in drug expenditures.

From the middle of 2000, the government will try to gradually regulate the market and price of drugs. First, the drug policy will be reflected in insurance. Insurance amounts will partially cover the costs of drugs. Second, the state will use mechanisms to keep drug prices down – as used in civilized countries – without violating market laws. Drugs are products of particular social importance, and even in the most classic market countries, the market and prices of drugs are normally regulated.

Humanitarian aid will also be regulated. This process has already begun. The country does not need huge volumes of humanitarian aid that comes to Armenia with either expired dates or dates that are close to expiration. They are not always in the quantities and variety that the country needs. Armenia should accept what is really needed for the country. The distribution of humanitarian aid should be much more fair and active. We will continue to carry out long-since forgotten acts targeted at assuring the provision of drugs to specific groups of the public: a network of humanitarian drug stores, drug stores for veterans, children, and ones with regional significance. This means that the elements of state policy will be strengthened, while staying within the laws of a market economy. Drug policy will be more socially targeted, balancing the market and market values.

We are planning to carry out an inventory and re-distribution of under-utilized medical equipment in institutions. A centralized system of technical servicing of particularly important medical equipment must be created, the mechanisms of certification of medical equipment should be regulated, and a system of long-term payment of government-guaranteed purchases should be developed. This is the only way in which medical institutions can obtain medical equipment in the current financial conditions.

The policy of medical education and human resources will be aimed at the optimizing of the human resource potential, raising the standards and structure of medical education closer to international norms. We must create possibilities to use efficiently the current potential in medical sciences. For this purpose, we are planning to adopt a new list of medical professions to comply with new and modern requirements. In addition, a new scheme of medical education will be put in place. An improved system of graduate medical education (for the currently less accessible system of specialization) will be developed. Professionals will be granted better opportunities for specialization after undergraduate education. There will be many more clinics with the right to carry out graduate education. There will be a longer list of professions in which it will be possible to go through residency.

The training system for existing doctors will be changed. Training will be shorter, but more frequent: once a year. More importantly, only new topics will be taught. The most important change in this field will be the installation of an accreditation system. The licensing system will be closely tied to the accreditation system. Various types of training will grant different credits. We will start implementing this system in 2000.

We will also have answers to such long-standing, painful issues as the private system of medical education. The new law on education finally allows licensing, and subsequently, of the certification of all education institutions. In this sense, all these institutions will be put on an equal footing.

Attention will be paid to international systemization. In Armenia, there currently are hundreds of international projects that are either in use or being planned. In this sense, health care is the most internationally involved field, but it is, unfortunately, the least systematized. Very often, not just the Ministry, but the international organizations themselves, do not know who is doing what in Armenia, who is doing what where, and what are the priorities, although an immense amount of significant work is being done. For these purposes, a special systems department has been established in the Ministry. The department will not dictate: it will account and advise international organizations on Armenia's priorities in health care. It will help avoid redundancies, and make investments more efficient. In addition, it is planned to create a number of international medical centers in Armenia to target not only the diagnoses and treatment of Armenian citizens, but also of foreigners. Armenia has this potential, and the state will carry out a special policy in order to sponsor the establishment and development of such centers.

A policy will be implemented in the direction of state-guaranteed and regulated exporting of some of the medical potential. This export will be regulated both for the specialists, and for the state, considering the huge medical potential of Armenia. It is planned to create an Association of Armenian doctors to include both local doctors and doctors from the Diaspora. It will be separate from the Ministry, and will be much more stable. It will be a circle to strengthen the medical ties between Armenia and the Diaspora for the future. This will be more of a Non-Governmental Organization character and will be the so-called "home" of Armenian doctors in Yerevan.

QUESTIONS AND ANSWERS

-How much additional money will be required for the implementation of the reforms you mentioned? Where are you planning to receive it from if the state owes several billion drums to the system?

-The whole strategy is targeted not at our planning new funding, but at using the existing funding more efficiently. We are going to use as much as is planned for three years by the medium-term budget. No more than that. The systemization of international organizations and forces will add up to that.

-Armenia used to be a potential regional center for a number of fields. The list of these fields included certain spheres of health care that had a unique level of development for the region. Is this no longer so. Has our health care system regressed so much?

-The issue you mentioned is becoming a subject of state policy and state interest. The first government-financed international medical center will be created in 2000. Aside from this, the state will promote privatization programs to bring in significant investments. In general, privatization will be re-assessed. It will be mainly linked to the presence of specific plans. If there is a plan, and the institution and health care in Armenia will benefit from the privatization, then the institution will be privatized. We think that such institutions will be targeted at becoming international centers.

-In case of implementing the reforms, what new functions and authorities will the Ministry and local government have? Is a re-distribution of these functions planned at all?

-First of all, these are not reforms. In many aspects, we are just using this to recall the past, the functional past. However, these are significant changes. As for the functions, the Ministry has been and remains the body that develops and implements health care policy in Armenia. With these changes, its daily management functions will not increase: that is not the aim of the changes. Local authorities will continue to carry out operative management of their systems, except for some narrowly specialized services that, by being in the regions, still have a nation-wide importance. This is a very small percentage. The other parts will stay the same, but the role of the government as a body implementing the health care policy, and as a body of management, will strengthen.

-How would you characterize the political course of this program? Do you not think that the liberalization of the health care system will give a chance to manage more efficiently the limited means of the budget? Who carries the political responsibility for this program?

-The program itself is very liberal, and it will result in more liberalization. However, before total liberalization, the state wishes to create a system that, with minimum expense, would guarantee free health care, leaving the rest up to liberalization. This is the difference in comparison to the current ideology, in which everything is left up to liberalization.

As for the political responsibility, it is the political forces and the government who carry it, the government that has adopted this policy, and included it in its program.

-Which services of the birth hospitals are financed by the budget? When a nurse asks for money for the vaccination of a child, what is it – a fee, a present, or a bribe?

-Birth assistance is officially free of charge in this country, if anyone wants to believe it. As for your second question, you should ask it to the nurses and the people who pay them; it is difficult to answer that question, being the Minister. However, what is the solution? The only solution is to have free-of-charge birth homes in the network of exclusively free medical institutions. Birth centers there would be an atmosphere of free treatment. In general, we must consider that this atmosphere is important to ensure really free treatment.

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Program Coordinator:
Hrair Zoryan

American University of Armenia
40 Marshal Bagramian Ave., Yerevan, Armenia
Tel: 27-16-58

Addressee: