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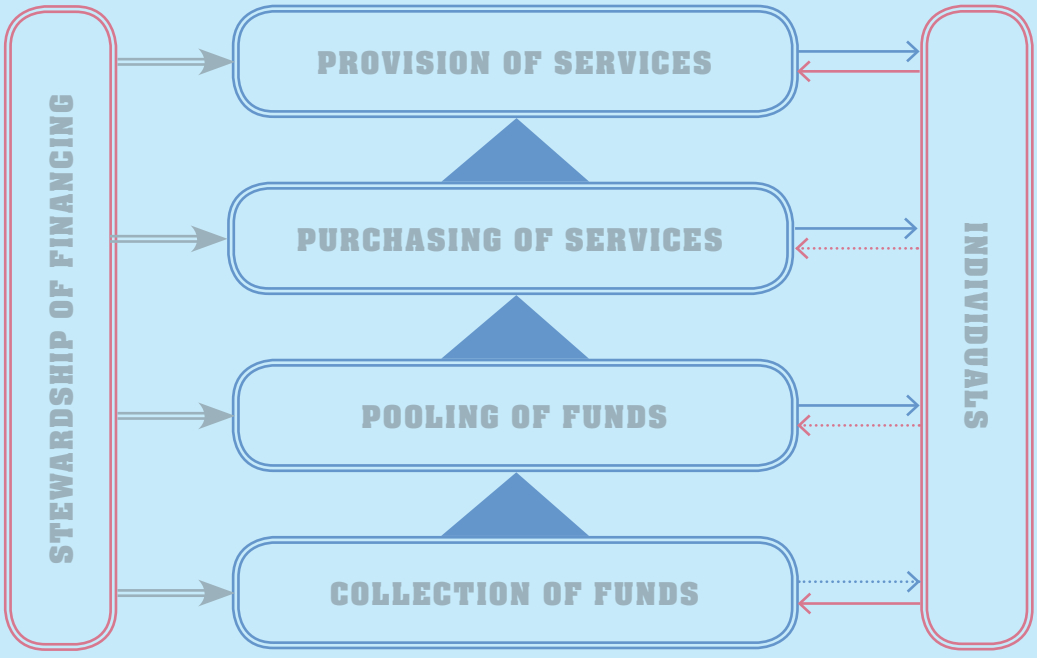

VOLUNTARY HEALTH INSURANCE IN ARMENIA

ISSUES AND OPTIONS

Health Financing Policy Paper 2007/3

WORLD HEALTH ORGANIZATION
EUROPE

VOLUNTARY HEALTH INSURANCE IN ARMENIA

ISSUES AND OPTIONS

BY: NEELAM SEKHRI
JOSEPH KUTZIN
SARO TSATURYA

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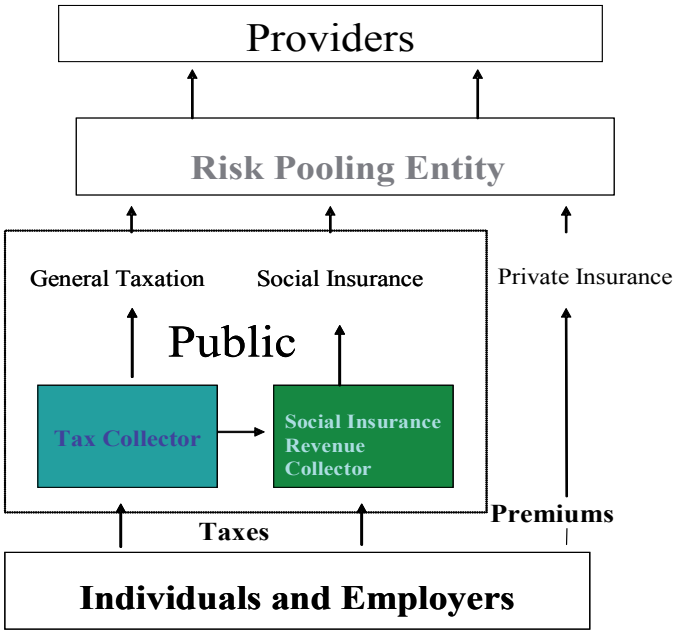
INTRODUCTION AND CONTEXT

As Armenia considers how to move towards financing mechanisms that will protect its population from the financially catastrophic effects of illness, improve access to care and create incentives for efficiency and quality in service delivery, it has to consider how to organize the pooling of funds from the revenue potentially available from public and private sources (Fig. 1).

Fig. 1. Types of risk-pooling based on collection of funds



Every country uses some combination of public and private sources to fund its health care system. The outcome in terms of population health, equity and responsiveness depends on how these different sources complement one another. In most countries that have high levels of formal employment and tax collection,[1] publicly funded (either from general revenue or earmarked social insurance contributions) risk-pooling mechanisms cover most of the population, with other methods (voluntary health insurance and out-of-pocket payments) playing secondary roles. In lower-income countries with large informal economies and low rates of tax collection, as in Armenia, private spending tends to dominate. But even in these countries, allocation of limited public funds is driven by choices regarding which services and population groups to cover. Most high-income, high-revenue countries use general taxation to fully or partly subsidize coverage for poor people (or to exempt them from co-payments). A few of these countries allow people covered by public funds to also purchase private health insurance to supplement or substitute for their public coverage.

1 The key contextual factor driving the ability of a country to publicly fund health (and other) services is the ability to mobilize public revenues relative to the size of the economy. This is positively correlated with the country's level of income but is not identical to it. Useful measures of this fiscal context are total public revenue (or total public expenditure) as a percent of gross domestic product.

Armenia currently uses general tax revenues as its primary source of funds for risk-pooling for health care services. The Ministry of Health manages this pool through the State Health Agency, which is responsible for purchasing a defined basic benefits package for the population. Since 2006, the basic benefits package has provided universal coverage for primary care. It also covers inpatient services for certain socially vulnerable groups as well as treatment of certain diseases and medical conditions for the whole population (tuberculosis, oncology, urgent care, etc).

However, due to the limited public resources that Armenia has available to spend on the basic benefits package, only 20% of total health care expenditure is actually paid through public funds (2003). Sixty-four per cent was paid for through direct out-of-pocket payments to providers at the time of care, causing financial hardship for many Armenians and presenting a serious barrier to accessing health care services.[2]

Armenia would like to provide greater financial protection and equity in health financing and is considering a variety of ways to do this. Most importantly, it is increasing the share of government funding allocated to the health sector (Table 1).

Table 1. Government expenditure for health care, 2000–2006

	2000	2001	2002	2003	2004	2005	2006
Total (billions of drams[3])	9.8	15.7	16.0	19.6	24.7	32.2	39.4
as a percentage of gross domestic product (GDP)	0.80	0.90	1.10	1.33	1.45	1.48	1.71
as a percentage of public spending[4]	4.4	6.4	6.0	6.3	7.9	8.2	8.2

Source: Ministry of Finance and Economy, medium-term expenditure framework 2006–2008.

Table 1 shows a stable increase in public spending for health: in six years its volume quadrupled in absolute terms, and its share of both GDP and total public spending has doubled. The state budget funding of health care was planned at 35.5 billion drams[3] for 2006 according to the poverty reduction strategy paper for Armenia (approved by the government in 2003) and 37.3 billion drams according to the 2006–2008 medium-term expenditure framework, but in fact the final figure exceeded both projections and was approved at 39.4 billion drams.

At the same time, for 2007 the government is apparently falling behind its own obligations: the actual increase in health sector funding will be less than planned (Table 2). However, since the 2007 budget still has not been approved, the final health care allocation figure may change.

2 WHO European health for all database, June 2006 update
3 €1 = about 582 drams as of January 2007.
4 The government expenditure for health as a share of total public spending in this table is somewhat higher compared to Figure 2. This is due to a lower estimate of total public spending (the denominator) by the Ministry of Finance and Economy compared to international estimates used by WHO.

Table 2. Health care budget for Armenia, 2007

	According to the 2005–2007 medium-term expenditure framework	According to the 2006–2008 medium-term expenditure framework	Budget proposal for 2007
Public spending for health care (billions of drams)	50.1	48.4	43.8

Recognizing that, even with possible further increases in the share of public spending devoted to health, in the short and medium term, public spending will be insufficient to cover the health costs of the whole population, the Ministry of Health would like to consider alternative financing mechanisms that could reduce the problems of financial protection and barriers to health care access associated with this high share of out-of-pocket payments. The principal mechanism in which it is interested is shifting some of the out-of-pocket payments into privately funded voluntary health insurance.

Although there are many examples of poorly operating voluntary health insurance systems, voluntary health insurance that is appropriately implemented through a sound regulatory structure can contribute to increased equity and fairness in health financing in four ways:

- by improving access to necessary care by transforming some of the existing out-of-pocket spending on health services to prepayment, thereby reducing the financial barriers and burden on households at the time a member needs care;
- by enabling more of those who can afford to pay to contribute to their health care costs through prepayment, so that policy-makers can effectively plan and target limited public resources towards the most vulnerable groups or towards the services more likely to pose a catastrophic risk;
- by building institutional capacity for future publicly funded health insurance schemes; historically, the social health insurance systems of many high- and middle-income countries have evolved from private health insurance schemes based on professional guilds or communities; and
- since private health insurance continues to be important even in countries where universal coverage has been achieved, countries that plan ahead for this supplementary role will be better prepared to ensure that private health insurance will complement public systems as they develop.

Only the first two are most relevant for Armenia. The existence of the State Health Agency and the ongoing investment being made to increase its capacity as the strategic purchaser for the basic benefits package show that Armenia is building institutional capacity in insurance and may not require introducing private health insurers to supplement this capacity.

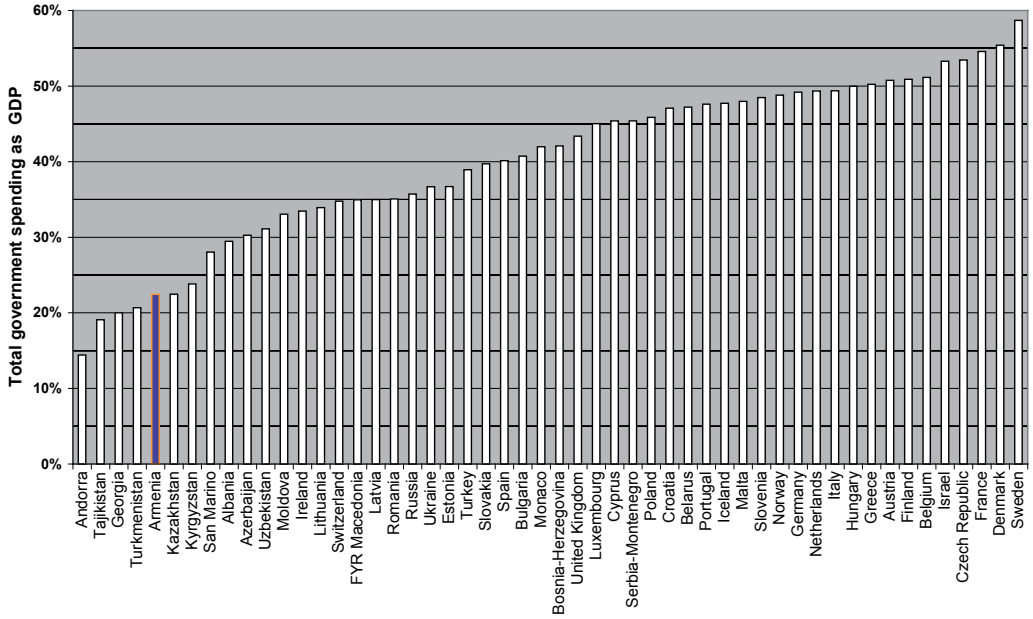
This publication provides a set of options for the Government of Armenia to consider for expanding voluntary health coverage. It begins by generally describing how private health insurance can be used in health care funding. Section 2 focuses on the specific health care funding situation in Armenia and identifies a set of objectives that could be achieved by expanding the voluntary health insurance market. Section 3 identifies prerequisites to expanding voluntary health insurance in Armenia; section 4 presents three policy options that Armenia might consider; section 5 outlines a set of policy questions that should

be answered in developing a regulatory scheme for voluntary health insurance; and the publication ends with a summary of the analysis and possible implications for each of the presented options from the perspective of the entire health system.

HEALTH CARE FUNDING IN ARMENIA

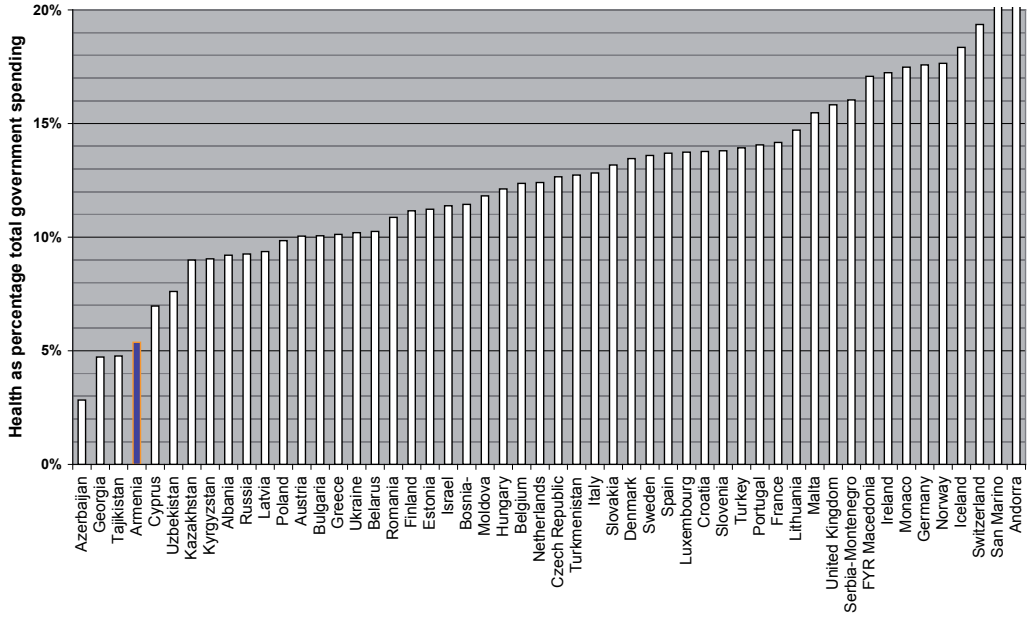
Both overall fiscal constraints and relatively low priority given to health in public resource allocation has contributed to low government spending on health in Armenia. Fig. 1 puts the fiscal situation of Armenia in the context of the countries in the WHO European Region. With total public expenditure comprising about 22% of GDP in 2003, the size of the state in the economy and its potential to spend on health are among the lowest in the European Region. Combined with this, Fig. 2 reveals the low priority the government has given to health in its resource allocation decisions. On the positive side, this low level of 5.4% increased to 6.3% in 2004 (WHO Regional Office for Europe, 2007), but even then remains one of the lowest in the Region.

Fig. 1. Armenia's government expenditure as a percentage of GDP relative to the rest of the European Region, latest available year



Source: WHO estimates of national health expenditure.

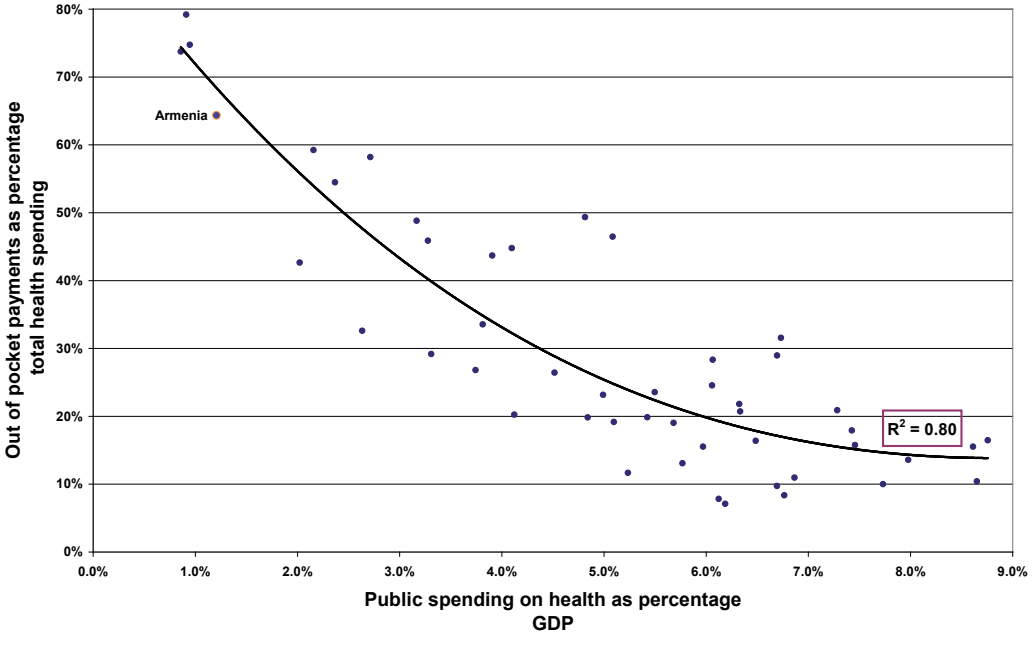
Fig. 2. Armenia's health expenditure as a percentage of total government expenditure



Source: WHO estimates of national health expenditure.

When the government expenditure as a percentage of GDP (the fiscal constraint from Fig. 1) is multiplied by the health care expenditure as a percentage of total government expenditure (decision on health as a government priority from Fig. 2), the result is the government health care expenditure as a percentage of GDP. The evidence from WHO European Member States suggests that this indicator (public expenditure on health care as a percentage of GDP) is strongly and inversely related to out-of-pocket expenditure as a percentage of total health expenditure. Data from about 50 countries in 2003 plotted in Fig. 3 show that public expenditure on health care as a percentage of GDP explains about 80% of the variation in the share of out-of-pocket payments in total health care expenditure. Armenia's experience (highlighted in Fig. 3) is consistent with this pattern: government expenditure on health was 1.2% of GDP, and the out-of-pocket payments share was 64% (or 76% excluding nongovernmental organizations) (WHO Regional Office for Europe, 2007).

Fig. 3. Relationship between government health expenditure as a percentage of GDP and out-of-pocket payments as a percentage of health expenditure in the European Region, 2003



Source: WHO estimates of national health expenditure.

A further implication of Armenia's fiscal context and limited potential to increase public spending on health is the critical importance of complementarity between public and private funding sources. This means that any detailed proposal for developing voluntary health insurance must be made in relation to (and preferably explicit coordinated with) plans for developing the publicly funded basic benefits package and the role of the State Health Agency as the public purchaser.

This implies the need for a comprehensive approach to health care funding in which the roles of public and private funding are defined explicitly and in coordination with each other. In situations of extreme scarcity of public funds, as in Armenia, failure to achieve complementarity in public and private funding will limit the scope for policy intervention to improve financial protection and is also likely to lead to inefficiency in targeting public resources to their best use.

Roles of voluntary health insurance in health care funding

The term voluntary health insurance is a broad category that describes privately funded coverage that may be structured and introduced in various ways into a system of health care funding. Before introducing voluntary health insurance, the Government of Armenia must address two policy questions.

What will be the role of voluntary health insurance in relation to publicly funded coverage?

Private health insurance can play four potential roles in health care funding: primary, substitutive, supplementary and complementary.[5] For the sake of simplicity, this publication emphasizes the difference between systems in which private health insurance provides primary coverage and those in which it provides secondary coverage.

- When it provides primary coverage, private insurance is de facto the main form of risk pooling for some portion of the population. This can occur either because no public benefits package exists or because public funds are insufficient to cover the entire population for a basic benefits package. Primary insurance packages usually cover a broad range of health services, often mirroring those financed in a basic benefits package.
- In secondary coverage, private insurance complements the coverage provided by a publicly funded benefits package, insuring a limited set of interventions that address particular gaps in a country's public coverage. Insurance policies may cover residual health care costs, such as co-payments or tariffs; cover services not included in the basic publicly funded package, such as outpatient drugs or dental care; or allow easier access to services offered by public and private providers.

Within the EU, the role of privately funded health insurance in most countries is limited to covering services that complement or supplement a system publicly funded through general taxation or social security contributions. In low- and middle-income countries, however, where out-of-pocket spending is high, private health insurance can play a broader role during a transition period to predominantly publicly funded coverage.

What are the policy objectives for introducing voluntary health insurance?

Since Armenia is considering introducing voluntary health insurance as a transitional mechanism to move towards predominately publicly funded coverage in the future, the key public policy objectives that it might wish to promote through voluntary health insurance are:

- to reduce barriers to access for health services for all Armenians;
- to provide financial protection from catastrophic financial expenditure;
- to provide affordable access to health care for vulnerable and rural populations;
- to promote equity in financing so that those who can afford to pay contribute to health care costs, allowing public monies to be targeted to poor and vulnerable people;
- to provide an additional, more predictable source of revenue for public hospitals;
- to provide incentives to improve the quality of health services;
- to reduce informal payments to providers by increasing transparency through formal provider contracts; and
- to increase administrative efficiency for the health system by potentially reducing or reallocating administrative costs for collecting revenue.

5 In their review of voluntary health insurance in the European Union (EU), Mossialos & Thompson (2002) define three kinds of roles voluntary health insurance plays in the EU. These correspond to three of the roles defined here: substitutive (voluntary health insurance that allows or even requires some people to apply their compulsory insurance premium to a private health insurance fund; also called opting out); complementary (voluntary health insurance that provides full or partial coverage for services that are excluded or not fully covered by the statutory system; the main example is voluntary health insurance to cover co-payments in the statutory system, such as in France and Slovenia); and supplementary (voluntary health insurance that increases consumer choice and access to different health services and can achieve faster access or better amenities). The other possibility that these authors recognize but note does not exist in the EU is, as defined here, voluntary health insurance as primary coverage.

CONSIDERATIONS IN INTRODUCING VOLUNTARY HEALTH INSURANCE

Regulation to achieve policy objectives

Any expansion of voluntary health insurance in Armenia will require creating a sound regulatory framework and the institutional capacity to ensure compliance with this structure. A regulatory programme is currently being developed in Armenia, under the direction of the Central Bank of Armenia.

The extent of the regulatory framework required will depend on how broadly coverage is expected to expand and the services that are allowed to be offered. A regulatory structure should at least address the market failures common in voluntary health insurance markets, including:

- adverse selection: the people who are less healthy join the insurance pool, whereas those who are healthier do not, and this can lead to rising premiums and a growing concentration of high-risk individuals in an ever-decreasing market and, in extreme cases, to the collapse of the insurance market;
- risk selection (cream-skimming): insurers try to counter adverse selection or maximize profit by discouraging people who are less healthy from purchasing insurance or by finding ways to insure only lower-risk individuals, which leaves those who are least healthy without adequate insurance, even if they are willing to pay for it;
- moral hazard: the tendency for insured individuals to use more (presumably unnecessary) services than if they were not insured, which results in higher overall health care costs and is a concern under both publicly and privately funded health care schemes; and
- provider-induced demand: a form of moral hazard in which doctors over prescribe medications or order unnecessary services, knowing that the insurer and not the patient will be paying, which decreases the affordability of coverage and insurance demand and can occur in both publicly and privately funded health schemes.

Overregulation, however, can strangle a market as easily as laissez-faire approaches can undermine the market's capacity to serve public policy goals. The European Commission addressed the extent to which governments should only loosely regulate insurers rather than more stringent controls as a precursor to creating an open market for trade in the EU. The EU issued a directive that health insurance should only be subject to financial regulation except where a "general good" could be demonstrated. In Armenia, given the absence of a universal safety net for health expenditure, a strong case can be made for careful and more extensive regulation of the health insurance market.

Section 5 outlines potential interventions the government may carry out in addressing health insurance market failures and policy objectives.

Building the insurance market

Another issue to consider in introducing voluntary health insurance is how to stimulate the purchase of private coverage. Insurance markets take time to develop, and unless private coverage is explicitly mandated, the market will require nurturing to establish adequate demand for health insurance and ensure a viable supply of insurers. In Armenia, where the

concept of insurance in other areas of life (house, agriculture etc.) is just beginning to be broadly understood, demand for insurance against the risks of ill health may be particularly difficult to stimulate. Depending on how quickly the Government of Armenia would like the market to grow, it might consider several interventions to increase demand for insurance.

Tax incentives or rebates

Voluntary health insurance can be advanced by amending the existing tax legislation including, in particular, the Law on Personal Income Tax (in terms of corporate profit tax, insurance companies are in the same tax framework as any other company; in terms of value-added tax, insurance activities are better off, because they are not subject to value-added tax). The Law on Personal Income Tax contains some obstacles to the development of insurance. Article 6 provides that the taxable gross personal income includes premiums made by employers for their employees (with the exception of compulsory social insurance contributions required by law). The same article further provides that gross income also includes insurance indemnity. However, Article 9, which defines the list of deductions from gross income, also refers to insurance indemnity. Thus, insurance indemnity is in effect not subject to personal income tax, and the problem is that premiums paid by employers to insure employees are viewed as salary and subject to personal income tax. Thus, people insured by an employer must pay additional income tax, even if they want to have voluntary health insurance. The logic behind this approach is that employers see the voluntary health insurance as an additional fringe benefit offered to employees, which is designed to make employment more attractive and to create additional incentives for higher productivity; therefore, it cannot be accompanied by a reduction in the main incentive for any employee, the salary, because if the salary were reduced because of insurance, insurance as an incentive would become meaningless.

Hence, if the objective is to promote voluntary health insurance, the Law on Personal Income Tax should be amended. This amendment will create more favourable conditions for employers and employees that want to have health insurance, and it would create mechanisms that would rule out any abuse in terms of tax evasion. This approach could be based on the principle of making a certain level of premiums tax-exempt. The tax-exempt amount of premiums should be determined on the basis of sound actuarial calculations, and the current tax rules should apply to any amount in excess of this minimum. Although such changes would indeed create a more favourable environment for voluntary health insurance, the actual impact on the take-up of voluntary health insurance cannot be predicted.

However, promoting voluntary health insurance is not an inherent policy objective. In particular, the potential positive effect of tax deductions on the purchase of voluntary health insurance coverage needs to be balanced against the likely negative effects on equity. By giving a tax deduction for voluntary health insurance premiums, the government is implicitly subsidizing the people who would purchase voluntary health insurance, who are more likely to be higher-income earners. This means that public money (the foregone tax revenue) would flow to higher-income people. Similar to the impact of this measure on the take-up of voluntary health insurance, the magnitude of this equity effect cannot be predicted.

Carrot-and-stick approach

A carrot-and-stick approach provides tax subsidies for lower-income groups that purchase private health insurance and imposes tax penalties on higher-income groups that do not. This approach was implemented in the early 1990s in Australia and has had some success

in increasing voluntary health insurance coverage. Unlike in Armenia, however, the policy of the Government of Australia was driven by considering the expansion of private health insurance as an inherent policy objective (rather than the objective of improving financial protection). It is arguable, however, that the public subsidies devoted to this objective could have been better and more efficiently used to promote better financial protection through the publicly managed health care funding system.

Lifetime community rating

Lifetime community rating provides an incentive for younger, healthier people to purchase voluntary health insurance by allowing the insurance premium to be set according to the age of entry into the private insurance market. People older than 30 years of age, for example, who do not purchase health insurance pay a uniform but higher premium over the remainder of their lifetime; the later they join, the higher the base premium. Lifetime community rating has been successfully applied in Australia to stimulate demand for private health services, and some consider it to be the most effective policy intervention undertaken in this area.

Improving the quality of health care services

The quality of health care services also needs to be improved to encourage people to buy coverage. This poses a chicken-and-egg dilemma: the quality of care and standard of services must be sufficient so that those who purchase coverage believe they are buying a high-quality product and receiving value for money. Insurance can provide predictable and perhaps additional revenues that can be used to improve the quality of health facilities. Expanding the insurance market requires sufficient providers of adequate quality and the money gained from insurance fees being put back into facilities to improve the quality of care and service.

Improving state-guaranteed health care schemes free of user charges and improving provider performance

For voluntary health insurance to develop, defining the health care package covered by voluntary health insurance and how it relates to the basic benefits package guaranteed by the state are very important. An overview of international experience shows that voluntary health insurance mainly acts as an auxiliary factor, complementing the health care funded from compulsory public sources (either from payroll taxes or general revenues for a basic benefit package). In other words, voluntary health insurance should cover the services that are not covered from public funds (possible examples are cosmetic surgery, health care that requires expensive technology and non-medical auxiliary hospital services). In Armenia, given the current scope of the basic benefits package, the state-defined prices for services in the basic benefits package and the problems with regard to this, the approach to voluntary health insurance faces a challenge that may require a somewhat different approach from the international experience. More importantly, the problems described below suggest the need for a comprehensive and fundamental approach to national policy on health care funding, including as a priority the creation of a credible and easy-to-understand benefit package that the State Health Agency can effectively purchase.

The basic benefits package established by the Government of Armenia has two basic definitions:

- certain types of health care, which are free of user charges for all groups of society (primary health care, emergency care, treatment of infectious disease and the like);

and

- socially vulnerable groups entitled to provision of all health care free of user charges, including primary health care and inpatient care (except for certain services specified in a list approved by the government, such as cosmetic surgery, organ and tissue transplants and the like).

The situation in Armenia is problematic in the sense that, by making some social commitments in public health, and taking into account the low state budget, the government funds services within the basic benefits package at a level that is lower than the cost of delivering such services. This situation forces citizens receiving health care in the framework of the basic benefits package to incur additional private costs to cover the gap between the real cost of health care and the state funding. Hence, there is a gap between the promise and the reality, and as a result the system has a problem of credibility in the eyes of the population and providers. Although state funding of health care has increased considerably in recent years, informal payments still exist and may take years to be eradicated. Hence, the government must address the need to make the basic benefits package credible, and as a result this can create the space needed for voluntary health insurance to develop in a complementary manner. Without effective policy development in this regard, voluntary health insurance schemes will have to cover some of the services in the basic benefits package. This duplication is inefficient, but it may serve effectively as co-funding for the available state funding. In this way, some part of the voluntary health insurance premiums could reduce some of the current informal payments for services in the basic benefits package.

In addition to improving the quality and performance of health care providers and developing voluntary health insurance, implementing prices for services that better reflect the costs of care and improving financial management are also very important. Strengthening public confidence in the entire system, including voluntary health insurance, requires addressing the informal payments that have become institutionalized in most health care institutions. Policies are needed to better balance entitlements with resources to progressively reduce the practice of under-the-table payments over time. People paying for insurance must be confident that when they seek health care they will not have to incur additional costs beyond what is defined in the terms of the entitlement; otherwise, the insurance market will be undermined and not be able to contribute to health policy objectives.

Raising public awareness

Insufficient public awareness is yet another obstacle to developing voluntary health insurance in Armenia. Not only ordinary citizens but also enterprise managers and executives are very poorly informed about the nature and arrangements of insurance. Conventional behaviour is another obstacle to developing voluntary health insurance. Most of the public is still not used to thinking about their health in advance, which means that many people still cannot accept the idea of paying for insurance before they actually fall ill.

Overcoming these obstacles requires developing and implementing a large-scale public awareness campaign on the content, mechanisms and advantages of insurance. Such a campaign should make extensive use of print and electronic mass media as well as other tools to influence public opinion. The campaign should not be a short-term event but rather be designed for at least 18–24 months. It would probably be a mistake, however, to embark on this without first taking steps to ensure that the health system is truly able to deliver on

the promise of both the publicly funded part of the system (the basic benefits package) and the services that would be open to voluntary health insurance coverage.

OPTIONS FOR INTRODUCING VOLUNTARY HEALTH INSURANCE

This section presents several options that the Government of Armenia might consider in introducing voluntary health insurance. These options are not mutually exclusive, nor do they represent all possible roles that voluntary health insurance could play in Armenia's health funding. They are intended to outline a range of possibilities, starting from a very limited role for voluntary health insurance to a broader one.

Each option has a range of possibilities for management, creation of insurance products and relationships with providers. These issues may be addressed through a regulatory framework and are further detailed in section 5. The three options presented are the following.

1. Voluntary health insurance is only allowed to cover the services and population groups that fall outside the basic benefits package or co-payments for services covered by the basic benefits package.
2. Voluntary health insurance is allowed to cover a full range of services and population groups (potentially overlapping with the basic benefits package) focusing initially on the formal sector and/or on the informal sector and rural populations.
3. Voluntary health insurance covers emergency services only.

Each option is discussed in greater detail below, including a description, what it is intended to achieve, its likely impact in relation to the policy objectives outlined earlier and how feasible it would be to implement.

Option 1: voluntary health insurance covers only the services and population groups that fall outside the basic benefits package or cost-sharing obligations for services covered under the basic benefits package

This option is based on creating an explicitly complementary role for private voluntary health insurance in relation to the publicly funded basic benefits package managed by the State Health Agency. In this case, voluntary health insurance could cover the population groups that fall outside the basic benefits package, the services not covered under the basic benefits package and/or co-payments for services defined in the basic benefits package. The main purpose of voluntary health insurance would be to increase risk-pooling and financial protection for population groups outside the basic benefits package and to provide financial protection from out-of-pocket payments for covered services. For the people covered, insurance payments to the provider could replace formal out-of-pocket payments and fees for services beyond the basic benefits package.

Services that voluntary health insurance could cover under this option would include planned (non-urgent) hospital care for non-vulnerable population groups, as well as such services exempt from the basic benefits package as cosmetic surgery and organ transplants. This may cover also existing official co-payments for certain services, such as open-heart surgery for people covered under the basic benefits package.

People who purchase voluntary health insurance would receive care through both public and private providers, which should be contracted by insurance companies providing voluntary health insurance services.

Currently public and private providers in Armenia are not clearly differentiated in terms of the scope of services they provide. Both public and private health care providers provide almost all types of services.

This option could introduce voluntary health insurance with minimal impact on the publicly funded system or the basic benefits package, but for it to be effective the basic benefits package must be substantially revised and, related to this, the official fees for services outside the basic benefits package must be changed to make the entire system more credible and create a clearer picture of the potential benefit package for voluntary health insurance as well. It would allow people to prepay for formal out-of-pocket payments in the form of insurance premiums, which could offer some financial protection to households because out-of-pocket payments can be shifted to prepayment. It might also improve access to care for needed services that are not included in the basic benefits package but are included in the supplementary voluntary health insurance package. It would also provide a more predictable source of financing, with lower administrative costs for public hospitals, at least for the portion of revenue collected directly from patients.

Official out-of-pocket payments for services not included in the basic benefits package accounted collectively for only 10.8% of total out-of-pocket expenditure for health care and for only 6.2% of total health care costs in 2005 (Table 3).

Table 3. Out-of-pocket payments, official and unofficial co-payments and total health care costs in Armenia in billions of drams, 2002–2005[6]

	2002	2003	2004	2005
Total health care costs	84.2	99.2	108.0	116.9
Official out-of-pocket payments for services outside the basic benefits package	4.0	5.0	6.6	7.2
Co-payments for services in the basic benefits package	–	0.017	0.057	0.061
Estimated unofficial out-of-pocket payments	46.6	57.5	58.2	59.1

Source: estimates by M. Aristakesyan, member of the National Health Accounts Working Group, and State Health Agency data.

If the basic benefits package is revised and, related to this, the official fees for services outside the basic benefits package are also revised (upwards, taking into account an insufficient share of formal out-of-pocket payments in health care costs), then this option of reforming the basic benefits package and introducing voluntary health insurance could potentially positively impact health policy objectives. In fact, for this option to be even more effective, a serious attempt would be required to make the basic benefits package a credible promise, including strengthening the State Health Agency as a purchaser and considering the real tradeoffs involved between service (or population) coverage contracting or co-payments.

6 The difference between total health care costs, public spending and out-of-pocket payments is the amount of humanitarian aid and donor-sponsored projects in the health sector.

Given the real limitations on service coverage for the basic benefits package and increases in fees for services outside the basic benefits package that this would imply, Armenia's variant of complementary voluntary health insurance (covering co-payments in the basic benefits package and/or what would effectively be primary coverage for referral services for the non-vulnerable population) could in theory offer the opportunity to transform some of the current out-of-pocket payments into prepayment. The potential payoff from this option could be great, because it is, by definition, not merely an option about a form of voluntary health insurance but instead an option that requires a comprehensive approach to national policy on health care funding. It also has a big conceptual advantage: this would enable a much broader state-regulated benefit package to be defined that would currently be only partly funded from public sources and (perhaps mostly for much of the population) funded from private payments (either co-payments or voluntary health insurance). The advantage of this is that it offers a clear direction for developing policy on health care funding over time: if and when more public funding becomes available, this can be allocated to the basic benefits package and replace the out-of-pocket payments. A clear and credible package would also facilitate potential demand for voluntary health insurance, as the package would become easier to evaluate for consumers.

Without such a comprehensive approach to policy on health care funding, however, we can assume that this option would minimally affect improving access to care and providing broader financial protection. Covering formal out-of-pocket costs through an insurance mechanism may positively affect increasing financial protection but would be unlikely to affect catastrophic health expenditure for most people.

Further, this option could result in a possible moral hazard problem by covering out-of-pocket expenditure above the tariff for a broad range of services, potentially increasing the use of services beyond what is necessary. This could result in higher overall health care costs to the public system.

The option may result in a diversity of insurance plans that cover very specific conditions and services: for example, only cover dental care or optical services. These could appeal to a broad range of people who are now paying out of pocket for this care and increase access to covered services. At the same time, this may increase the costs for these services if provider fees are not controlled.

This option would allow those who can afford to pay to contribute to their health expenditure in a prepaid form. However, this may be no greater than their current out-of-pocket payments. The positive impact on public expenditure is likely to be small.

This could increase transparency in provider payments for covered services if the insurance payment to providers is high enough to compensate for the previous informal and formal co-payments and strong disincentives for charging service users are built into contracts.

Finally, this option could benefit public hospitals by providing a more predictable source of revenue from insurers, which could be used to improve the quality of health care.

Because the current basic benefits package lacks credibility, how much demand there would be to cover this range of services alone and these population groups is unclear. It is also not clear whether insurers will want to cover payments above the tariff and what the administrative costs of this coverage would be. The private insurance market may therefore grow slowly in this option, and insurance premiums are likely to be high. Although the extent to which

demand for voluntary health insurance would be motivated by the improvement of the basic benefits package and strengthening of its purchasing as suggested here cannot be predicted with confidence, a strong positive impact would be expected due to the overall increased credibility of the health system and the greater clarity on what, precisely, the voluntary health insurance would cover.

The variant of this option that includes substantial reform of the basic benefits package and official fees would be more difficult to implement than the variant that assumes no changes to the existing publicly funded service package and official fees. This latter option would be the easiest to implement because it would minimally affect the public system. The people who would purchase this type of coverage would most likely be the employed, wealthier members of society who could afford to buy voluntary health insurance. Because of the more limited impact, the regulatory framework required may not be extensive. So there is a clear trade-off between the expected effectiveness of the policy and the challenge of implementation.

Option 2: voluntary health insurance is allowed to cover a full range of services and population groups (potentially overlapping with the basic benefits package)

This option recognizes the de facto reality that, although a formal basic benefits package exists, it is not adequately funded to cover the majority of the population. It would allow private insurers to cover a full range of services (except primary care) that are included in the basic benefits package as well as a broad range of people. In fact, this is how voluntary health insurance schemes currently operate in Armenia: they often provide comprehensive coverage to their clients, including certain primary health care services and a full range of hospital services, regardless of the basic benefits package.

The voluntary health insurance package would also provide coverage of formal and informal payments to providers by allowing insurers to develop contracts with providers that set a tariff that includes both these types of payments. For this to be effective, providers would need to be paid directly by the insurer and would not be allowed to charge the user of services at the time care is provided. Those who purchase voluntary health insurance could potentially receive care at both public hospitals and private facilities.

A variation of this option is to specifically target vulnerable and rural populations through insurance coverage. This would most likely require the government to provide subsidies to these groups to purchase insurance. It is also likely to require the entry and/or in-country development of not-for-profit insurers, nongovernmental organizations and community insurers, who are most experienced with dealing with these populations. The experience of such organizations as Oxfam, which has piloted community revolving drug fund schemes in several villages in Armenia, should be taken into account.

This type of voluntary health insurance is intended to offer broad financial protection to those who are not adequately covered through the publicly funded system. It would also encourage those who can contribute to their health care costs to do so through a risk-pooling mechanism rather than through out-of-pocket payments.

This option effectively ignores the basic benefits package and the need to improve the credibility of the publicly funded service package. As such, its potential is less than that of the variant of the first option that takes this comprehensive approach. Nevertheless, the

implementation of this type of voluntary health insurance would need to be carefully regulated and monitored to protect against market failures, escalating health care costs and inequity. This option could reduce barriers to access for some of the population. For it to reduce access barriers for larger segments of the population, the government may need to consider subsidies to help those with lower incomes to purchase coverage.

This option could provide necessary financial protection against catastrophic expenditure since a broad range of services and populations would be covered. It could potentially provide greater risk-pooling if insurers were required to accept a wide range of people but could result in cream-skimming if these requirements are not in place.

This variant would allow those who can afford to pay to contribute to their own health care costs and not rely on public expenditure. This may allow public expenditure to be more directly focused on poor and vulnerable populations.

This option could enhance equity if community rating, which provides cross-subsidies between healthier and less healthy people, were mandated. However, this could discourage younger, healthier people from purchasing insurance and result in higher insurance costs for everyone and limit the growth of the insurance market.

Equality in access could be negatively impacted by providing easier and more rapid access to health care for people who purchase insurance compared with those who cannot afford to do so. If public facilities are treating insured people, they may naturally tend to give priority to these insured people. This could allow those with insurance to jump the queue and potentially decrease access to people without insurance.

Public hospitals could benefit if insurance policies encourage the use of public facilities (for example, through preferred-provider arrangements) by providing an additional, more predictable source of revenue. However, if policies encourage the use of private providers, the public system could lose an important revenue source, and quality in public facilities could suffer.

The quality of care could improve if insurers practice active purchasing with preferred providers. This option could eliminate informal payments by providing greater transparency of fees to providers and ensuring that tariffs to providers cover both informal and formal co-payments.

Public administration costs would increase because a regulatory structure would be needed to monitor insurers. Overall administration costs in the system would increase because private insurers need to cover their operating costs and reserves. However, hospital-level administration costs may decrease because receiving payments from insurers may be less expensive than collecting out-of-pocket payments at the time care is delivered.

Finally, this option could help to build institutional capacity for a compulsory insurance system in the future if the State Health Agency were allowed to sell private coverage. The insurance market may develop more rapidly than in option 1 since insurers would be allowed to cover a full range of services and populations.

This option has greater potential for achieving policy objectives. However, it is more difficult to implement because it requires a sound and complete regulatory structure and compliance with this structure. Implementing this option without formally changing the basic benefits

package may be possible, although more information on the basic benefits package would be required before deciding this.

The variant of this option by which subsidies could be used to promote voluntary health insurance coverage for vulnerable and rural populations should be considered in relation to alternative approaches to using public funds to improve access and financial protection for these groups. From the perspective of these policy objectives, there is no reason why subsidizing voluntary health insurance coverage would bring any advantage to this option. It only makes sense if increasing private insurance coverage is an inherent policy objective, which it is not. Presumably, these are the population groups that already have publicly funded expanded entitlement under the basic benefits package. So in theory, these people are already covered by public funds. If the government would consider using more public funds to subsidize their purchase of private insurance, this has to be compared against the alternative of investing the same amount of money (and probably somewhat less, given the greater efficiency of putting the public money into the existing system) into the basic benefits package and making it more credible. In effect, if the option of using public subsidies to promote voluntary health insurance coverage for vulnerable and rural populations is pursued, it effectively means declaring the basic benefits package to be a failure, giving up on having a single public purchaser and redirecting public subsidies to the purchase of private health insurance. In the extremely fiscally constrained environment of Armenia, having two uncoordinated channels of public spending for the same population groups would use government money poorly.

Option 3: voluntary health insurance covers emergency services only

This option was suggested by representatives of Armenia's health care providers and was discussed during a policy seminar on voluntary health insurance in Yerevan in 2006. Justification for excluding emergency medical care (also called "urgent care") from the basic benefits package and covering it through voluntary health insurance is that many emergency conditions result from accidents and incidents, which are unpredictable, occur rarely and are associated with high costs. In theory, therefore, this could be an ideal domain for voluntary health insurance – all people are under more or less similar risk and they cannot predict when they will need emergency care, which lowers the risk of adverse selection and moral hazard.

Currently emergency care represents a major budget line for the State Health Agency and is also very difficult to monitor. Once a person is admitted to hospital and receives medical attention, the State Health Agency cannot prove whether this was really an emergency case or not. This fact is often used to bill the State Health Agency for people outside the basic benefits package which, in turn, provides more opportunities for out-of-pocket payments to the health care staff.

The budgetary resources saved by the state as a result of reducing the scope of hospital care services (including emergency care) could be used as additional financing for preventive care, primary health care and chronic disease management. Insured people would be able to receive full service and avoid out-of-pocket expenditure, which are currently unaffordable for most of the population for emergency care.

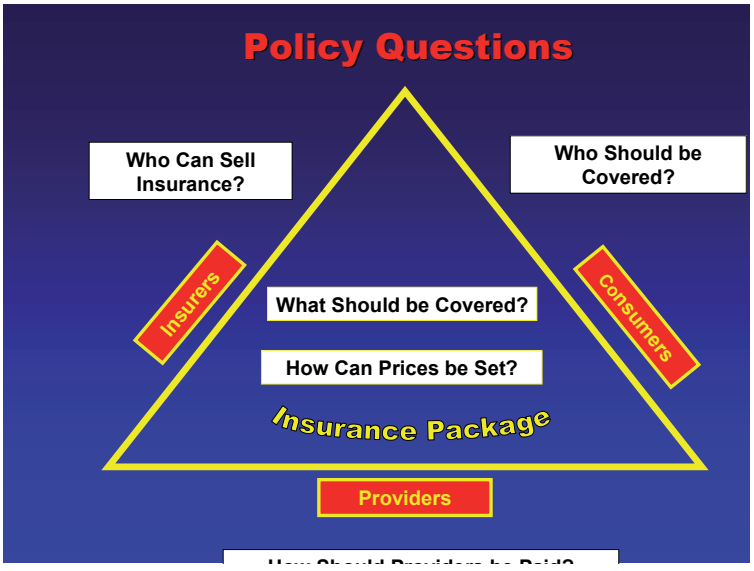
This approach requires political commitment from the government, which may not be forthcoming for the following reason. Although insurance theory suggests that insurance works best for unpredictable, rare and expensive events, in practice no system in the world explicitly excludes such coverage from public responsibility, in part because, despite the theory, not

everyone will purchase such coverage. As a result, it is very likely to create social tension and will certainly create ethical dilemmas for health care providers facing true emergency patients who lack voluntary health insurance coverage for this. One possibly acceptable version of this is that the state could finance a certain volume of health care needed in acute or emergency situations, which could include the first one or two days of stay in an intensive care unit, after which continued health care will be compensated by voluntary health insurance or, in its absence, by the individual. Most countries try to address the problem of gaming the system referred to above (cases coded as emergency that are not – a challenge virtually all systems have to face) through the administrative mechanisms used by the public purchasing agency. Although this will not catch every miscoded case, this is a trade-off countries accept to ensure that those who truly need emergency care are able to get it.

POLICY ISSUES FOR REGULATORS[7]

In developing a regulatory scheme for voluntary health insurance, policy-makers should answer five key questions regarding the interaction of the principal actors in the health insurance market: insurers, health care consumers and health care providers. In Armenia, given the limitations on public funding, voluntary health insurance could potentially be the primary form of coverage for at least some portion of the population, and the discussion is most relevant for regulating primary insurance, not purely secondary coverage (Fig. 4).

Fig. 4. Five policy questions for regulators



Who may sell insurance?

Policies concerning which entities may sell insurance benefit both clients and firms, offering consumer protection and ensuring a viable insurance market. Carmichael & Pomerleano (2002) and the Insurance Committee Secretariat of the Organisation for Economic Co-operation

7 This section is based on Sekhri, Savedoff, Regulating Private Insurance to Serve the Public Interest (2004).

and Development (1997) describe minimum regulatory requirements for private insurance institutions. In determining which regulations to introduce, policy-makers must answer the following questions.

- Will private insurers be an important source of health care funding? This will depend on which option the government selects and how quickly it would like to encourage the insurance sector to grow. If option 1 is selected or if the sector is expected to reach a greater percentage of the population, more extensive consumer protection will be needed. High-income countries in which private insurance plays an important role often impose more stringent regulations than those in which private insurance covers fewer people.
- How much competition should be encouraged? Managing the level of competition is important in emerging markets. Too many insurers make oversight difficult and can threaten the viability of the insurance pool, whereas insufficient competition can negate the benefits of a market. In this context a key question for Armenia will be whether it wishes to allow the State Health Agency to sell private coverage.
- How much insurer collaboration should be encouraged? In general, insurers should not be allowed to collude in setting prices or to share information, particularly about clients' health risks. But the insurance market works better when operations are transparent and information about general costs and actuarial risks is available. In establishing reporting and disclosure requirements, regulations must strike the appropriate balance between protecting proprietary data and gathering information about the health needs of the population, use of services and total health system costs.

Who should be covered?

Choices regarding who should be covered by private health insurance allow policy-makers to influence the breadth and diversity of the insurance risk pool, the level of participation in the market and the pace of market growth. These choices also allow policy-makers to address adverse selection and risk selection. The following policy questions should be addressed.

- What will be the basis of affiliation with insurers (group versus family or individual)? Group affiliation is preferable because it spreads health risks more evenly across insurers. Affiliation through employment is common, because members are easy to identify and payments are readily linked to earnings. However, such affiliation may limit labour mobility and make coverage difficult to sustain during economic downturns and periods of high unemployment. Family or household insurance may be more suitable where a large informal sector exists and is preferable to individual coverage, which is more expensive to administer and runs the greatest risk of adverse selection.
- How will low-risk individuals be encouraged to join the risk pool? Voluntary markets in which rating methods or other mechanisms promote equity can increase the cost of coverage for low-risk individuals. Explicit incentives such as tax rebates, exemptions and/or lifetime community rating are often required to broaden risk-pooling in the market.
- How can private insurers be encouraged to cover high-risk individuals without the viability of the insurance market being undermined? No high-income country, including the United States, uses voluntary private insurance to cover poor or elderly people. Other categories of high-risk groups may be part of the risk pool, but in the absence of explicit safeguards for both insurers and individuals these groups will be left without affordable coverage. If high-risk people are covered by public programmes and are not part of the private insurance market, less regulation is needed in this area.

What should be covered?

Requirements concerning basic benefits are intended to protect consumers from unreasonable exclusion and to address adverse selection and risk selection. In addition, they determine how much financial protection will be provided and can control for moral hazard. Policy-makers must consider the following questions.

- What benefits, if any, should be mandated? Primary insurance often contains a core set of benefits to provide adequate financial protection for those who purchase coverage. The services covered may be the same as those included in the basic benefits package. Mandating benefits, however, increases the costs of basic benefits packages and can make insurance unaffordable for some. To prevent cream-skimming, Armenia may want to consider a standard benefits package that all insurers must offer and a common pricing mechanism for this package.
- How important are consumer choice and customization in meeting the needs of different groups? If consumer choice is a policy goal, fewer restrictions on benefits may be appropriate. Choice must be weighed against the confusion and inefficiency that can occur when myriad plans with minor differences are offered. Excessive customization can increase the costs associated with administering multiple benefit designs and can create fragmented and unsustainable risk pools.
- What mechanisms will be used to curb unnecessary demand for services from consumers? Cost-sharing mechanisms such as co-payments or deductibles can address consumer-induced demand, but attempts to curb this demand must be balanced with measures to ensure that those who cannot afford to share health care costs receive needed services.

How can prices be set?

Regulating how private companies can price their products is a significant government intervention and can have unintended consequences. In health insurance markets, pricing policies are particularly difficult to design because of the many competing objectives: affordability, equity and viability, as well as avoiding adverse selection, risk selection and moral hazard. Rating policies can significantly affect equity and will guide the extent of risk pooling; they can protect the viability of the market by ensuring that insurers use the same pricing method for any stipulated standard benefit package. Otherwise, some insurers will use risk-rated premiums to attract low-risk individuals, potentially leading to market collapse. In setting pricing policies, policy-makers must answer two questions.

- To what extent is private insurance intended to promote equity by low-risk individuals and affluent people subsidizing high-risk individuals and poor people? In efficient markets, insurers will wish to charge actuarially fair premiums, which are related to the amount of risk the insurer is assuming. These premiums can accelerate the expansion of voluntary health insurance markets, but they do not provide the cross-subsidies necessary to ensure equity and can make insurance unaffordable for high-risk populations. Other forms of rating, such as community rating, are more equitable but decrease the attractiveness of coverage for low-risk individuals who are paying more than market value for the services they use.
- Are premiums intended to cover the current costs of care (pay as you go) or to provide reserves for future health care expenditure? Instability in the prices of insurance premiums is a particular problem where government intervention in provider prices and service use is minimal. Capital premium-setting mechanisms such as the one used in Germany can improve the predictability of premiums because, like life insurance policies, they include a reserve for future health care costs.

How should providers be paid?

How providers are paid will directly address supplier-induced demand. When insurers are passive, as in traditional third-party indemnity coverage, consumers tend to demand more health care and providers tend to induce more health care than might otherwise be justified. Where passive insurance arrangements have contributed to cost escalation, a variety of active purchasing and risk-sharing arrangements between providers and insurers have emerged to better align incentives. These arrangements have led to integrated insurer and provider arrangements such as managed care plans in which insurers oversee the care provided to enrolled people.

Policies and regulations governing provider fees are new in many developed insurance markets. These interventions address how providers are paid, how much they are paid and how care is delivered. The following policy questions are relevant in this area.

- How will prices in the private sector affect prices in the public system? To the extent that the same providers serve both the public and private sectors, cost inflation in the private sector may increase overall prices in the health care system. On the other hand, comparatively higher charges in the private sector, subject to effective controls, can be used to subsidize the public sector.
- How can price inflation resulting from insurance be constrained? Provider charging practices can affect the amount of financial protection offered through insurance. Some studies show that rather than reducing out-of-pocket spending, insurance can lead to an overall increase in that spending when providers respond by raising their prices to insurers and health care users. Price controls and individual insurance contracts can ensure that insurance actually provides financial protection and can keep health insurance premiums affordable.
- How can provider-induced demand be reduced and access and quality maintained? How much risk can be appropriately transferred to providers and how should this be structured? Considerable research has been done on provider payment mechanisms and how they affect provider-induced demand. Some of the research shows that sharing risks and rewards with providers and constraining supplier-induced demand may be even more important than reducing consumer demand in controlling health care costs. Aligning the incentives of payers and providers gives providers a financial stake in the viability of the system. Mechanisms such as global capitation transfer significant amounts of risk from the insurer to the provider but require policy-makers to ensure that providers can manage this risk and remain solvent.
- Is consumer choice of providers a key policy objective or will insurers be free to select providers? Will private insurance be used to promote coordinated care delivery? Encouraging insurers to purchase services from high-quality, cost-effective providers can limit cost escalation but also restrict freedom of choice of providers. Introduction of private coverage can be used to create incentives for providers to form links or vertically integrate, thereby improving the continuity of care. Managed care plans that are vertically integrated with or otherwise linked to other plans have positively affected the cost and quality of health care.

There are a variety of mechanisms to address the questions above and to achieve the overall policy objectives of a voluntary health insurance system. Table 4 identifies some of the instruments Armenia may consider in developing its regulatory framework.

Table 4. Policy instruments to address voluntary health insurance objectives in Armenia

Policy goal	Policy objective	Potential policy instruments to address the objectives
Protect consumers	Ensure the financial solvency of insurers	1. Establish sufficient minimum capital and reserve requirements. Review reserve requirements as insurance plans grow in size 2. Establish financial reporting requirements and ensure transparency in reporting
	Promote manageable competition in the market to encourage affordability and consumer choice	3. Establish reserve requirements that allow different types of insurers to enter the market, such as not-for-profit, community and managed care plans. Publicly funded guarantee funds may need to be established if these insurers are less well capitalized 4. Establish rules against monopolistic pricing
	Promote transparency and fairness in transactions between consumers and insurers	5. Establish disclosure requirements for policies and ensure that their content is understandable to consumers 6. Monitor advertising and sales practices to ensure consumer protection 7. Provide an independent mechanism to resolve consumer grievances
	Ensure that insurance packages provide adequate financial protection	8. Define at least one standard benefit package that all insurers must offer and require insurers to set premiums for this package in a similar way (such as community rating)
	Address issues of merit goods and externalities in health care	9. Directly provide or purchase health care interventions that are defined as public goods through public funds 10. Ensure that the minimum benefit package contains the items that are considered public goods 11. Subsidize insurers through public funds to provide coverage for public goods
Promote equity	Minimize adverse selection and encourage broader risk-pooling	12. Require insurance to be mandatory at least for certain categories of households 13. Encourage group enrolment through employer groups, associations, cooperatives and labour unions 14. Create incentives for low-risk individuals to join the insurance pool (such as tax incentives, rebates and lifetime rating methods) 15. Permit defined waiting periods for pre-existing conditions 16. Permit insurers to require people enrolling to disclose medical history
	Minimize risk selection or cream-skimming and encourage broader risk-pooling	17. Cover high-risk individuals through publicly funded programmes 18. Provide mechanisms to protect insurers such as high-risk pools, reinsurance and risk equalization schemes 19. Require guaranteed issue and renewal along with pricing guidelines that do not make premiums unaffordable for less healthy individuals 20. Limit exclusions and waiting periods to the first time that an individual purchases continuous insurance coverage
	Establish premium-setting guidelines that promote cross-subsidies between healthy and less healthy people and/or between income levels	21. Require community rating or lifetime community rating to promote cross-subsidies between healthy and less healthy people 22. Encourage income-based contributions where feasible to promote cross-subsidies between high- and low-income individuals (usually done only in social insurance)
Promote affordability	Reduce supplier-induced demand	23. Encourage provider payment mechanisms that share risks and rewards with providers such as case rates, per diem payments and capitation. With these, establish quality requirements and methods to monitor the underutilization of services
	Reduce consumer-induced demand (moral hazard)	24. Allow consumer cost-sharing through deductibles and co-payments. Monitor cost-sharing practices to ensure that they do not limit access to needed services and that they provide adequate financial protection

SUMMARY AND POSSIBLE IMPLICATIONS OF EACH OPTION FOR THE ENTIRE HEALTH SYSTEM

This section very briefly analyses what can be reasonably expected from introducing voluntary health insurance in Armenia.

Expanding coverage of voluntary or private health insurance is a means to an end rather than an end in itself. It is a way to contribute to achieving one of the most important objectives of policy on health care funding in Armenia – to reduce the share of total health spending in the form of out-of-pocket payments, assuming that this will improve financial protection, improve equity in financing and improve access to needed care (plus some other, indirect benefits in terms of more regular and predictable flows going to providers). Further, given the scarcity of public resources and concerns about poverty limiting the availability of household resources, the strategy should reduce reliance on out-of-pocket payments and make the most efficient use of available resources. So from this perspective, the real aim of policies aimed at increasing voluntary health insurance coverage in Armenia should be to substitute for out-of-pocket payments and to do so in a manner that is likely to be superior to other options for reducing the burden of out-of-pocket payments.

Option 1 (voluntary health insurance covers only the services and population groups that fall outside the basic benefits package or cost-sharing obligations for services covered under the basic benefits package) would absolutely require the government to clarify the coverage of the basic benefits package in terms of population groups and services. Making this option effective would require further strengthening the State Health Agency as a purchaser and considering the real tradeoffs involved between service (or population) coverage contracting and co-payments, to make the basic benefits package a credible promise. Given the real limitations on basic benefits package coverage this would imply (much of this is reality today), Armenia's variant of complementary voluntary health insurance (either co-payments in the basic benefits package or for what would effectively be primary coverage for referral services for the non-vulnerable population) could theoretically offer the opportunity to transform some of the current out-of-pocket payments into prepayment.

The potential payoff from this option could be great, because it is, by definition, not merely an option about a form of voluntary health insurance but instead an option that requires a comprehensive approach to national policy on health care funding. It also has a major conceptual advantage: a much broader state-regulated benefit package could be defined that would currently be only partly funded from public sources and (perhaps mostly for much of the population) funded from private payments (either co-payments or voluntary health insurance). The advantage of this is that it offers a clear direction for developing policy on health care funding over time: if and when more public funding becomes available, this can be put towards the basic package and replace the out-of-pocket payments. A clear and credible package would also facilitate potential demand for voluntary health insurance, as the package (either reduced co-payments or package services not covered for more affluent population groups) would become easier for consumers to evaluate.

The main difference offered by option 2 (voluntary health insurance is allowed to cover a full range of services and population groups) is that it essentially ignores the basic benefits package and public funding: that is its weakness in terms of potential impact on policy objectives and also its political strength. The main difference in service coverage would be that this would

open primary care to voluntary health insurance. Option 1 would already include all the referral services to which non-vulnerable people are not entitled under the basic benefits package. In a way, option 1 would be focused almost entirely on catastrophic coverage, whereas option 2 would potentially include comprehensive coverage. One efficiency concern of option 2, therefore, is that it potentially duplicates coverage for some populations and that it does not target catastrophic coverage. The long-term scenario for option 2 is not clear, since there is no explicit relation to public funding.

Option 3 (voluntary health insurance covers emergency services only) targets catastrophic coverage but needs to be considered with caution to avoid affecting negatively the access of the population to health care services.

If emergency conditions are to be excluded from the basic benefits package on the assumption that the more affluent population groups will be interested (in a way, forced) to buy the voluntary health insurance package instead, then considerable effort will be needed for clarifying the categories of socially vulnerable population groups (that will still need to be covered through the basic benefits package). Further, the government will need to clarify and brush up the definition and categories of emergency.

Option 3 is also aimed to reduce the burden on the public sector in terms of funds spent on treating emergency cases and to improve the monitoring of such cases to avoid fraud. The explanation is that the State Health Agency cannot prove whether a given case really was an emergency, whereas the insurance companies may be able to ensure better monitoring. But such an approach does not contribute much to building the capacity of State Health Agency as a strategic purchaser.

In the best-case scenario, Armenia may reach 10–15% population coverage with voluntary health insurance over 10 years. That would be remarkably high in the light of international experience in low-income or low-tax countries.

This publication attempted to comprehensively assess some options for voluntary health insurance from the perspective of the entire health system and the objective of transforming out-of-pocket payments into prepayment as efficiently as possible and described the potential implications.

The choice of an option (or their combination) is left for policy-makers and the Government of Armenia.

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WHO Regional Office for Europe
Scherfigsvej 8, DK-2100 Copenhagen Ø, Denmark
Tel.:+45 39 17 17 17. Fax: +45 39 17 18 18
E-mail: postmaster@euro.who.int

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EUROPE

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