International Labour Organization

Extending social health protection: Accelerating progress towards universal health coverage in Armenia

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1. Introduction

Armenia is one of the 15 republics (state formations) of the former Soviet Union, characterized by typical features of socio-economic development in other countries in the region. The population of Armenia is 3.03 million people in 2024 (ARMSTAT 2025). According to the UNDP Human Development Report 2025, Armenia ranked 69 out of 193 states, with a Human Development Index (HDI) of 0.811, placing it among the countries with high levels of human development (UNDP 2025). In the early 1990s, after independence, the economy of Armenia experienced a deep crisis of recession. The country's GDP almost halved from U$9.8 billion in 1990 to US$4.97 billion in 1993 (World Bank Database, n.d.). Economic growth has been recorded since the second half of the 1990s, with GDP reaching US$8.15 billion in 2000, and US$62.11 billion in 2023 (World Bank Database, n.d.). According to the World Bank classification, based on GNI per capita (Atlas method), Armenia advanced from a lower middle-income to an upper middle-income country in 2017 (World Bank 2018). In 2023, GDP at purchasing power parity per person amounted to 20,781 international dollars (World Bank Database, n.d.).

The Government of Armenia introduced a Basic Benefits Package (BBP) financed by general taxation in 1996. The BBP covers several vertical health programs, which provide mostly free-of-charge, publicly funded medical services for all Armenian citizens, including PHC services, emergency care, oncology, maternal and childcare and treatment of HIV/AIDS and TB.

The BBP also identifies socially vulnerable and other distinct categories of the population, for whom most of the hospital services are covered for free, with some exceptions. These categories include the disabled, children under 18, pregnant women, and those eligible for the Family Benefit Programme (FBP). Armenia has a very high share of out-of-pocket (OOP) spending on health, which comprises population spending on outpatient medicines, formal co-payments for certain services under the BBP, direct payments for services not covered by the BBP and informal payments (European Observatory on Health Systems and Policies 2022).

In addition, since 2012, a so-called social package covers certain categories of population through mandatory enrolment into private health insurance subsidized by the State.

▶ 2. Context

Armenia built its health and social health protection systems based on plans and programmes that existed in the era of the Soviet Union, the main features of which included a high degree of centralization and free medical care for the entire population, with a heavy emphasis on secondary and tertiary care (the Semashko heath care model was widely applied in the former republics of the Soviet Union).[1] However, due to a deterioration of the economic situation in the early 1990s following the dissolution of the Soviet Union, the effectiveness of the state health care system significantly decreased, leading to a decline in the accessibility and the quality of medical care (ILO and UN Women 2021).

The health care system of Armenia has undergone significant organizational and legal reforms over the last two and a half decades. The Government introduced several key health care reforms in late 1990s, including reforming the primary health care network, financing of social health protection and optimization of the hospital network (Lavado et al. 2020). Between 1990 and 2021, the total number of hospital beds was reduced by 58 per cent (from 30.5 thousand to 12.7 thousand) and the number of hospitals decreased by 32 per cent (from 183 to 122), while the number of PHC facilities did not change significantly (503 to 487) (National Institute of Health of the Republic of Armenia 2022a).

With the adoption of the Law on Medical Care and Services to the Population in 1996, institutionalizing the universal nature of access to health care in Armenia, the BBP, alongside new provider payment mechanisms, was introduced. Line-item based budgeting and direct financing of health facility maintenance costs were replaced with the model of service purchasing through output-based financing of inpatient health facilities and per-capita funding of primary health care. A major step in social health protection reforms was the establishment of the State Health Agency (SHA) in 1997 as an independent public body charged with the task of purchasing of all publicly funded outpatient and inpatient medical services on behalf of the population (European Observatory on Health Systems and Policies 2022). The initiative of the Family Doctors Programme, implemented in 1996, aimed at improving provision of integrated primary health care services and prevention of chronic diseases, which also marked a critical change in the health care system (World Bank 2005).

While most basic medical services under the BBP are free for all, the population has to pay to access inpatient services available at public and private medical facilities, except for vulnerable groups (Tonoyan and Muradyan 2012).

In February 2023, the Government approved the first sector-wide policy document for health (Health Sector Development Strategy 2023-2026)[2] and a concept note for the introduction of a universal health insurance (UHI) system in Armenia.[3] The UHI proposal aims at expanding population coverage by introducing a payroll health tax for the working population which will provide them with the same package of services currently guaranteed for only socially vulnerable categories of population under the BBP. The Government also plans to gradually expand service coverage for already covered groups, closing existing gaps between service packages for different categories of BBP beneficiaries (Lavado et al. 2020). Initially, full implementation of UHI was envisaged for 2027. However, as of November 2024, the introduction of UHI has been postponed indefinitely due to limited fiscal space. The 2025 state budget does not include funding for the scheme, and previously allocated funds in 2024 were reallocated to other priorities. Additionally, the draft law on comprehensive health insurance, though prepared in 2023, has not yet been adopted, largely due to unresolved questions regarding the state's ability to subsidize contributions for vulnerable groups. Despite these delays, the government has stated that preparations

[1] Named after the first minister of health of Soviet Russia, Nikolay Semashko, this system of health care organization was characterized by its centralized, integrated, hierarchically organized structure with the Government providing state-funded health care to all citizens. It provided universal access to health care and was broadly a "benefits in kind" system.

[2] Government of Armenia Decree No. 174-L on Approval of Health Care System Development Strategy of the Republic of Armenia for 2023-2026 and the Resulting Action Plan, dated 9 February 2023, available (in Armenian) at: https://www.e-gov.am/gov-decrees/item/39848/

[3] Government of Armenia Decree No. 133-L on Approval of the Concept Note for Implementation of Universal Health Insurance, dated 2 February 2023, available (in Armenian) at: https://www.e-gov.am/gov-decrees/item/39809/

will continue, and in June 2024, the World Bank announced a $110 million loan to support Armenia's efforts to advance universal health coverage (Aiypkhanova 2024).

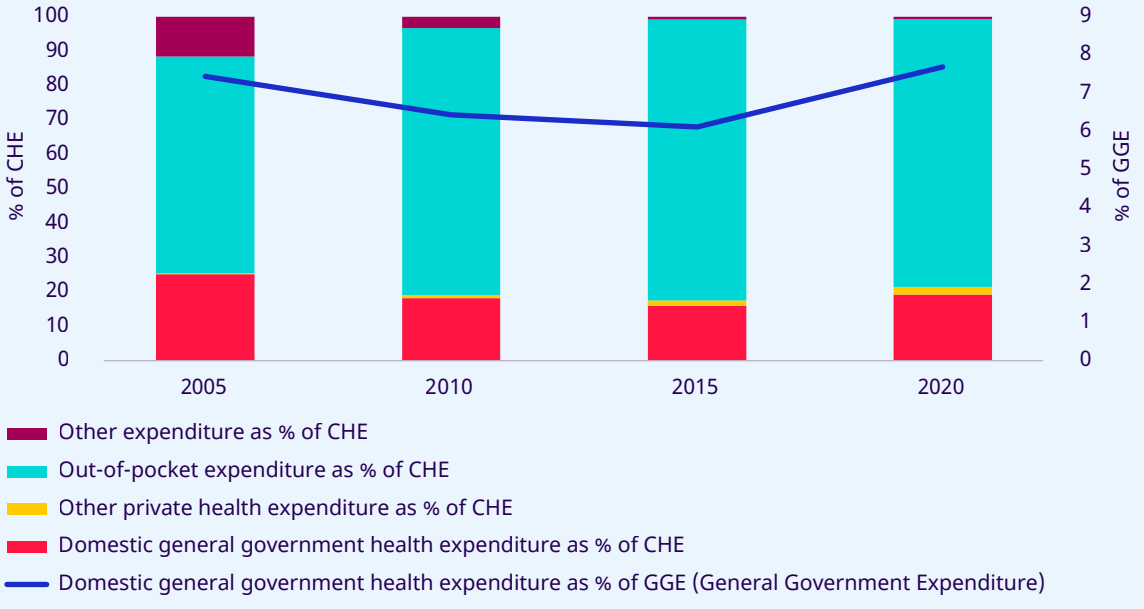
3. Design of the social health protection system

Financing

From 2014-2019, public health expenditure varied between 5.5 per cent and 6.2 per cent of the total government budget expenditure and 1.2-1.6 per cent of GDP (European Observatory on Health Systems and Policies 2022). In 2021, health spending increased to 7.5 per cent of total budget expenditure and 2.3 per cent of GDP, primarily due to additional public spending to address the COVID-19 outbreak (European Observatory on Health Systems and Policies 2022). In 2021, Current Health Expenditure (CHE) per capita was US$577, from which US$454 (or 79 per cent) comprised household private spending for health. In the same year, public expenditure in Armenia on health care amounted to 17.8 per cent of CHE (compared to 12.4 per cent in 2019), while private spending accounted for 81.4 per cent (down from 86.6 per cent in 2019), and external sources accounted for 0.9 per cent. OOP payments were the main source of health spending (accounting for 78.7 per cent in 2021 and 84.8 per cent in 2019), and voluntary health insurance (VHI) accounted for a small portion of total health expenditure (1.9 per cent) in 2021 (National Institute of Health of the Republic of Armenia 2022b).

The public budget (including for health) is generated from general tax revenues and is consolidated through the treasury of the Ministry of Finance. Around 80 per cent of the health budget is used for the procurement of BBP services and the remaining 20 per cent is used to finance public health programmes, centralized procurement of medicines and so on. The budget is managed by the MoH, mainly through the State Health Agency and directly through its financial-economic department (Dale et al. 2018; European Observatory on Health Systems and Policies 2022).

Figure 1. Composition of current health expenditure (CHE) in Armenia, by source of financing, 2005-2020



Source: Based on data from the WHO Global Health Expenditure Database.

Governance

Between 1997 and 2001, the SHA was directly subordinated to the Government of Armenia and acted independently from the MoH. In 2002, the SHA was made a part of the MoH structure, and in 2011, it was further incorporated into MoH. SHA is now de-facto a department of the MoH. The head of the SHA is appointed by the Minister of Health. The SHA prepares contracts with the providers, processes the reporting and disbursement of funds from the budget and conducts audits, while all major purchasing decisions are made by the MoH, including authorization of the contracts with providers (European Observatory on Health Systems and Policies 2022).

On the provision side, the MoH is responsible for developing and implementing health care policy in the country, and directly manages a limited number (around 20) of health care facilities and institutions, some of which are multi-profile or specialized medical centres. The decentralization of health care system which took place in the 1990s expanded the role of municipal (regional) governments (Armenian et al. 2009). Health departments of regional (marz) administrations and local (community) authorities currently manage most public health facilities in Armenia, including regional hospitals, urban polyclinics and rural PHC centres (European Observatory on Health Systems and Policies 2022).

The MoH approves health sector regulations, such as service delivery standards, protocols and guidelines (mainly developed by the National Institute of Health) and exercises its regulatory functions by licensing health care providers through its Licensing Agency (Chukwuma et al. 2020a). Sanitary and epidemiological surveillance services in the country are organized through the National Centre for Disease Control and Prevention, which is also subordinated to the MoH (Farrington et al. 2016).

While the management of the health system is decentralized, its financing is consolidated at national level. The MoH acts as the sole purchaser of budget-funded medical services. Both public and private health facilities (around 500 in total) are contracted by the MoH under the same legal framework to provide BBP services (European Observatory on Health Systems and Policies 2022; Chukwuma et al. 2020a). A new Health Project Implementation Unit (HPIU) has also been established under the MoH to coordinate donor-supported health programs, including those related to universal health coverage (World Bank 2024).Governance arrangements are different for the social package programme of the BBP, which is delegated to private insurance companies licensed by the Central Bank to provide health insurance services in Armenia. Under this system, the MoH signs contracts with insurers and provides proportional monthly payments based on the number of beneficiaries allocated to each insurer. Insurers then sign contracts with health care providers approved by MoH for delivery of medical services to beneficiaries. The benefits package under the scheme is approved by the Government, while the price list for the covered medical services is approved by the MoH.

Legal coverage and eligibility

The Constitution of 1995 (amended in 2015) guarantees social protection rights, as well as the right to health care. Article 83 states that "everyone shall, in accordance with law, have the right to social security in cases of maternity, having many children, sickness, disability, accidents at work, need of care, loss of bread winner, old-age, unemployment, loss of employment, and in other cases." Additionally, article 85 of the Constitution states that "everyone shall, in accordance with law, have the right to health care. The law shall prescribe the list of free of charge basic medical services and the procedure for the provision thereof."[4]

More specifically, article 13 of the Law on Medical Care and Services of the Population of 1996[5] stipulates that all residents have the right to receive medical care and services "regardless of nationality, race, gender, language, religion, age, state of health, disability, political or other views, social origin, property or other status, in accordance with the procedure established by the Constitution, this law and other laws, as well as international treaties of the Republic of Armenia." The Law also notes that everyone has the right to receive medical care and services on free or preferential terms within the framework of

[4] Constitution of the Republic of Armenia, amendments adopted 6 December 2015, available at http://www.parliament.am/parliament.php?id=constitution&lang=eng#2

[5] The Law on Medical Care and Services of the Population dated 4 April 2006, available (in Armenian) at: https://www.arlis.am/DocumentView.aspx?DocID=153795

health protection and improvement programmes approved by the Government, while medical care can also be provided outside the scope of these programmes through medical insurance benefits, personal payments, and other sources not prohibited by law. The Government approves the annual health protection and improvement programmes annually and submits them along with the draft budget to the National Assembly as an integral part of the budget (Chukwuma et al. 2020a; Dale et al. 2018).

The list of socially vulnerable and special categories of the population (as well as covered medical services for different categories of beneficiaries, but also purchasing, contracting and provider payment mechanisms), is approved by the Government. The main legal act regulating the BBP is Government Decree No. 318-N of 4 March 2004, which regulates provision of BBP services for the general population.[6] This Decree approves the list of socially vulnerable and special categories of population. It currently includes 22 categories (see box 16).

▶ Box 1. Socially vulnerable and special categories of the population in Armenia

- Beneficiaries of the family benefit scheme with a vulnerability score of at least 28.01
- Disabled people with high degree of functional limitation
- Disabled people with severe degree of functional limitation
- Disabled people with moderate degree of functional limitation
- Children (0-18 years)
- Participants of Great Patriotic War and their equivalents
- Pregnant women and new mothers (42 days after childbirth)
- Young people (aged 18-23 years) left without parental care
- People undergoing medical tests for assessment of the degree of functional limitations
- People of conscription age (for inpatient expertise and treatment)
- Military service personnel and their family members, retired military service personnel
- Rescue service personnel and their family members, retired rescue service personnel
- People in custody
- People in care in orphanages, retirement homes and temporary shelters for homeless people
- Oppressed people (for example, victims of political repression during the Soviet period)
- People involved in recovery works after the Chernobyl disaster
- Victims of human trafficking
- Asylum seekers and their family members
- People discharged from military service due to mutilation, injury and disease which occurred during military service who have not been recognized as disabled after a functionality assessment
- People discharged from military service due to mutilation, injury and disease occurred during military service, during the first three months of treatment, before referral for medical and social expertise
- Members of national olympic teams and olympic family sports teams
- People referred for forensic tests

In addition, medical care for military service personnel and their family members under the BBP is regulated by the Government Decree No 806 of 25 July 2013.[7]

Another segment of the covered population includes beneficiaries of the social package—a programme that was introduced by the Government in 2012. This service package is part of the BBP, in that it is funded from the government health budget and covers civil servants, teachers at public schools, health workers

[6] Government of Armenia Decree No. 318-N on Free and Preferential Medical Care and Services Guaranteed by the State, dated 4 March 2004, available (in Armenian) at: https://www.arlis.am/DocumentView.aspx?DocID=175656

[7] Government of Armenia Decree No. 806-N, dated 25 July 2013, available (in Armenian) at: https://www.arlis.am/DocumentView.aspx?DocID=161119

at public PHC facilities and employees of other specified public institutions (dependents are not covered under this programme). The provision of medical care for social package beneficiaries is regulated by Government Decree No. 375-N of 27 March 2014. [8]

Another important component of the BBP is the provision of publicly-funded medicine for vulnerable categories of the population and patients with certain medical conditions, which is regulated by Government Decree No. 642-N of 30 May 30 2019. [9]

Benefits

The BBP was first introduced in Armenia in 1996. Since then, the BBP has been periodically revised and expanded, based on available budget resources allocated to the health sector. The MoH is responsible for defining the benefit package. While the initial BBP composition was informed by evidence, including on efficacy of services, the country's burden of disease and cost-effectiveness of services, as well as their financial implications, subsequent revisions do not follow a defined process (Chukwuma et al. 2021). Under the BBP, residents are entitled to outpatient care (including primary care and some specialist visits, but excluding dental care), emergency care and care provided through hospital vertical programmes.[10] Access is free, with the exception of a few services (services for sexually transmitted diseases, oncology and hematology diseases), for which a co-payment might be required for non-vulnerable populations (Lavado et al. 2020).

Co-payments are also applied for inpatient care (percentage co-payments), diagnostic tests (fixed co-payments),[11] dental care treatment and outpatient prescribed medicines (percentage co-payments).[12] Some co-payments for hospital services vary between Yerevan and other regions due to differences in provider costs and tariffs. Overall, the co-payment amount can vary from 10-15 per cent to more than 50 per cent of the total service cost.

In addition, people included in socially vulnerable and special categories (comprising around 50 per cent of the population), as well as military staff and their family members, are entitled to other types of available inpatient care, some dental care and additional (so called hard-to-reach) diagnostic tests (such as CT, MRI and PET CT). These groups are exempt from co-payments.

In recent years (since 2019), BBP coverage has expanded significantly. Notably, co-payments for cancer surgeries were abolished and coverage for children has been expanded from 7 to 18 years. Moreover, the threshold score for beneficiaries of the family benefits scheme was lowered from 30.01 to 28.01 to enable more people to benefit from the scheme, and additional services were added to the list of vertical programmes available to the whole population, including outpatient emergency care in hospitals and palliative care, as well as urgent surgical treatment of acute myocardial infarction (coronary stenting), treatment of acute or subacute ischemic brain strokes and surgeries for ruptures and (or) exfoliation of aortic aneurysms (ILO and UN Women 2021; Lavado et al. 2020).

[8] Government of Armenia Decree No. 375-N, dated 27 March 2014, available (in Armenian) at: https://www.arlis.am/DocumentView.aspx?DocID=171451

[9] Government of Armenia Decree No. 642-N, dated 30 May 2019, available (in Armenian) at: https://www.arlis.am/DocumentView.aspx?DocID=179755

[10] These include services for intensive care; tuberculosis treatment; treatment of psychiatric and narcological diseases; treatment of communicable diseases; health services for people of conscription and pre-conscription age; childbirth; hemodialysis services; surgical treatment of oncological diseases; outpatient emergency care in hospitals; palliative care; urgent surgical treatment of acute myocardial infarction (coronary stenting); treatment of acute or subacute ischemic brain strokes; and surgeries for ruptures and (or) exfoliation of aortic aneurysms.

[11] Government of Armenia Decree No. 375-N, dated 27 March 2014, available (in Armenian) at: https://www.arlis.am/DocumentView.aspx?DocID=171451

[12] Government of Armenia Decree No. 642-N, dated 30 May 2019, available (in Armenian) at https://www.arlis.am/DocumentView.aspx?DocID=179755

Inpatient medicines are free for BBP-covered services, with certain exceptions or caps. The cost of outpatient medicine is subsidized by the Government for certain categories of the population based on social status criteria or medical conditions. Depending on social status, beneficiaries can obtain the medicine prescribed by their PHC providers either free of charge, or with a discount of 50 per cent or 30 per cent. Patients with the following medical conditions are also entitled to receive free medicine: Tuberculosis, mental illnesses, cancer, diabetes, epilepsy, myocardial infarction, periodic fever syndrome, heart valve defects, malaria, chronic renal failure, phenylketonuria, respiratory disease syndrome in premature infants, HIV/AIDS, hormonal medicines and viral hepatitis C (Lavado et al. 2020).

▶ **Table 5. Social categories of the population eligible for fully or partially subsidized outpatient medicine in Armenia**

	Categories
For fully subsidized outpatient medicine	• Persons with disabilities with high, severe or moderate degree of functional limitations • Children with disabilities (up to 18 years old) • Participants of the Great Patriotic War and their equivalents • Children left without parental care, and children of those left without parental care (up to 18 years old) • Children of families with many children (with 4 or more children under the age of 18) • Family members of military service personnel who passed away while defending the Republic of Armenia, or during the fulfillment of official duties • Children of families with persons with disabilities (up to 18 years old) • Children up to 7 years old) • Beneficiaries included in the Family Benefit Scheme with a vulnerability score of 28.01 and above • Different categories of military hostility victims
For partially subsidized outpatient medicine (50% discount)	• People involved in Chernobyl disaster restoration work • Oppressed people (people who were subject to political repression during the Soviet period) • Single non-working pensioners • Non-working pensioner households (households without any working members) • Children (7-18 years) with a single parent
For partially subsidized outpatient medicine (30% discount)	• Non-working pensioners (part of a household with other working members, including children)

Source: Lavado et al. 2020.

Provision of benefits and services

In 2021, Armenia had 487 institutions (371 public and 19 private) providing primary health care and 122 hospitals (80 public and 42 private), and there were 12.7 thousand hospital beds, 14.5 thousand medical doctors and 16.6 thousand nurses available in the country. Around one third of these resources are concentrated in the private sector, including 4.3 thousand doctors (or 34 per cent of the total number of doctors), 4.8 thousand nurses (29 per cent), and 4.1 thousand hospital beds (32 per cent) (National Institute of Health of the Republic of Armenia 2022a). To be eligible for applying for a BBP-funded contract (also informally referred to as "state order"), medical institutions must hold a license for the medical services which the provider is seeking funding from the state budget for (Chukwuma et al. 2020a).

In rural areas, PHC services are provided by rural ambulatories or family medicine centres, whereas in cities those services are provided by polyclinics, which are outpatient facilities that host both PHC providers such as family doctors, general practitioners and pediatricians along with the standard set of

specialists and diagnostic services under one roof. Polyclinics currently exist as independent facilities only in the capital Yerevan, as well as in Gyumri and Vanadzor, while in other urban settings they are included under the structure of regional medical centres (typically, along with a hospital and maternity centre). Some rural ambulatories also include FAPs (Feldsher/midwife health posts), which are not legally considered to be separate health facilities, and exist only in villages where a nurse is present. Usually, PHC is provided to people at their place of residence (Lavado et al. 2020; European Observatory on Health Systems and Policies 2013). On average, one PHC doctor serves 1,500 to 2,500 persons and one paediatrician serves 700 to 800 children (Atun et al. 2005).

Inpatient services are provided by a mix of public and private hospitals and medical centres. Regional hospitals, which mainly provide secondary specialized services, are under public ownership and are managed by marz (regional) administrations. Yerevan-based hospitals are managed either by Yerevan municipality or the MoH, and also include private facilities. They provide both secondary and tertiary level (narrow and specialized) inpatient services (European Observatory on Health Systems and Policies 2022).

People need to register with a PHC provider in order to access BBP-covered health services. Access to BBP-covered diagnostic tests, outpatient specialist services and inpatient care requires a referral, and access to covered outpatient prescribed medicines requires a prescription from PHC providers (Chukwuma et al. 2020a).

BBP-covered medical services are provided as benefits in kind. If patients opt to visit either a private clinic not contracted by the MoH or a different primary care facility (other than the one where they are registered) they must pay the full cost of the service. Health facilities (both public and private) providing BBP services are contracted by MoH on an annual basis and operate under the same contracting and reporting arrangements regardless their ownership status (Chukwuma et al. 2020a). PHC services are financed on a per capita basis, according to the number of people enrolled with each provider, while hospital services are mainly financed on a case-by-case basis, based on claims that facilities submit to SHA through a a nationwide electronic health information system called ARMED (European Observatory on Health Systems and Policies 2022).

ARMED was launched in 2017 and currently operates in around 560 health care facilities, six private insurance companies and the MoH/SHA. All health facilities that are contracted by the MoH for the delivery of BBP services are connected to ARMED to facilitate claims submission and management, but the system can also be accessed by individual patients, as well as by other public and private users. In February 2021, a three-year action plan for further development of the eHealth system was approved by the MoH, including a full-scale implementation of electronic prescription and electronic referral modules, as well as disease registries. ARMED is connected with the population registry, which allows a real-time check of patients' personal data. Further integration with other electronic government systems, such as the civil registration and vital statistics database of the Ministry of Justice and the social status registries of the Ministry of Labour and Social Affairs, is ongoing (European Observatory on Health Systems and Policies 2022).

For the social package programme, insurers have to contract all providers under the same terms and conditions for delivery of medical services to beneficiaries, essentially acting as third-party administrators of the system. Thus, insurers perform only certain key functions: Contracting of providers, case management and claims processing. Both public and private health care providers report the number of cases, including both outpatient and inpatient, to insurers monthly, and receive payments based on the reported volume of services. The actual amount of monthly payments from the MoH to insurers reflects the approved budget, which is fixed by the contract for each insurer, and is not linked to the actual volume of medical services provided. If an insurance company spends less than the total amount received from the MoH, the company makes a profit. However, if they receive more claims from health care providers than initially anticipated, they have to settle those claims at their own risk (Chukwuma et al. 2020b).

4. Results

Coverage

Armenia's health care legislation guarantees the provision of PHC and basic hospital medical services to all. However, in practice, access to services is limited, primarily due to financial barriers to care and a shortage of medical specialists in the regions.

In theory, the BBP covers PHC services for the entire population. However, most beneficiaries still have to bear direct costs of seeking health care. It is likely that many forgo basic health care due to an inability to cover the cost of co-payments and informal payments. According to the 2019 Integrated Living Conditions Survey, even among vulnerable groups, effective coverage is relatively low (28.6 per cent of children aged 0-4 years; 21.9 per cent of Family Living Standards Enhancement Benefits beneficiaries; 11.8 per cent of persons in the lowest consumption decile; and 52.3 per cent of persons registered as disabled) (ILO and UN Women 2021).

While coverage is low among all age groups, coverage among children is highest (17.5 per cent), likely due to the fact that all children up to the age of seven and several other groups within this demographic are considered vulnerable and are therefore exempt from BBP co-payments. Coverage among working-age persons is the lowest (8.3 per cent) and increases only slightly for older persons (9.5 per cent). This could also be attributed to the fact that unemployed pensioners are classified as a special group under the BBP. Notably, a greater share of the male population is covered by the BBP (11.3 per cent) compared with the female population (9.8 per cent), despite the fact that all women of reproductive age are considered a special group (ILO and UN Women 2021).

Adequacy of benefits/financial protection

Due to limited effective coverage in Armenia, financial protection when accessing health care services is very limited. As a result, OOP payments are among the highest in the world. OOP as a share of current health spending was 78.7 per cent of CHE in 2021, down from 84.8 per cent in 2019 (see figure 30), but still far above the average for upper-middle-income countries (44.1 per cent of CHE), obstructing the affordability of health services for the population. OOP spending includes costs for outpatient medicines, formal co-payments for services under the BBP, direct payments for services not covered by the BBP and informal payments (European Observatory on Health Systems and Policies 2022).

Historically, in a context of low wages, informal payments have been requested by medical staff (Chukwuma et al. 2020a). The implementation of formal co-payments for certain BBP services in 2011 was one of the measures aimed at reducing and gradually eliminating informal payments in the health sector. However, a lack of coverage of inpatient care for the non-vulnerable population and outpatient pharmaceuticals for all remain the main drivers of high OOP payments in Armenia (ILO and UN Women 2021; European Observatory on Health Systems and Policies 2022).

In addition, the country has relatively high rates of catastrophic spending on health, at 23.2 per cent of the population with household expenditures on health greater than 10 per cent of total household income, and 5.5 per cent of the population with health expenditures greater than 25 per cent of household income in 2020 (WHO, n.d.). High catastrophic spending in Armenia pushes households into deeper poverty, with the highest risk among low-income residents, residents of rural areas and informal economy workers, leaving them with inadequate financial protection for accessing care (WHO Regional Office for Europe 2019).

Responsiveness to population needs

Accessibility and availability

Since 2000, Armenia's universal health coverage index has increased by almost 1.5 times, from 45 points to 69 points in 2019 (WHO, n.d.). While this is higher than the global average (64 points), it is still below the European average (77 points) (WHO, n.d.). In 2021, there were 49.1 doctors, 56.1 nurses, 42.9 hospital beds per 10,000 people, and 16 hospitalizations per 100 residents (National Institute of Health of the Republic of Armenia 2022a).

Despite seemingly satisfactory national staffing rates in Armenia, there are considerable differences in the provision of medical care between the capital city and other areas. Around 37 per cent of the total population lived in Yerevan in 2021, and 74 per cent of all doctors were based there. This can be partially attributed to the concentration of most tertiary-level specialized hospital services in Yerevan. However, the imbalance in medical workforce distribution can also be explained by lower salaries in the regions and poor living and social conditions compared with the capital city (European Observatory on Health Systems and Policies 2022). The number of nurses per 100,000 persons in Armenia is below the Europe and Central Asia regional average and above the Central and Western Asia subregional average, whereas the number of physicians is slightly below the regional average and above the subregional average.

Hospital beds are distributed unevenly across the country. With 44 per cent of the hospitals and 65 per cent of hospital beds located in the capital city, Yerevan has a higher density of hospital beds than other regions. Secondary level hospital care, such as general surgery, maternity and OBGYN, and general therapeutic and pediatric services are available in all 122 hospitals across the country (National Institute of Health of the Republic of Armenia 2022a), while patients who need more hi-tech or specialized services are typically transported to Yerevan, where specialized hospital care and the provision of certain technology-based diagnostic procedures (such as CT or MRI) are predominantly concentrated (European Observatory on Health Systems and Policies 2022). Ambulance services are fully covered by BBP, including an air ambulance service to promptly evacuate patients in need of urgent treatment to medical centres in Yerevan.[13]

Prior to 2018, health infrastructure investments were mostly financed by development partners. Since 1998, more than 170 regional PHC facilities (rural ambulatories and family medicine centres) and around 20 regional medical centres (hospitals) were renovated and equipped, mainly through support from World Bank credit programmes and other donors. Further renovation or construction of health facilities are included in the current Government Programme 2021–2026 to be financed from the state budget. This includes the target to renovate more than 30 health centres and provide them with updated equipment (European Observatory on Health Systems and Policies 2022).

However, there are still issues with the development of infrastructure and the availability of modern medical equipment. Most polyclinics still only have basic medical equipment for medical check-ups, such as X-Ray machines or lab equipment, which are often outdated. As such, the types of pathologies that can be diagnosed at PHC level are limited. The modernization of health care facilities is a crucial priority that the Government should consider to enhance the quality of medical services (JICA and Nomura Research Institute, LTD 2019).

While most of the dental clinics in the country and some of the largest multi-profile hospitals in the capital city Yerevan are private, the rest of the health service delivery system (especially in the regions) is still publicly owned and managed. In 2021, around 71 per cent of all doctors and nurses were employed by publicly owned health facilities, in which more than two-thirds of the total hospital bed capacity in the country was concentrated (European Observatory on Health Systems and Policies 2022).

[13] Government of Armenia Decree No. 318-N on Free and Preferential Medical Care and Services Guaranteed by the State, dated 4 March 2004, available (in Armenian) at: https://www.arlis.am/DocumentView.aspx?DocID=175656

Quality and acceptability

Armenia lacks a comprehensive system of health care quality monitoring and management. A 2018 study showed that among preventable deaths in Armenia, the majority (53 per cent) were due to low quality of care rather than non-utilization of services (Kruk et al. 2018). A situational analysis of quality of care in Armenia carried out by the Asian Development Bank (ADB) through two surveys in 2019 (which were reflected in the strategy for improving health services, approved by the MoH in April 2022),[14] found that there is insufficient leadership to address quality concerns. In particular, it was noted that there is an absence of an overall governance structure, insufficient use of the eHealth system, minimal data for quality improvement, little patient involvement, and insufficient knowledge and skills on quality management among facility managers and health workers. While hospital epidemiologists are tasked with monitoring and reporting nosocomial infections, ensuring compliance with guidelines on infection prevention and control, and investigating reasons for cases of high infection rates, nosocomial infections remain underreported.

A system to license health facilities is in place, and this function is performed by the MoH through its licensing agency. However, the licensing process focuses mainly on availability of physical inputs (trained medical staff, infrastructure and equipment) but does not include any quality standards. Facility licenses used to be issued without fixed renewal terms, but this regulation has been recently revised; from now on, licenses have to be renewed every five years, which will help to establish quality monitoring elements (Chukwuma et al. 2020a; 2020b).

In addition, insufficient staffing in the regions and overloaded family doctors, who may have more than 3000 patients (compared with the standard of 2000), negatively affects the quality of services. Similarly the low wages of doctors, especially in regional health facilities, makes it difficult to recruit highly qualified specialists for health care institutions who can provide high-quality medical care services to the population (JICA and Nomura Research Institute, LTD 2019).

As a result, the population is often reluctant to use PHC services, mainly because of the perceived low quality of services. Data from the Integrated Living Conditions Survey 2021 indicated that 61.9 per cent of non-poor respondents and 63.2 per cent of poor respondents cited self-treatment as the main reason for not visiting a PHC facility, suggesting that there are issues related to trust and quality of care. Lack of financial means was the second leading reason for not seeking PHC (among 15.7 per cent of poor respondents and 13.5 per cent of extremely poor respondents). Distance to the nearest PHC facility (remoteness) was cited by only 0.1 per cent of non-poor respondents, while other groups did not mention it at all (Statistical Committee of the Republic of Armenia 2022).

Patients often bypass PHC services, with a tendency to use secondary and tertiary health care when their health situation is already aggravated, requiring highly specialized and urgent medical interventions; as such, health conditions among the population can be exacerbated (Chukwuma et al. 2020b).

In Armenia, life expectancy at birth increased from 70.7 years in 1990 to 76.5 years in 2019 (Statistical Committee of the Republic of Armenia 2022). The infant mortality rate per 1000 live births in Armenia fell by more than 60 per cent between 2000 and 2019, from 27 to 10.5 per 1000 live births (European Observatory on Health Systems and Policies 2022). The most recent national data on infant mortality suggest that in 2021, this figure was 6.9 (National Institute of Health of the Republic of Armenia 2022a). The maternal mortality rate (MMR) per 100,000 live births decreased from 43 in 2000 to 26 in 2017 (World Bank, n.d.). However, as the absolute numbers of births and maternal deaths in Armenia are relatively low, national data on MMR may exhibit major fluctuations from year to year, for example from 8.0 in 2017, 21.9 in 2018, 33.3 in 2019, 22.0 in 2020 and 43.7 in 2021 (Statistical Committee of the Republic of Armenia 2022). To address this issue, the MoH publishes the triannual moving average of MMR, which was 33.0 for the period 2019-2021 (National Institute of Health 2022). Immunization coverage rates for routine childhood vaccinations remain high (above 95 per cent) and the overall mortality rate in Armenia is the lowest among countries of the Commonwealth of Independent States (European Observatory on Health Systems and Policies 2022).

[14] Ministry of Health of Armenia Order No. 1614-L of 20 April 2022 on Approval of the Strategy and the Action Plan for Improving the Quality of Health Services.

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▶ 5. Way forward

Overall, Armenia exhibits positive trends in health outcomes. However, the country lacks an adequate social health protection system to provide financial protection to all, and improvements need to be made to the efficiency of the country's health care system performance and management to increase quality. It is necessary to strive towards increasing the availability of services nation-wide, ensuring financial protection of the population and reducing OOP payments, thereby improving access to health services.

The Government's overarching goals for social health protection are achieving financial risk protection to increase affordability of health services, including increasing public health spending, and improving the quality of health care. The Government's reform priorities are laid out in the Government Programme 2021–2026, the Health Sector Strategy 2023–2026 and the Concept Note for Universal Health Insurance (UHI), which were approved in February 2023. From 2027, the Government plans to increase financial resources for health to a minimum of 4 per cent of GDP to fully roll out UHI and implement activities dedicated to strengthening the health care system and improving its infrastructure.

One of the critical actions planned in the reform is the establishment of a compulsory health insurance system for formal workers in the country. The new scheme should cover the formally employed population as well as vulnerable population groups [15] under the centralized and publicly managed health insurance fund (which should pool social contributions and tax-based funding). The new insurance system is planned to be implemented in stages, starting in 2024, pending the approval of corresponding laws by the National Assembly.

The implementation of the UHI proposal assumes creation of a new independent purchasing agency (the UHI Fund), which will pool financial resources and incorporate the current functions of SHA into its structure, thereby relieving the MoH from its double role as both a provider and a purchaser of publicly funded medical services. It is hoped that the UHI fund will act as strategic purchaser under the new

[15] All the categories of the population covered by BBP under vertical programmes or other health budget programmes, including socially vulnerable population groups, children, people with certain diseases, and others.

scheme, contributing to achieving better quality of care for patients and greater financial transparency among providers (Lavado et al. 2020).

In parallel, the Government will need to make unprecedented efforts to expand coverage to the informal sector, which constituted 50.2 per cent of total employment in 2021, while working towards formalization (ILOSTAT, n.d.). In turn, efforts towards the formalization of the informal economy will provide more fiscal space for financing social health protection.

Moreover, the Basic Benefits Package of services needs to be streamlined and made more comprehensive to close existing coverage gaps between different population categories and services. The current segmentation of the BBP is not only detrimental to the objective of equity, it lacks also of clarity for beneficiaries. In addition, as the inclusion and exclusion of services in the BBP does not follow any established policies or procedures and is mainly ad-hoc in nature, a cost-benefit analysis and use of health technology assessment (HTA) methodologies for BBP design need to be introduced.

In order to expand social health protection coverage, further comprehensive reforms in the health sector are needed, not only through investments in infrastructure and human resources at the local level and increasing public health expenditures, but by also radically improving health care system management.[16] The Government already plans to further expand the use of existing eHealth systems, improve staff capacity, modernize health care institutions and introduce primary health care reforms. The goal is to increase coverage, ensure access to medical care, improve medical services and ensure financial protection of the population.

6. Main lessons learned

- Armenia's social health protection system is inadequate to provide acceptable financial protection to all. The population's high OOP payments, which the Government endeavors to reduce, limit equal access to health services, Moreover, the quality of provided medical services remains an issue. These challenges are mainly caused by insufficient funding, limited and outdated infrastructure and gaps in the availability of qualified personnel in rural areas. The digitalization of the health information system, which was initiated in 2017 and is gradually expanding, is an encouraging step.
- Since Armenia's social health protection system is largely dependent on state budget allocations, the low financial government budget flows into the health care system have adverse effects. Nevertheless, the Government is committed to identifying sustainable financial resources to cover the budget deficit.
- Despite the aforementioned challenges, Armenia has managed to maintain relatively good health indicators, including on life expectancy, and satisfactory levels of childhood vaccination and infant and maternal mortality rates.
- Universal legal coverage is a prerequisite but does not guarantee effective coverage for all, as observed by low coverage rates among the population. Countries wishing to reach universal health coverage need to take efforts to raise awareness on entitlements, expand financial protection for services included in the benefit package, as well as increase quality and acceptability of services.

[16] A positive step towards this was the adoption of a health care quality improvement strategy and an action plan developed by MoH in April 2022, which provides for the establishment of a central unit under the MoH responsible for coordination of activities related to quality of care across the country and the implementation of measurable quality indicators and their monitoring systems in all health facilities.

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