Is there a role for user charges? Thoughts on health system reform in Armenia

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Introduction

Patient user charges are widespread in health systems worldwide and are an increasingly controversial aspect of health financing policy. This paper discusses the current plan in Armenia to introduce formal patient user charges for hospital services. This measure has the potential to improve financial access to health services if carefully implemented as part of a broader package of reforms.

The problem

In Armenia, out-of-pocket payments comprise 40% of total health spending. Only 10% of these payments are made as official patient charges. The remaining 90% are unofficial cash payments to health workers and payments for diagnostic tests, medical supplies and medicines. These unofficial payments take place almost entirely in hospitals. The amount paid varies considerably across departments, facilities and individual practitioners. For example, treatment in a department of general surgery in a hospital in the capital city of Yerevan can range from between 100–200 000 Dram (260–530 United States dollars, US$), with treatment in other departments generally lower at around 10–50 000 Dram. To put this in context, per capita income was US$ 3350 in 2008. In contrast to hospital services, primary health-care services were declared free at the point of service following reforms in 2006 and evaluations show that unofficial payments are now negligible.

In addition to the adverse effects of unofficial payments on both treatment-seeking behaviour and financial protection for patients, tackling unofficial payments is high on the government's agenda for several reasons. First, they are considered symptomatic of broader corruption in society, an issue receiving widespread media coverage. Second, tax authorities are demanding that these payments are formalized so that they can be taxed; most hospitals are managed as profit-motivated companies and hence are liable for corporate taxes.

Reasons for unofficial payments

Unofficial payments form part of a vicious cycle in which an over-concentration of low-paid doctors in Yerevan seek to make additional income from patients. Relatively low service usage exacerbates the problem; inpatient admissions were 8.85 per 100 population in 2007 (half the European average), with only 30% of people with injuries or illness actually seeking care. The reason for low utilization is partly because patients are uncertain about what they will be asked to pay, as well as having problems "finding the money for treatment", according to 65% of women who reported problems accessing care in a national survey.[1]

Widespread unofficial payments are the result of much deeper problems in the health system. Formalizing co-payments alone will not eradicate unofficial payments but can play an important part in reducing them.

Low government spending

Following independence from the former Soviet Union in 1991, Armenia entered a period of economic collapse with a reduction in its gross domestic product (GDP) of more than 50% between 1990 and 1993; a 42% drop in 1992 represented the "steepest annual rate of decline recorded for any post-Soviet state".[2] As a result, total health spending fell from US$ 152 per capita in 1990 to US$ 27 in 1995, recovering to US$ 119 in 2007. More importantly, government spending remains very low; at 1.50% of GDP in 2008,[3] it is one of the lowest levels in the world. Despite substantial increases in government allocations to the health sector in recent years, overall taxation in the economy is very low and, as a result, the health budget only nominally funds the extensive basic benefit package (BBP) which covers approximately half the population. Essentially there is a severe mismatch between the promise of free services and the available financial resources. This leads to shortages of supplies, for example, and patients end up paying for these themselves.

Expensive hospital services

As in most former Soviet Republics, Armenia's service delivery system is dominated by hospitals. Following independence in 1991, the price of fuel, medical supplies and other critical inputs increased rapidly, while subsidies from the Russian Federation and domestic tax receipts plummeted, making the hospital-heavy system financially unsustainable. Substantial infrastructure downsizing took place in the 1990s but focused heavily on rural hospitals. As a result, despite the current ratio of 407 hospital beds per 100 000 population, slightly below the European average, capacity remains heavily concentrated in Yerevan which hosts 32% of in-patient medical facilities and 52% of hospital beds. Despite positive reforms in primary health care over the past four years, many people continue to seek care directly from hospitals.

Poorly paid doctors

The concentration of hospitals in Yerevan skews the distribution of human resources for health. While the country's 344 physicians per 100 000 population looks reasonable compared with the average of 340 per 100 000 in Europe as a whole, 68.3% of physicians are located in the capital. With a high supply of doctors, and relatively low activity in terms of patients, physician wages are low, and were estimated to average US$ 134 per month

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in 2006, equivalent to 88% of the average national wage.[4] Market forces are not the only explanation; low doctors' wages were a feature of the Soviet Union, the health sector being considered part of the "non productive sphere" and explicitly a low priority. This attitude persists and leads to many doctors demanding unofficial payments to supplement their income. In many cases these payments are necessary to earn a living wage, but sometimes such payments represent pure profiteering.

Current reform plans

The current policy of promising a generous benefit package free at the point of service is not working, and unofficial payments continue to be the norm for hospital services. Any attempt to tackle this problem needs to recognize the underlying problems already discussed to have any chance of success. In Kyrgyzstan, reforms focused on making patient payments more transparent and improving the efficiency of allocations by reducing fixed costs in hospitals. Financial protection for patients has improved significantly as a result although unofficial payments still comprise 26–34% of total health expenditures.[5]

The reform measures under consideration by the Armenian government focus on better aligning promises with available resources, and increasing transparency and control over patient payments. In summary they aim to: (i) increase the amount paid by the state health agency to hospitals for services provided under the BBP. The assumption is that salaries of medical professionals will increase as a result, although whether private facilities can be forced to allocate greater revenue in this way remains an open question; (ii) reduce the scope of services included in the state-funded BBP; (iii) reduce the population eligible for free care; and (iv) introduce an easy-to-understand co-payment system for BBP hospital services.

Missing from this agenda, however, are measures to further reduce the dominance of hospital services, especially in Yerevan. Any such measures would benefit from the formalization of patient payments; as long as significant hospital revenues remain under the radar, government policies will have limited effect. Finally, regulating co-payments will be critical to their success. Patients must be made aware of their rights and encouraged to make complaints, and sanctions must be imposed on practitioners who continue to demand unofficial payments. Without such measures, official payments may simply be seen by hospitals as an opportunity to increase revenues further.

Official user-charges

The starting point in Armenia is very different from most low- and middle-income countries, with poor financial protection the result of a combination of economic collapse, inadequate government funding of the BBP, heavy reliance on hospital services and an over supply of poorly paid medical professionals, all exacerbated by low patient utilization.

Introducing an easy-to-understand system of patient charges would remove the uncertainty patients now face over their financial obligations. State funding could target priority patients more effectively and improve financial protection if reforms were made to align available government funding with realistic promises of free care, as well as to achieve further efficiencies in service delivery. Research from Kyrgyzstan shows some success in substituting formal for informal payments through reforms which focused on the centralized pooling of funds, output-based provider payments, greater provider autonomy and a transparent system of formal co-payments.[5] Conversely in Tajikistan a BBP was implemented without complementary reforms and, as a result, levels of informal payments have not reduced.[6]

Conclusion

Continuing to declare user charges for BBP services in hospitals as illegal will not improve the situation for Armenians, many of whom don't seek treatment for injury and illness due to both uncertainty over payment amounts and an inability to pay. Politically, there is a strong desire to formalize charges but there is limited appetite for substantial reductions to the scope of services in the BBP or to eligible groups.

Experience shows that no single measure will improve financial protection under such circumstances. The Government of Armenia has substantially increased allocations to the health sector but it still cannot meet existing promises of free care. Only by making patient payments more transparent, further matching promises with available funds and tackling broader inefficiencies in service delivery, can the government start to gain greater control and introduce measures that will reduce patient payments and in turn improve financial protection. ■

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