

**POLICY OPTIONS FOR SHIFTING FROM A “CATCHMENT AREA BASED”  
SYSTEM OF FINANCING PHC SERVICES TO AN “ENROLLMENT BASED” SYSTEM**

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**1. Objective:** To have the full population of Armenia enroll with a PHC facility and physician as a means of promoting a more effective, efficient, and equitable health system.

**2. The Problem:** What is the best method for shifting from a “catchment area based” system of financing PHC services to an “enrollment based” system of financing PHC services?

**3. Status of Enrollment as of April 31, 2008** (details by Marz shown in Annex 1; details by facility and Marz shown in Annex 2)

- Percentage of population enrolled: 86%
- Percentage entered into computer: 65%
- Percentage verified as accurate: 59%

**4. Policy Options:**<sup>1</sup>

**Option 1: Free services for enrolled; fee-for-service for non-enrolled; full State payments to facilities for enrolled and no payment for non-enrolled.**

Description: Enrollment with a PHC physician is voluntary. Those who enroll receive free PHC services at the point of service delivery, with those services financed by the State. Those who choose not to enroll may still receive PHC services, but they must pay the full cost, to the facility, of any services received. Revenues from fees are retained by facility with appropriate accountability. Non-enrolled people may enroll when first presenting themselves and get free services with reimbursement to facility by the state. Prices of all services would be posted in PHC facilities for everyone to see along with notice of free emergency care and patients’ right to enroll at the time her or she presents at the facility for services.

**Strengths:**

- Is a powerful incentive for the non-enrolled to enroll
- Promotes the GOA/MOH goal of having everyone enroll. Over time, more and more people will enroll (since they otherwise would need to use personal disposable income to pay for PHC services)
- Discourages patients from “shopping” among PHC facilities when they are already enrolled at a facility
- The non-enrolled person can enroll at the time he or she first presents at the facility and therefore will not need to pay any fee. Thus, there is no reason why any Armenian needs to be charged for any PHC services
- Protects the poor and vulnerable because those who choose not to enroll are not likely to be poor
- Is consistent with the RA constitution and GOA/MOH decree in that it does not violate principle of all Armenian citizens being “eligible” for free PHC services. Constitution and decree allows for interpretation that in order to become “eligible” for free PHC services, people must enroll.<sup>2</sup>

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<sup>1</sup> Notes: (1) the current OE Information System does not allow for identification and counting of the non-enrolled population; (2) all emergency cases are free of charge as per existing regulations; (3) for all options, enrollment is voluntary

<sup>2</sup> The RA constitution states that the list and delivery order of free basic health care services is defined by the law on health. The law on health currently under revision is permitted to state that the registered patient can be eligible for free state funded PHC services, under the service delivery order section.

- Lowest transaction (administrative) costs over long run because a larger percentage of population is enrolled

#### Limitations:

- Is limited incentive for providers to get the non-enrolled to enroll if the amount reimbursed by SHA is less than the fee paid by non-enrolled patients for services provided
- Those who chose not to enroll would pay out-of-pocket and this could lead to less household income being available for other needs or wants.
- There will be higher transaction (administrative) costs in short run (such as reimbursing the facility when non-enrolled patients enroll and get free services at that visit), but less in long run as more and more people enroll due to higher opportunity costs of not enrolling.

### **Option 2: Free services for enrolled; non-enrolled pay a subsidized fee; full State payment to facilities for enrolled and lower payment for non-enrolled; payments to the non-enrolled for the subsidized portion from a global budget.**

Description: Enrollment with a PHC physician is voluntary. Those who enroll receive free PHC services at the point of service delivery with those services financed by the State. Those who choose not to enroll may still receive PHC services, but they must pay a subsidized fee for services received, with the State paying the subsidized share from a global budget using some national or regional average. Revenues from fees are retained by facility with appropriate accountability. Prices of all services would be posted in PHC facilities for everyone to see along with notice of free emergency care and patients' right to enroll at the time he or she presents at the facility for services. The unsubsidized share could take several forms:

- Patients pay some fixed percentage (say 75%) of the estimated cost of actual services received
- Patients pay some fixed amount (say 75% of the average cost of a visit) and receive all services required. For example, if the average cost of a visit is AMD 2000, then the patient would pay AMD 1500 which is 75% of 2000)
- Patients pay some fixed amount (a fixed co-payment rather than a percentage) that is intended to cover facility maintenance, salaries (or any other) costs.

#### Strengths:

- Is an incentive for the non-enrolled to enroll, although not as strong as Option 1, and thus promotes GOA/MOH goal of having everyone enroll.
- Discourages patients from "shopping" among PHC facilities when they are already enrolled at a facility, although not as strong as Option 1.
- The non-enrolled person can enroll at the time he or she first presents at the facility and therefore will not need to pay any fee. Thus, there is no reason why any Armenian needs to be charged for any PHC services
- Protects the poor and vulnerable because those who choose not to enroll are not likely to be poor
- Is consistent with the RA constitution and GOA/MOH decree in that it does not violate principle of all Armenian citizens being "eligible" for free PHC services. The constitution and decree implies that in order to become "eligible" for free PHC services, people must enroll.
- As larger shares of the population enroll, transaction (administrative) costs will decline since over the long run a larger percentage of population becomes enrolled

#### Limitations:

- Is weak incentive for providers to get more people enrolled
- Those who chose not to enroll would pay out-of-pocket and this could lead to less household income being available for other needs or wants.
- There will be higher transaction (administrative) costs in short run, but less in long run as more and more people enroll due to higher opportunity costs of not enrolling.
  - The size of the transaction costs will vary according to which form of subsidy is selected.

- Accuracy of State payment for the non-enrolled will be limited, since there is not an accurate calculation available of the unit cost of the different PHC services; nor is there an accurate count of the number of non-enrolled who may enroll.
- If the global budget is not adjustable during the fiscal year, some PHC facilities may not get reimbursed for all services provided to the non-enrolled population if the demand is beyond the size of the global budget

**Option 3: Free services for enrolled and non-enrolled; State payment to facilities is the same for enrolled and non-enrolled, but State payments from a global budget for the non-enrolled made retrospectively and only for those who receive services.**

Description: Enrollment is voluntary. Both enrolled and non-enrolled receive full set of free PHC services. Payment rates are the same for the enrolled population and the non-enrolled. Facilities get reimbursed retrospectively for the non-enrolled population but only those people who receive services. State payments are made from a global budget, using some national or regional average, for all services received by non-enrolled.

Strengths:

- Has some incentives for providers to enroll the non-enrolled
- Allows free choice for those who do not want to enroll
- Ensures free of charge PHC services for those not enrolled
- Supports costs of operating facility (such as maintenance or salaries) with poor registration figures
- Relatively temperate social consequences for medical personnel

Limitations:

- No incentive for the non-enrolled to enroll since they receive free services either way
- Payments for non-enrolled are made retrospectively
- Allows patients to go to multiple facilities for additional services at no cost to them and increased cost to the State
- Will be reduced continuity of care if patients go to multiple facilities for services
- High transaction (administrative) costs at both facility level and national level
- Accuracy of State payment for the non-enrolled will be limited since there is not an accurate calculation available of the unit cost of the different PHC services; nor is there an accurate count of the number of non-enrolled who may enroll.
- If the global budget is not adjustable during the fiscal year, some PHC facilities may not get reimbursed for all services provided to the non-enrolled population if the demand is beyond the size of the global budget.

Variations on policy:

- Free services for enrolled and non-enrolled. Reimbursement for non-enrolled is based on a fixed amount per visit with funding from a global budget. Size of global budget is derived from reports submitted by the facility on provision of services to population who choose not to enroll but reside in (catchment) area served by facility.

**Option 4: Free services for enrolled; limited set of services free for non-enrolled with out-of-pocket fee for additional services; higher State payment for enrolled than non-enrolled with payment for non-enrolled made retrospectively from a global budget only to those who receive services.**

Description: Enrolled population will have access to the full package of PHC services identified by the State, and the State funding covers those services by per-capita payment for each person enrolled. Non-enrolled populations still have access to some defined set of "limited free PHC services" (set could include services such as MCH and infectious diseases impacting on "public" health). Any additional services would be paid out-of-pocket by the non-enrolled patient. State payments for non-enrolled made retrospectively from a global budget using some national or regional average.

Strengths:

- Guarantees basic level of free PHC services for non-enrolled people.
- Maintains some incentive for non-enrolled to be enrolled in order to get full package of free of charge PHC services.

- Creates incentive to the physician to provide services to the non-enrolled population and to have them enrolled.

Limitations:

- Has relatively high transaction costs – particularly on the provider side
- Limited incentive for the non-enrolled to enroll.
- Identifying the sub-package of “limited free PHC services”, and not having it expand to the full package, could be a problem
- Allows patients to go to multiple facilities for additional services at no cost to them and increased cost to the State
- Continuity of PHC service and patient management coordination will not be ensured for non-enrolled by one PHC physician.
- Accuracy of State payment for the non-enrolled will be limited since there is not an accurate calculation available of the unit cost of the different PHC services; nor is there an accurate count of the number of non-enrolled who may enroll.
- If the global budget is not adjustable during the fiscal year, some PHC facilities may not get reimbursed for all services provided to the non-enrolled population if the demand is beyond the size of the global budget.

**5. Criteria for evaluating policy options:**

- **Effectiveness:** an effective policy is one which meets the goal of having as many people as possible enroll with a PHC facility and physician, and which will lead to improved quality of care and health status
- **Efficiency:** an efficient policy is one that has low transaction (administrative) costs for PHC facility providers and staff, patients, and the State (SHA)
- **Equity:** an equitable policy is one that protects the vulnerable, and, when considering financing options, takes into account the different conditions of different PHC facilities and their surrounding environment.

Exhibit 1 combines the three evaluation criteria with the four policy options. While the scores shown in the cells of the table reflect PHCR’s evaluation, it is important that the MOH officials also conduct their own assessment and fill in the cells of the table, and use the results to inform decision-making.

**Exhibit 1: Summary framework for evaluating policy options\***

<b>Criteria for evaluating options</b>	<b>Options for shifting from catchment area based system to enrollment based system</b>			
	<b>Option 1:</b> free services for enrolled; fee-for-service for non-enrolled; full State payment to facilities for enrolled and no payment for non-enrolled	<b>Option 2:</b> free services for enrolled; non-enrolled pay a subsidized fee; full State payment to facilities for enrolled and lower payment for non-enrolled	<b>Option 3:</b> free services for enrolled and non-enrolled; State payment to facilities is same for enrolled and non-enrolled. Payment for non-enrolled who receive services is made retrospectively from a global budget.	<b>Option 4:</b> Free services for enrolled; limited set of services free for non-enrolled; higher State payment for enrolled than non-enrolled. Payment for non-enrolled who receive services is made retrospectively from a global budget.
<b>Effective:</b> high enrollment	1	1.75	3.25	2
<b>Efficient:</b> low transaction costs – for patients, providers and State	1.25	2.25	3.5	3.5
<b>Equitable:</b> vulnerable protected; provider payment fair	1.25	2	2.25	2.5
<b>Average score</b>	1.17	2.08	3.00	2.67
<b>Rank</b>	1	2	4	3

\* Scoring is based on a scale of 1 to 4, with 1 being the “best” score and 4 being the “worst” score. Scores shown in cells are from PHCR evaluation.

**6. Recommendation**

According to an evaluation of the options by PHCR shown in Exhibit 1, Option 1 received the highest score on all three evaluation criteria, and thus is ranked as the most effective, most efficient, and most equitable option. It is the most effective because it is the option that most quickly meets the goal of having as many Armenian citizens as possible enroll with a PHC facility and physician, which in turn is expected to lead to improved quality of care and improved health status. The main reason for this is that Option 1 has strong financial incentives for the providers to enroll the unrolled, and, for the non-enrolled population to enroll themselves.

Option 1 is also the most efficient because in the long run it has the lowest transaction costs for both the facility providers and staff, for the population, and for the State (SHA). Option 1 is also the most equitable over the long run because not only do the enrolled population receive the full set of PHC

services free of charge, but so do the non-enrolled who enroll when they first come to the facility for services.

While Option 1 has the best ranking, there are some limitations with this option. For example, reimbursing facilities for the non-enrolled that enroll when they first come to the facility for services involves additional administrative work for SHA. This will be a short run phenomenon lasting only until all those who intend to enroll actually enroll. In the long run however, transaction/administrative costs are the lowest because there will be larger percentages of the population enrolling more quickly.

Implementation of this option will require careful planning, including a good “public education” campaign to inform the public of this transition to enrollment based financing. PHCR is prepared to support the MOH in this and other transition activities.