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ARMENIAN REPRODUCTIVE HEALTH SYSTEM REVIEW:

STRUCTURE AND SYSTEM INEFFICIENCIES THAT HINDER ACCESS TO CARE FOR
RURAL POPULATIONS



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ARMENIAN REPRODUCTIVE HEALTH SYSTEM REVIEW:

Structure and system inefficiencies that hinder access to care for rural populations

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TABLE OF CONTENTS

ACRONYMS.....	III
EXECUTIVE SUMMARY	IV
1. INTRODUCTION	1
A. RATIONALE AND APPROACH	1
B. HEALTHCARE IN ARMENIA	2
C. NATIONAL EFFORTS TO STRENGTHEN THE HEALTH SYSTEM	2
2. THE NATURE OF CORRUPTION IN THE HEALTH CARE SYSTEM	4
A. INFORMAL PAYMENTS FOR HEALTHCARE SERVICES	4
i. Contraception	4
ii. Abortion.....	5
iii. High-risk pregnancy, antenatal and delivery care	5
B. ABUSE OF GOVERNMENT-FUNDED HEALTHCARE SERVICES	5
3. ENABLERS OF CORRUPTION	7
A. NON-TRANSPARENT FINANCIAL FLOWS, REPORTING AND BUDGETING	7
i. Facility Financing and Financial Flows	7
ii. Misreporting	9
iii. National Budget Allocation Process.....	10
B. WEAK POLICY IMPLEMENTATION	12
i. Funding for FAPs Maintenance.....	12
ii. Capitation Estimates.....	12
C. HEALTHCARE REFORMS	12
i. Privatization and Optimization.....	13
ii. Decentralization	13
C. SOCIETAL TOLERANCE.....	18
4. RECOMMENDATIONS FOR PROJECT NOVA	20
A. IMPROVE RH/MCH POLICY FORMULATION AND IMPLEMENTATION	20
i. Work to Reconcile State Order for FAPs with State Funding.....	20
ii. Undertake Policy work to define capitation estimates (in relation to the maintenance of FAPs)	20
iii. Research Economic and Social Justification for FAPs	21
iv. Explore the Use of Community Tax Revenues.....	21
v. Facilitate Cost Estimates for RH/MCH Services.	21
vi. Contribute to Decentralization Analysis and Mapping.....	22
vii. Participate and Contribute to the UNDP monthly anti-corruption meetings	23
B. STRENGTHEN MANAGEMENT & SUPERVISION OF RURAL RH/MCH FACILITIES	23
i. Strengthen Understanding of Government Reimbursement Policies and Procedures.....	23
ii. Conduct a Budgeting and Accounting Exercise (including tax obligations)	24
iii. Increase Awareness of Inaccurate Reporting.....	25
iv. Promote Internal Controls (including medical supply inventories).....	26
v. Reinforce the Concept of a Code of Ethics.....	27
vi. Invite UNDP Anti-Corruption Into Facility(ies) To Use The 20 Anti-Corruption Tools	27
vii. Work with Policy Pillar and Community Pillar on Reconciling the State Order(s) for Maintenance of FAPs with Funding	27
C. INCREASE CONSUMER DEMAND FOR RH/MCH SERVICES THROUGH COMMUNITY EDUCATION AND MOBILIZATION	28
i. Disseminate the BBP “free services” information	28
ii. Promote Budget Awareness and Monitoring	28
iii. Cooperate and Coordinate with UNDP Civic Groups	29
iv. Assist the Community Action Groups in Undertaking Watchdog Functions.....	29
D. IMPROVE RH/MCH PERFORMANCE OF RURAL HEALTH FACILITIES THROUGH TRAINING & EQUIPMENT PROVISION	29
i. Create and Provide Training for Physicians and Nurses on Ethical Behavior	29
ANNEX A: SCOPE OF WORK.....	31

ANNEX B: REFERENCES / BIBLIOGRAPHY	36
ANNEX C: DOCUMENTS REVIEWED.....	37
ANNEX D: INTERVIEW QUESTIONS.....	38
ANNEX E: LIST OF INTERVIEWEES	42
ANNEX F: DONOR ANTI-CORRUPTION ACTIVITIES IN ARMENIA.....	43

This assessment was written by Alisa Pereira, a consultant of Emerging Markets Group (EMG), with assistance from Anna Benton and Gohar Jerbashian of EMG, and Rebecca Kohler of IntraHealth International. It was funded by the United States Agency for International Development (USAID) through Project NOVA, which works to strengthen reproductive and child health services in rural Armenia.

ACRONYMS

AMD	Armenian Dram (currency)
ASTP	USAID-funded Armenia Social Transition Project
BBP	Basic Benefits Package
DFID	Department for International Development
FAP	Feldsher Acoucher Punkt (Russian)
FM	Family Medicine
GoA	Government of Armenia
GRECO	Group of Countries Against Corruption
HAG	Health Action Groups
IDB	Inter-American Development Bank
IUD	Intrauterine Device
MoH	Ministry of Health
MEDI	USAID-funded Micro Enterprise Development Initiative
NGO	Non-governmental Organization
NIS	Newly Independent States
OB/GYN	Obstetrician/Gynecologist
PHC	Primary Healthcare
RH/MCH	Reproductive Health/ Maternal Child Health
SHA	State Health Agency
STI	Sexually Transmitted Infection
UNDP	United Nations Development Program
USAID	United States Agency for International Development
UNCAC	United Nations Convention against Corruption

EXECUTIVE SUMMARY

The assessment provides a review of the health sector in Armenia, with emphasis on determining how structure and system inefficiencies, including corruption, impact access to and quality of reproductive health (RH) and maternal and child health (MCH) services for rural families in Armenia. A major goal of the report was to determine the specific areas in which Project NOVA and its counterparts can strengthen the accountability, transparency, and efficiency of the healthcare system. This report is not a comprehensive review of corruption in the Armenian health sector, but rather a starting point for developing interventions that address the underlying causes for the poor performance of the health system as it relates to RH/MCH care in rural areas. The report is based on research gathered through 1) document review; 2) meetings and interviews with stakeholders; and 3) field visits to several clinics. The assessment took place between February and March, 2005.

Although the Government of Armenia (GoA) has prioritized MCH in recent years, health indicators remain poor. Corruption touches every level of the healthcare system, and hinders progress in healthcare indicators. Pervasive informal payments prevent patients from seeking needed care. Facilities are squeezed by inadequate government funding, and misreporting and fraud are common. Complex reporting rules and norms lead to disincentives for facilities to provide patient-centered care or to report activities accurately. In turn, bad reports serve to perpetuate a cycle of ill-informed funding decisions. A weak executive body, despite a good legal and policy framework, fails to enforce laws or create policies that might improve the situation. The “norm” of gift-giving, transformed into widespread informal payments, makes reducing corruption even more difficult.

Over the past decade, hurried healthcare reforms have played a significant role in creating confusion and contradiction within the health care system. Privatization has largely failed, with only a handful of healthcare facilities privatized to this point. Decentralization, which remains a priority for the GoA, has had mixed results: some elements of the system have been decentralized (such as responsibility for planning and implementing programs) and others are still highly centralized (such as evaluations). Armenia has jumped ahead in health reform without first establishing the necessary regulatory framework or strengthening management capacity.

Recommendations for Project NOVA include the following, within each of the four pillars of the project:

IMPROVE RH/MCH POLICY FORMULATION AND IMPLEMENTATION

- Conduct further research into the role of health posts, also referred to as *FAPs*
- Conduct a cost analysis of specific RH/MCH services across types of providers
- Undertake decentralization analysis and mapping to depict responsibilities of each level of the healthcare system within the context of RH/MCH care

STRENGTHEN MANAGEMENT AND SUPERVISION OF RURAL RH/MCH FACILITIES

- Prepare materials on government reimbursement policies and procedures for facilities
- Conduct a budgeting and accounting exercise for selected facilities
- Raise awareness of the consequences of inaccurate reporting
- Help create/reinforce internal controls at facilities
- Reinforce the concept of a Code of Ethics

INCREASE CONSUMER DEMAND THROUGH COMMUNITY EDUCATION AND MOBILIZATION

- Disseminate more widely the BBP “free services” information
- Make the community aware of local budget and monitoring issues
- Assist the community action groups in undertaking watchdog functions

IMPROVE RH/MCH PERFORMANCE OF RURAL HEALTH FACILITIES THROUGH TRAINING AND EQUIPMENT PROVISION

- Integrate issues of client rights and ethics into existing training programs for physicians and nurses

1. INTRODUCTION

A. Rationale and Approach

The Government of Armenia considers reproductive and maternal and child health (RH/MCH) a priority. This is evidenced by the creation of policies which aim to improve access to and quality of RH/MCH services in Armenia, including the integration of these services within primary healthcare, and their inclusion in the package of government-sponsored services – the Basic Benefits Package (BBP). Yet basic MCH health indicators remain inadequate, and there is a stark disparity between urban and rural populations in terms of infant mortality, use of antenatal care and contraception, and delivery outside a health facility.

This report provides a review of the health sector in Armenia with an emphasis on determining the degree to which corruption and systemic inefficiencies impact access to and quality of reproductive health (RH) and maternal and child health (MCH) services for rural families. The scope of the assignment was to analyze the different elements of the health system and the degree to which they lack effective controls, are inadequately funded, or are susceptible to corrupt practices (see Annex A for the full Scope of Work). This report is not a comprehensive review of corruption in the Armenian health sector, but rather a starting point for developing interventions that address the underlying causes of the poor performance of the health system as it relates to RH/MCH care in rural areas. The report is based on research gathered through 1) document review (see Annexes B and C); 2) meetings and interviews with key donor projects, representatives of the international community, government counterparts, beneficiaries, Project NOVA staff, non-governmental organizations (NGOs), and select medical facility managers (see Annexes D and E); and 3) field visits to several clinics. The assessment took place between February and March, 2005.

USAID’s official definition of corruption is “the abuse of trusted authority for private gain.”¹ The Inter-American Development Bank (IDB) further describes three levels of corruption in the health sector: 1) grand corruption, when individuals in management or government posts directly or indirectly benefit from decisions regarding constructing, rehabilitating, equipping, or supplying hospitals; 2) mid-level corruption, when officials benefit directly or indirectly from theft, procurement, or unauthorized use of facilities or services, and 3) user corruption, when staff solicit payments which are formally unnecessary or alter decisions to favor specific clients.²

Corruption in the health sector, whatever its roots, can lead to lack of accountability and corresponding mistrust between physicians and patients, facilities and physicians, government and facilities, and between government and its citizens. Families in need of quality RH/MCH care are adversely affected by inefficient and unregulated systems. Women and children are at risk of receiving insufficient, inappropriate or even excessive care depending on whether the (formal or informal) financial reimbursement system benefits the providers of care. Some may avoid seeking needed care for fear of not being able to afford the services rendered. Further, a corrupt system does not effectively reach those families that are entitled to receiving subsidized care.

This assessment analyzes the health sector to determine the specific areas where Project NOVA, together with its national and local level sector counterparts, can most effectively intervene to strengthen accountability, transparency and efficiency of the system. More specifically, the assessment reviews certain elements of the service delivery system, the organizational structure of the health system, health financing (with an emphasis on the official financial flows), budgeting and reporting, and the legal framework.

¹ USAID Anti-Corruption Strategy, 2005
http://www.usaid.gov/our_work/democracy_and_governance/publications/pdfs/ac_strategy_final.pdf

² “Transparency and Accountability: The Case of Public Hospitals in Latin America,” IDB, referenced in Duncan 2003.

B. Healthcare in Armenia

The GoA spends an estimated 1.2 percent of GDP on public health services³ which, according to Ara Ter-Grigoryan, Director of the State Health Agency, equates to approximately \$12 per person per year. The percentage of the national budget dedicated to health services has been steadily increasing from a low of 4.4 percent⁴ in 2000 to 7.6 percent⁵ in 2004. At the same time, the government has continually improved its ability to spend the amounts budgeted.

Health sector reform efforts over the last 10 years have greatly altered the structure, reporting relationships, and availability of resources in Armenia's healthcare system, particularly in rural areas. The health sector is currently wrought with the complexity of decentralization, partial privatization, the lack of regulatory frameworks, confusion over ownership, and poorly-trained facility managers. The package of state-funded services (known as the Basic Benefits Package or BBP) exceeds the state budget allocation by five times⁶ and reimburses at best estimate 50 percent of actual costs, and individuals are either unaware of their rights to free services or are too vulnerable to demand them.

Reproductive health and maternal and child health services in particular are characterized by antiquated, costly, and underutilized facilities, and an inappropriate skills mix in many providers. RH/MCH services are predominantly offered through a network of marz-level and regional-level hospitals and polyclinics, with limited or no services available in rural and remote communities. Care is further limited by a vertical system, as the concept of integrated primary healthcare has not taken root. For example, only obstetrician/gynecologists (OB/GYN) are authorized to provide most RH services, including pregnancy care, contraception provision and abortion services. Very few obstetricians are situated outside of urban areas. Family Medicine (FM) physicians were recently granted permission to offer basic RH/MCH services but in practice there are very few FM physicians and they are inadequately trained. Only venerologists are allowed to provide comprehensive treatment for sexually transmitted infections (STIs), while OB/GYNs can treat a limited number of infections. Only in-patient maternity hospitals are allowed to handle deliveries and provide abortions. These narrow medical specialties limit access to care, create disincentives to offer preventative or cost-effective treatment options, and artificially increase the formal and informal cost of care. All of these structural and system inefficiencies combine to inhibit access to reproductive and maternal health care for rural populations in Armenia.

This assessment found that corruption appears to be less prevalent in rural healthcare than in urban areas. Three possible explanations for the lower corruption rates are 1) fewer resources flow to rural facilities, 2) facilities have limited power or influence as a result of their remote location and proximity to the center, and 3) the community serves as a strong counterweight to corruption in that the general perception is that everyone in the circle of interaction (patient, physician, nurse) are too poor to extract anything from one another other than perhaps some agricultural products, sweets, or nominal amounts of money. The types of corrupt practices most prevalent in rural primary care facilities are categorized as petty corruption. The term should not be interpreted as meaning insignificant or justifiable, but rather related to the amount of money involved in each transaction.

C. National Efforts to Strengthen the Health System

Over the last several years, the GoA has undertaken several important strides to better target government investments in human development and to improve accountability and efficiency of government programs. Some of these efforts have been directly aimed at reducing corruption. At the

³ Economic Development Research Center, http://www.edrc.am/project.html?cat_id=82

⁴ http://www.edrc.am/project.html?cat_id=68

⁵ 2005-2005 Mid-Term Public Expenditure Framework http://www.gov.am/armversion/programms_9/pdf/mid2005_07.pdf

⁶ Oxfam, "CSPN Pilot Project on Monitoring and Evaluation of Health and Irrigation Water Situation in Shirak, Tavush, Vayots Dzor and Syunik Marzes, Main Findings Report, 2004.

same time, donors have also launched their own anti-corruption strategies and activities (see Annex F for further details). Anti-corruption efforts include the below:

- 2003 – USAID, through its democracy and governance-supported World Learning program, funded several anti-corruption grants to local NGOs
- March 2003 – United Kingdom Department for International Development (DFID) and the GoA launched the Public Sector Reform Programme to improve the efficiency, effectiveness, accountability, transparency, and responsiveness of the public administration (implemented by PricewaterhouseCoopers)
- August 2003 – Armenia adopted the Poverty Reduction Strategy Paper by Governmental Decree No. 994, which is a socio-economic policy document for poverty eradication and also aims at improving the transparency of governance structures
- December 2003 – Armenia adopted the Government Anti-Corruption Strategy
- January 2004 – Armenia began the process of accession to the United Nations Convention against Corruption (UNCAC)
- January 2004 – Armenia acceded to the Group of Countries Against Corruption (GRECO)
- February 2004 – UNDP’s “Support to Civil Society in Anti-Corruption Initiatives” Project is launched, focusing on corruption in the Health and Education sectors
- June & December 2004 – Armenia participated in the Review of Legal and Institutional Framework for Fighting Corruption, supported by the OECD
- June 2004 – The President established a council, chaired by the Prime Minister, coordinating the implementation of the anti-corruption strategy. A Monitoring Commission was established to monitor the progress and implementation of the strategy. The commission has a Health Working Group (including representatives of NGOs working in the area of health)

While Government efforts have been laudable, they have largely been donor driven, and have not resulted in a documented reduction of corruption. According to representatives from the Monitoring Commission, the concept of an anti-corruption strategy and commission is new to Armenia. The Monitoring Commission is attempting to define ways in which it can effectively reduce corruption within the framework of its mandate. Those interviewed indicated that the Council and the Commission are highly aware of the nature and magnitude of corruption in Armenia, but are trying to address these issues in a tailored and Armenia-specific way. The Commission representatives pointed out that Armenia is homogenous and some spheres are heavily linked through “clanism”. The Chair of the Health Working Group of the Commission asserts that effective anti-corruption measures will “touch the interests” of those most benefiting from the informal system, and the best way to achieve that is by building anti-corruption strategies adapted to Armenian culture and society.

2. THE NATURE OF CORRUPTION IN THE HEALTH CARE SYSTEM

A. Informal Payments for Healthcare Services

The most significant obstacle to transparent and accountable services throughout the health system is the pervasive and culturally-accepted practice of informal payments. According to a World Bank Study in 2000, Armenia ranked the highest of the newly independent states (NIS) in terms of informal payments, with 91 percent of respondents indicating that they were required to make informal payments for medical services.⁷ The following year, the World Bank estimated that official payments are 10 – 12 percent of total income of Armenian medical facilities and that out of pocket/unofficial payments are 3.5 – 4 times greater than the state budget allocation.⁸

Informal payments are justified by medical professionals based on 1) slow or no reimbursement from the Government for Basic Benefits Package (BBP) services, 2) low salaries for physicians and nurses, and 3) insufficient medical supplies and drugs. Unofficial payments to providers are also expected for paid services (that generate revenue for facilities) to help supplement physicians' salaries. According to one interviewee⁹, the posted price is only the starting point, not the actual price of the service. The general consensus from the interviews is that OB/GYN services reap the greatest amount of informal payments, followed by surgery, and any procedure or service related to death or dying. According to several representatives of international organizations, it is common for physicians to pay the head physician a portion of all informal payments collected, thus creating a pyramid scheme within facilities. Head physicians, in turn, it is alleged, must pay for their positions to government officials (no health professionals admitted to participating or even knowing of others who participate in this practice).

The amount of the informal payment apparently varies from person to person; however, it is so institutionalized that the amount is told to the patient as part of a consultation prior to service delivery. Informal payments are made directly to the physicians, nurses and even janitors, while official payments are made at the cashier. Drugs are often purchased separately and may require informal payments to the pharmacist, which may come in the form of elevated prices. It is common practice for family members to have to pay additional fees to visit patients. One interviewee described a facility that had improved its "customer service" by centralizing all informal payments directly to the physician who would then divide the money between all parties.

Individuals tend to seek very basic medical care from the *Feldsher Acoucher Punkt* (FAP) nurse, but avoid going to a polyclinic, ambulatory, or health center unless they have a medical emergency because they know the cost of care will be higher than they can afford. Interviewees gave examples of relatives encouraging pregnant women not to seek antenatal care of any kind unless there were problems, because the family would not be able to provide the requested payments (despite the services being state-ordered). Informal payments often exceed a family's means and require the family to sell assets such as livestock or property or to borrow money from extended family and the community.¹⁰

I. CONTRACEPTION

Next to condoms, IUDs are the most popular method of modern contraception. Most IUDs available in Armenia are supplied by the United Nations Population Fund (UNFPA) as part of the national program. These IUDs are distributed free of charge at a network of family planning cabinets around

⁷ World Bank, *Who is Paying for Health Care in Europe and Central Asia? Issues, Trends and Policy Implications*, 2000.

⁸ European Observatory of Health Care Systems - Armenia, 2001, pg 34.

⁹ Due to the nature of the assignment, the names of the interviewees will not be included in this report.

¹⁰ European Observatory on Health Systems and Policies, *Health Systems in Transition: Learning from Experience.*, 2004, pg 60.

the country. Limited supplies of private sector IUDs are available in urban areas. As a method requiring physician administration, IUD insertion ranked high among interviewees for being susceptible to corrupt practices. Those that choose IUDs are faced with two aspects of corruption. The first is a possible informal payment to ensure proper insertion. Patients are afraid of mediocre care if an appropriate informal payment is not provided. The second relates to IUDs supplied by the private sector. It is alleged that some physicians recommend more expensive brands in order to receive kickbacks.

II. ABORTION

According to the Armenia Demography Health Survey (DHS) in 2000, 55 percent of all pregnancies end in abortion.¹¹ Every woman in Armenia has the legal right to an abortion through the first 12 weeks of pregnancy. Further, women in need of an abortion for defined medical and social reasons have the right to free care. Only an OB/GYN working in a maternity hospital can provide an abortion. According to international organization representatives, many physicians do not educate women on family planning, but rather encourage abortion. As such, abortion is commonly used as a form of birth control. The reason given for this practice is that induced abortion is physician-controlled; it is a relatively quick procedure that draws formal payments as well as opportunities for additional informal payments. There is also a perception among the population that abortion is more accessible, safer and cheaper than modern contraceptive methods.

A commonly-mentioned practice is performing “off the book” services, allegedly either at night in the hospital or at home or other locations. Abortions, for example, were reported to be sometimes performed at night because the head physician is not present and therefore the physician can keep the entire payment. Physicians also reportedly see numerous patients at their home or at the patient’s home, again to retain the full fee. Head physicians may also approve of not registering some services in order to avoid facility corporate tax obligations.

III. HIGH-RISK PREGNANCY, ANTENATAL AND DELIVERY CARE

The healthcare system has built-in incentives to over-diagnosed high-risk pregnancies, require cesarean sections, and order additional lab tests and/or screenings, all of which require additional payments (both official and unofficial). While not directly revealed as part of this assessment, many representatives of international organizations provided stories of women subjected to high informal payments or who received compromised care during delivery. In one alleged incident, a woman’s placenta was not delivered until her family paid an additional informal payment. In another, a newborn was not issued a birth certificate because an adequate informal payment was not provided. In a third, a woman had to escape out of the hospital with her newborn child because the physician would not release them until additional money was paid.

Antenatal care and delivery are considered to be highly susceptible to corruption. The prevalence of corruption in this area contributes to women receiving inadequate pre- and post-natal care and possibly choosing to deliver at home to avoid interaction with the formal health sector. The great bulk of these services are designed to be free for all women attending public and private sector facilities, yet there is an expectation that informal payments will be provided, particularly for a successful delivery. Delivery care falls under the state-ordered programs and is reimbursed to the facility for each client served at a rate approved by the government.

B. Abuse of government-funded healthcare services

After the collapse of the Soviet Union, the GoA was unable to finance free healthcare for the entire population. With support from the World Bank in 1998, the Government introduced the BBP in an

¹¹ Measure DHS+: <http://www.measuredhs.com/pubs/pdf/AS6/AS6.pdf>

effort to target its limited resources toward priority health care and to serving the most vulnerable in society. The BBP outlines the government-funded services (known as state-ordered funding) that the population is entitled to receive.¹² The BBP, which is tied to the national budget, is revised annually and is approved by a Governmental Decree. Each year, methodological guidelines for each component of the BBP are issued via MOH decree (for example, Guidelines on OB/GYN Services Covered in the State-Ordered Funds). The State Health Agency (SHA), a semi-autonomous branch of the MOH, manages the financial reimbursement of BBP services to contracted health facilities.

Such a subsidized program, if not carefully designed and administered, is subject to inherent incentive structures that encourage or at least condone abuse of these services for private gain. Typically, the payment mechanisms inadvertently enable informal incentive structures that encourage unnecessary referrals, additional and unnecessary lab tests, and misdiagnosis to obtain additional reimbursement from the BBP. The GoA is aware of these potential abuses, and therefore, has over time made adjustments to the payment structure to try to reduce its vulnerability to such practices. However, restructuring the payment mechanisms to address one weakness may lead to different and perhaps more complicated informal incentives.

The state-ordered funding for OB/GYN care provides a good example to illustrate the difficulty in creating a transparent, accountable and efficient government subsidy program. All pregnant women are entitled to four antenatal visits, laboratory-instrumental diagnostics, and delivery through state-ordered funds as part of the BBP, and these therefore should be free for all women and reimbursed to the respective facilities that offer care (i.e., maternity hospital, outpatient facility). Early in the BBP program, physicians received a higher reimbursement for antenatal care services offered to women diagnosed with a high-risk pregnancy. The number of such cases appeared to be grossly over-reported. The following years, the payment structure was altered such that the physician received the same payment regardless of whether or not a pregnancy was high risk or not, but high-risk women were then entitled to additional laboratory tests (which were reimbursed to the facility that offered the laboratory services).

Similarly, this year the BBP was altered to address overall under-spending of the funds allocated for antenatal care. Although it is an internationally recommended best practice for women to initiate antenatal care in their first trimester, only 54 percent of Armenian women do so.¹³ As such, the outpatient facilities were unable to get the reimbursement for the *missed* services that would have been paid if care was initiated on time. Therefore, the funds were underspent in the government allocation. At the same time, there was an incentive for facilities

RH Services included in the Basic Benefits Package - 2005

- Antenatal care
 - Gynecological care of pregnant women and postpartum care
 - Provision of social-psychological support, education and physical preparation for delivery
 - Examination and provision of care by specialists
 - Laboratory/instrumental diagnostics with no limitation of tests
- Management of pregnancy complications and delivery care
- Emergency gynecological care for all women
- Physical and sexual maturity assessment, ultrasound examination of 15 year old girls, and treatment if necessary
- Planned gynecological care of socially vulnerable groups and women above 65
- Gynecological examination of all women once a year
- Abortions for medical and social reasons
- Provision of family planning counseling
- Voluntary counseling and testing for HIV infection to all pregnant women
- Provision of medicine (including contraceptives) to certain groups
- Preventive breast examination
- Examination and treatment of women who have undergone trafficking and violence

¹² European Observatory, 2000.

¹³ MOH government statistics, 2004

to make up for this loss by labeling the pregnancy “high risk/complicated” and by encouraging the women to make additional visits (and thereby receiving additional formal and/or informal payments). Beginning in 2005, the government has altered the payment scheme to reimburse outpatient facilities for ANC based on a capitation rate of the total number of women of reproductive age in the facility catchment area. While this might help in fully spending the budget allocation, it will create a disincentive to identify and care for pregnant women as the payment is no longer tied to actual performance.¹⁴

3. ENABLERS OF CORRUPTION

A. Non-transparent financial flows, reporting and budgeting

As mentioned previously, there appears to be less corruption in rural versus urban areas. However, there is a lack of managerial capacity and knowledge of how to interact with the larger health sector in the rural network of facilities, which leads to inefficiencies and inadequate financing. The following points exemplify the lack of controls, systems, and capacity and the impact on accountability and ultimately on service delivery.

I. FACILITY FINANCING AND FINANCIAL FLOWS

Each meeting with stakeholders produced different ideas on how the money flows from the Government budget to the State Treasury, and ultimately to the facilities (and down to the linked/supported facilities). There were conflicting reports on how the facilities were financed, ranging from a combination of flat capitation, to BBP reimbursement, to paid services with some individuals (in the international community) asserting that local taxes also finance the facilities. Even more surprising was that the facilities interviewed all gave different answers to when and how they were reimbursed for BBP services – monthly, quarterly, and some even claimed annually.

Clearly since there is such widespread confusion about the money flows it is unfair to focus solely on the facilities in this area. However, it should be the responsibility of the facility head to understand how the facility is financed and to budget and forecast spending in order to ensure that sufficient funds are available to offer consistent and high quality services. Even the best facilities interviewed had never prepared an operational budget to estimate how much it costs to run the facility or provide particular services, much less to forecast expenditures and revenues. Some interviewees believe that this “use what you get” mentality is a holdover from the Soviet time when facilities received a lump sum every month to cover all expenses. Now that there are insufficient government budget funds to cover even the BBP services, much less all medical care for the population, the onus is on the facility managers to manage the scarce financial resources available.

The problem is particularly acute in rural health care facilities that rely almost solely on government reimbursement since the majority of their clients fall within the vulnerable groups (and therefore are eligible for free services). One facility manager indicated that in an entire year the facility obtained only 150,000 Armenian Dram (AMD) (some 280 USD in 2004) for paid services with the remainder of the revenue coming from government reimbursement. The problem is magnified for rural facilities because the SHA reimburses on an accrual basis and the FAPs are in very poor condition and require more resources than are currently provided for operation and maintenance. Historically there was no financing available the first months of the fiscal year due to the delays in revenue collection, so the facilities were forced to use residual funds from the previous year (post corporate profit tax) and/or revenues from paid services to fund operations and pay salaries in the first month(s) of the fiscal year. Delayed state funding availability, the lag (and accrual) of reimbursement, and the inability to deliver paid services compound the financial burden on rural health facilities.

¹⁴ Source: this comes from discussions with MOH representatives, March 2005

In order to improve the discipline and state budget performance the National Assembly of Armenia adopted (in 1997) the Law on State Budgets System. Starting in 1999, the GoA has issued yearly decrees called “Measures Ensuring State Budget Implementation”. These decrees contains clear guidelines and timetables for State Budget Law implementation for the respective year. Gradually, as the budget implementation culture has been nurtured, the discipline of health facility reporting and ensuing reimbursement has been improving. Today, the facilities are supposed to report performance to the regional SHA by the tenth day of the next month. If everything is prepared appropriately and approved by the SHA, then the Central Treasury will release funds into the facility account by the 20th of the month, but sometimes only for a portion of the total reimbursement request. The first quarter reimbursement norm is 25 percent of the annual plan fixed in the Contract signed between the facility and the SHA, the next quarter 50 percent, and so on until reaching 100 percent by year’s end. Of course, there may be discrepancies between the plan and actual performance. If the volume of the services rendered by a facility exceeds the volume fixed in the Contract, the facility gets reimbursed for the excess services only if funds were not used by other facilities (which actually underperformed) and money is available. However, this occurrence is highly uncommon, as almost all facilities attempt to receive the maximum funding from the state budget. Given the scarce resources provided by the state budget, the facilities must be able to finance operations with either paid services (which are very minimal in rural areas) or very sound financial management, making the available funding stretch.

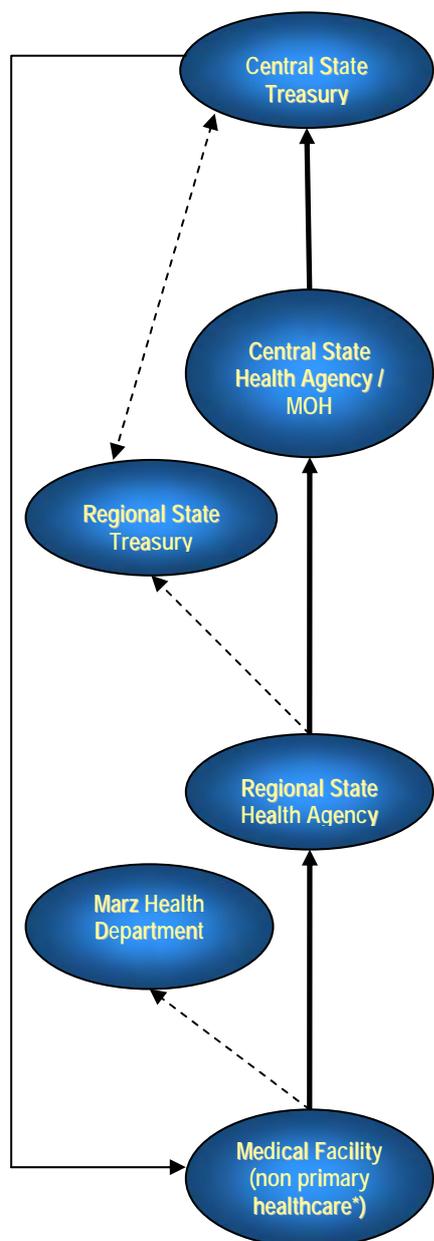
The financial gap created by accrual reimbursement, poor financial management, reimbursement at lower than the real cost of the health care service, and patients’ lack of information encourages the solicitation of informal payments. For example, the Law on Wages requires a facility to pay salaries no later than the 15th day of the next month, and the Law on Mandatory Social Insurance Contributions requires that social contributions be paid until the 20th day of the next month, or the facility will be fined. If there are insufficient legitimate funds, then the facility turns to informal payments or the other practices mentioned above, to pay even low salaries/social contributions in order to avoid fines. In addition, the natural lag in reimbursement (on average a month between rendering the service and receiving reimbursement¹⁵) also explains incidents where individuals seeking medical treatment under the BBP are told by physicians that they have not received reimbursement (and cannot be guaranteed that they will be reimbursed) from the government for BBP services and as such, cannot offer the service for free. It also explains why FAPs are not being maintained. If supporting facilities (ambulatories, health centers, etc) do not have sufficient funding to run the primary operations, then maintaining FAPs becomes nearly impossible.

Reviewing only available information on informal payments and/or the denial of services leads to the incorrect conclusion that physicians and facilities are corrupt and simply lining their pockets. Looking at the health system holistically, one can see systemic reasons why these practices occur and why the population justifies and accepts the situation.

Exhibit 1 below is a rough overview of how the money flows through the health system. Additional research is needed to confirm the information and add details.

¹⁵ Taken the perpetual character of the flow of the service delivery and reimbursement the lag should have been accepted as natural and not a matter for anxiety. In reality, however, there is a problem when a facility renders BBP included service in excess to the volume fixed in the Contract between the facility and SHA.

Exhibit 1: Basic Reporting and Reimbursement Flows in the Armenian Health Sector



- Central State Treasury reviews reimbursement requests.
- It compares information received from the State Health Agency with the Regional State Treasury to guarantee that the requests match and that there are no inconsistencies.
- Money is released directly into the medical facility's bank account by the 20th of the month.

If there are irregularities in the request, then those portions are withheld and returned to the Central State Health Agency (and down the chain of command) for correction.

- Central State Health Agency/MOH reviews consolidated report
- It submits reimbursement request (per the accrual rate, i.e. 17 percent, 33 percent, etc.) to the Ministry of Finance/Central Treasury.

If there are suspicious irregularities in any facility reimbursement report, then the SHA can order its branches to conduct an investigation. That portion of the request will be extracted from the submission to the Central Treasury until the investigation is complete.

- Regional State Health Agency reviews and consolidates all facility reports under its jurisdiction
- It submits consolidated report to the Central State Health Agency (flagging any questionable requests)
- It simultaneously submits the consolidated report to the Regional Treasury.

- Medical facility prepares a report/reimbursement request form for the previous month's activities, per its annual service plan
- It submits report to the Regional State Health Agency and the Marz Health Department by the 10th of each month. The Marz Health Department is not involved in the process after this initial step.

**Primary healthcare is financed on capitation, and does not require financial reporting. Capitation funding is provided to the facility each month (further research is required to fully understand the specific nature and timing of these payments).*

II. MISREPORTING

Misreporting has serious and detrimental effects on facility finances, the national budget allocation for health, and national health programming. The SHA prepares the annual facility plans based on the prior year's performance. If the facilities submit inaccurate reports, then the cycle will continue, and there will be insufficient allocations for various services and perhaps overallocation for others. And if the reports provided to the Ministry of Health appear to be exactly in line with the services delivered, salaries paid, and facilities maintained, then the Ministry of Health has no reason or justification for

requesting additional government revenues to be allocated to the health sector. Misreporting also leads to misinformation on the health of the population.

Numerous examples of misreporting were revealed during the interviews and research for this assignment. There appears to be at least three different explanations for facility misreporting: i) desire to show that all the money has been fully spent, ii) to receive maximum reimbursement by adjusting line item services, and iii) misunderstandings.

Showing that Money is Fully Spent. This practice can be attributed to “old habits dying hard.” The Soviet system was based solely on spending all of the money, not on how the money was used. Even today other donor projects are battling to change this mentality in government spending in general. The rationale is that a certain amount of money was allocated and spent, therefore all must be well. This attitude appears to be supported by the government: several interviewees responded to questions about misreporting by saying that the Ministry of Health would reject reports that showed actual performance if it diverged from set levels.

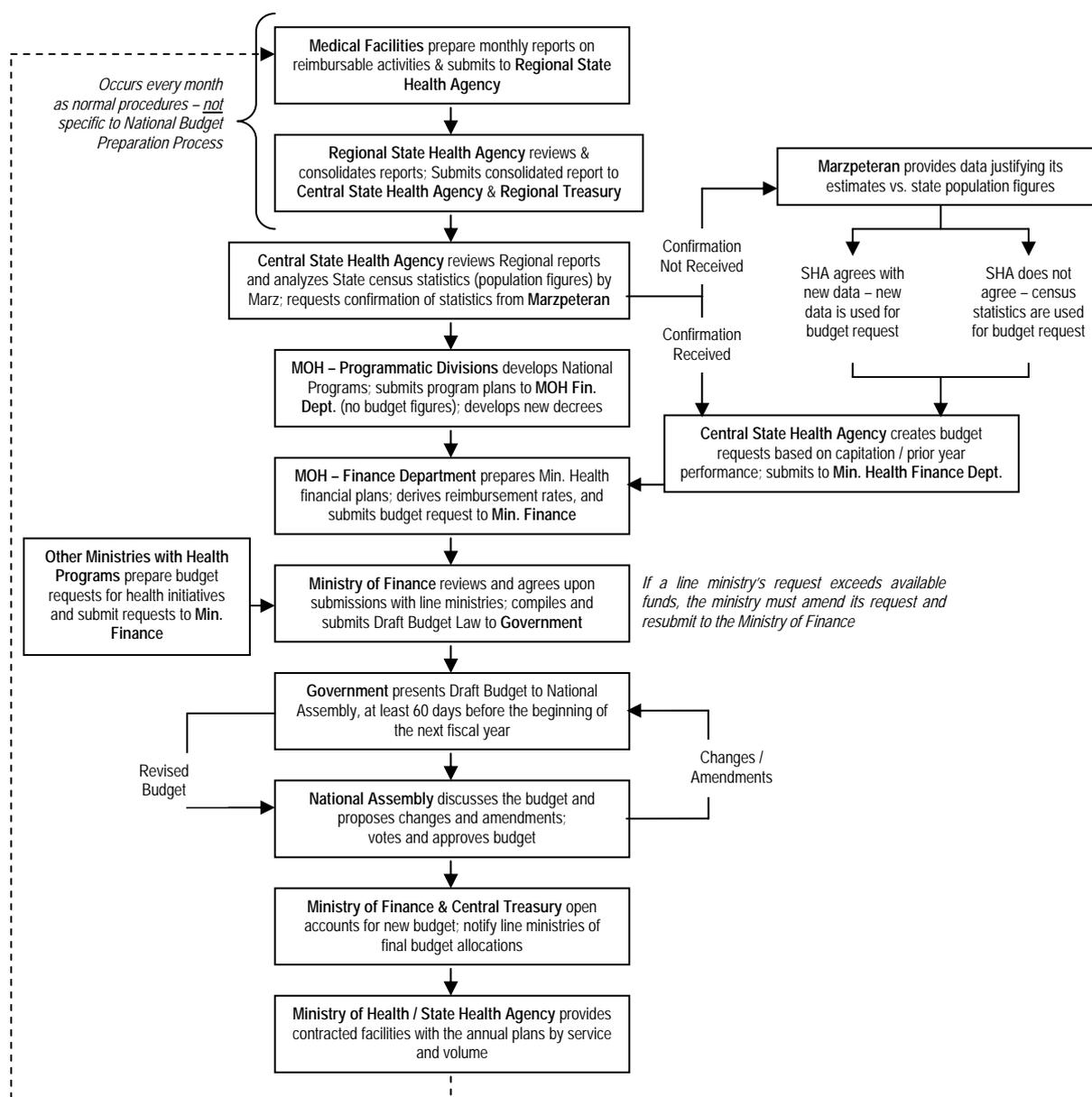
Maximum Reimbursement. SHA capitation plans are very rigid, like the government budget. The plans do not allow for easy modifications based on trends or for fungibility in line items, which is problematic for something as elastic as healthcare. The plans, based on the previous year’s performance and the population, may include four pediatric neurological cases, when in fact a facility only has one. Meanwhile, the facility may have five visits for another type of service, when the plan only allows for reimbursement of two. According to facility interviews, they are not allowed to apply money for one service to another, leading some facilities (none of the facilities interviewed admitted to doing this themselves) to “fix” the reports in order to reap the maximum reimbursement available. There is likely a mechanism in place with the SHA to change line items, since the Director of the SHA has indicated that he reallocated money during the year if he saw different trends appearing, however, additional research is needed to determine the exact process for doing this.

Misunderstanding. There was evidence of facilities misunderstanding the reimbursement process and only registering the number of cases allowed in the facility capitation plan. For example, one facility head indicated that she was confused about the process and her plan allowed for only ten of a certain type of pediatric visit, while she saw 20. She only reported the reimbursable ten because she assumed that the report was only used for reimbursement.

III. NATIONAL BUDGET ALLOCATION PROCESS

There is a general consensus that government funding for public health is inadequate. Similarly, there is agreement that poor financing is one of the greatest systemic impediments to quality service delivery and utilization. Ironically, there is much apathy about government budgeting. Those interviewed in facilities and the international community tended to believe that the government is so poor that the situation will remain unchanged. The diagram below shows the government budgeting process linked with facility funding. Additional research should be conducted to add detail and confirm information contained herein.

Exhibit 2: The Health Sector and the National Budget Preparation Process



As shown in the diagram and mentioned above, the facilities do not prepare budget forecasts for inclusion in the MOH requests. The regular monthly reports are used as a basis for the Ministry's budget request to the government. Since budgeting and forecasting are not done and reports are fixed to make it appear that everything is spent fully and is exactly to plan, there is no rationale for increasing the government budget allocation.

B. Weak Policy Implementation

Numerous international organization representatives indicated that Armenia has a good body of law, but the laws are not implemented effectively. Further, the array of government and ministry-level policies, strategies, standards and protocols are vast, often inconsistent and overlapping, and are not well-disseminated to health professionals. A legislative and policy review was not conducted as part of this assignment, yet two relevant examples of inconsistency or inadequacy between legislation and practice were found in the course of the assignment.

I. FUNDING FOR FAPS MAINTENANCE

State Order funding provides resources for the maintenance of FAPs as a part of the supporting facilities (ambulatories, polyclinics, etc) and obliges the supervisory facilities to maintain a health post and a nurse in the rural communities. It also mandates that physicians from the supervising facilities must make monthly visits to the communities. The population served by the FAPs is included in the capitation estimates for the supporting facility, which determines the SHA funding. The State Order, however, is not enforced, and the maintenance of FAPs and the physician visits are reliant on the discretion of the head physician.

Community programs can greatly improve the relationship between head physicians and communities, such that more frequent visits are made. In addition, donor community activities contribute substantially to the renovation and maintenance of some FAPs. These activities are critical to providing communities with necessary health services. However, it is common to find that money intended to maintain FAPs (which should receive the nurse's salary, compensation for utilities, and a minimal level of supplies) actually is spent for the head facility needs. In those instances, the facility is not accountable to either the population it serves or to the government.

II. CAPITATION ESTIMATES

As mentioned above, the population served by FAPs is included in the capitation estimates for supporting facilities. As of this year, those facilities responsible for FAPs will receive additional funding for the salaries of the FAP nurses. The maintenance of the physical infrastructure is the responsibility of the facility. A facility that serves the same size population but has responsibility for no FAPs will receive the same maximum funding as a facility with six FAPs. Limited funding is the justification for not maintaining (repairing, utilities, providing supplies to) the FAPs, and a lack of enforcement enables this practice. This is another structural and systemic gap that hampers health care service delivery in rural locations.

C. Healthcare Reforms

As part of the Soviet Union, the Armenian health system was centrally controlled from Moscow. Standards, protocols, regulations, and funding were dictated by the center and implemented by state-owned facilities. After the collapse of the Soviet Union, Armenia was left with a centralized health care system and insufficient funding to support it. Quality of care plummeted as the system was overburdened by the health requirements of the population at a time when the country was experiencing devastating economic and social upheaval.¹⁶ The demand for health services, combined with the lack of funding, required the GoA to initiate drastic reforms in the health sector to target limited resources to the most vulnerable, and to reorient services toward more cost-effective primary health care. Many reforms, such as privatization, optimization, and decentralization, began and then stalled, or were partially implemented.

¹⁶ European Observatory, 2000, pg. 6.

I. PRIVATIZATION AND OPTIMIZATION

Privatization was first introduced by the Ministry of Health in 1994, but to date only the pharmacies, dental polyclinics, and medical technical services have been privatized.¹⁷ Most healthcare facilities remain in the public sector, and there are only a handful of privatized facilities in Yerevan.

The Government, with assistance from the World Bank, is working towards optimizing the health system by reducing the number of hospitals and by creating a functioning PHC system. Optimization ideally would also reduce the number of medical staff in order to increase efficiency and the available funds for paying staff salaries. The reform efforts began in 1996 when the hospitals were granted autonomy, and some were privatized.

In February of 2001, Governmental Decree No 80 approved the Health Sector Optimization Implementation Plan, which aimed to cut the number of beds in hospitals and create mergers of certain health care facilities. For example, the optimization in Tavush marz (Governmental Decree No 557 of June 21, 2001) aimed to allow 370 beds (instead of 721) in the hospitals and to have freed 2500 square meters; to merge certain ambulatories and polyclinics (especially children's and adults' polyclinics); and to close some women's consultations or stomatologic polyclinic's facilities. The optimization goals were similar in other Marzes. A report by the Ministry of Health in 2002 indicated that nationally, there was a 30 percent reduction in bed capacity and a 15 percent reduction in non-medical staff; however, most of these achievements took place in facilities outside of Yerevan.¹⁸

II. DECENTRALIZATION

Decentralization began in the Armenian health sector in the mid 1990s and remains a priority for the GoA. Decentralization has proved to have the largest impact on rural facility efficiency, transparency, and accountability and as such, is emphasized in this section of the report.

Decentralization, according to Management Sciences for Health, is defined as “the transfer of power from higher to lower management levels in diverse organizational settings. It can mean transferring control over specific management functions, such as planning and budgeting, from a central office to field offices, or shifting the responsibility for an entire program to an institution with a distinct geographic boundary, such as provincial or district government.”¹⁹

Major elements of Armenia’s health sector decentralization include the following:

- 1995 – Health care facilities’ status changed to State Enterprises from budget organizations²⁰
- 1996 – Ministry of Health created the Basic Benefits Package of medical services for the most vulnerable groups of the population
- Mid 1990’s (until 1998) – Regional governments became third-party payers of health care that fell under the government’s Basic Benefits Package
- 1996 – Provision of primary and secondary care was transferred to regional and local governments
- 1997 – Health care facilities’ status changed from State Enterprises to State Joint Stock Companies with the owners being the state or local government²¹

¹⁷ Ibid., pg 23.

¹⁸ World Bank, Project Appraisal Document, “Health System Modernization Project in Support of the First Phase of the Health Sector Reform Program,” February 2004.

¹⁹ Management Sciences for Health (MSH), “Decentralizing Health and Family Planning Services,” <http://erc.msh.org/mainpage.cfm?file=2.2.1.htm&module=health&language=English>

²⁰ PADCO Armenia Social Transitions Program (ASTP), “Report No. 86: Recommendations on How to Reduce Informal Payments for Medical Services in Armenia.” Available at <http://www.padco.am>

²¹ PADCO ASTP Report No. 86. The GOA owns republican facilities, Marzpetrans own most non-Republican medical facilities, and town or village governments own some polyclinics and rural ambulatories, pg. 9.

- 1998 – Rural outpatient clinics were transferred to the community (village) government
- 1997 & 1998 – The State Health Agency was created by Government Decree No. 593 which separated the provision and payment for health services included in BBP
- 1999 – The SHA began full operations and was the only government body permitted to reimburse providers for government sponsored services (the SHA was initially created as a separate body from the Ministry of Health, but was reabsorbed in August 15, 2002 by Governmental Decree No 1301)²²
- 2002 – Health care facilities were to become State Non-Commercial Organizations (has not occurred to date)²³
- 2003 – Several marzes returned rural outpatient clinics to the control of urban based polyclinics away from local government control.

The intent of any type of decentralization is to improve efficiency while decreasing costs and improving performance.²⁴ The concept is to place management and oversight for certain activities at the appropriate levels of government that best serves the population. For example, waste collection is often decentralized to the municipal level because it is the level that is closest to the issue and which interacts with the community to deliver adequate and appropriate service. The following matrix, created by Management Sciences for Health,²⁵ shows the various degrees of decentralization ranging from low to highly decentralized functions. The bold boxes represent roughly where the Armenian health sector could be currently categorized. The classification of the Armenian health sector is based on very rudimentary and certainly imperfect information that was collected and pieced together from interviews and documents reviewed. Additional research might alter the classifications.

Exhibit 3: Degrees of Decentralization

Management Function	Degree of Decentralization (descriptions applicable to Armenia in bold)		
	Low	Moderate	High
Program Planning and Implementation	Planning is done at the central level. Field units of the agency or organization are responsible for implementation. Programs are fully managed by central-level employees with the central level handling all administrative, research, and training functions.	Semi-autonomous or autonomous local/government units are responsible for planning and implementing programs. Programs are managed by a mix of government and private employees through wage or service contracts for certain services.	An autonomous public or private legal entity is given responsibility for planning and implementing a program or may be contracted to do so. Programs are privatized and employees are hired largely from private sector.
Financial Planning/ Management	Program budgets are developed at the local level. Funds are allocated to field units by the central level. Field units submit financial reports; the central level usually manages finances.	Block allocations are made by the central level to subsidize funds generated by the local units. Budgets are set by the local level. Financial management is conducted by the local level.	Contracts for services or facilities are made with outside entity, which budgets for and manages all its contracts and finances independently. Funding is provided through contracts for specific services.

²² European Observatory of Health Care Systems, “Health Care Systems in Transition (Armenia)” 2001.

²³ PADCO ASTP Report No. 86.

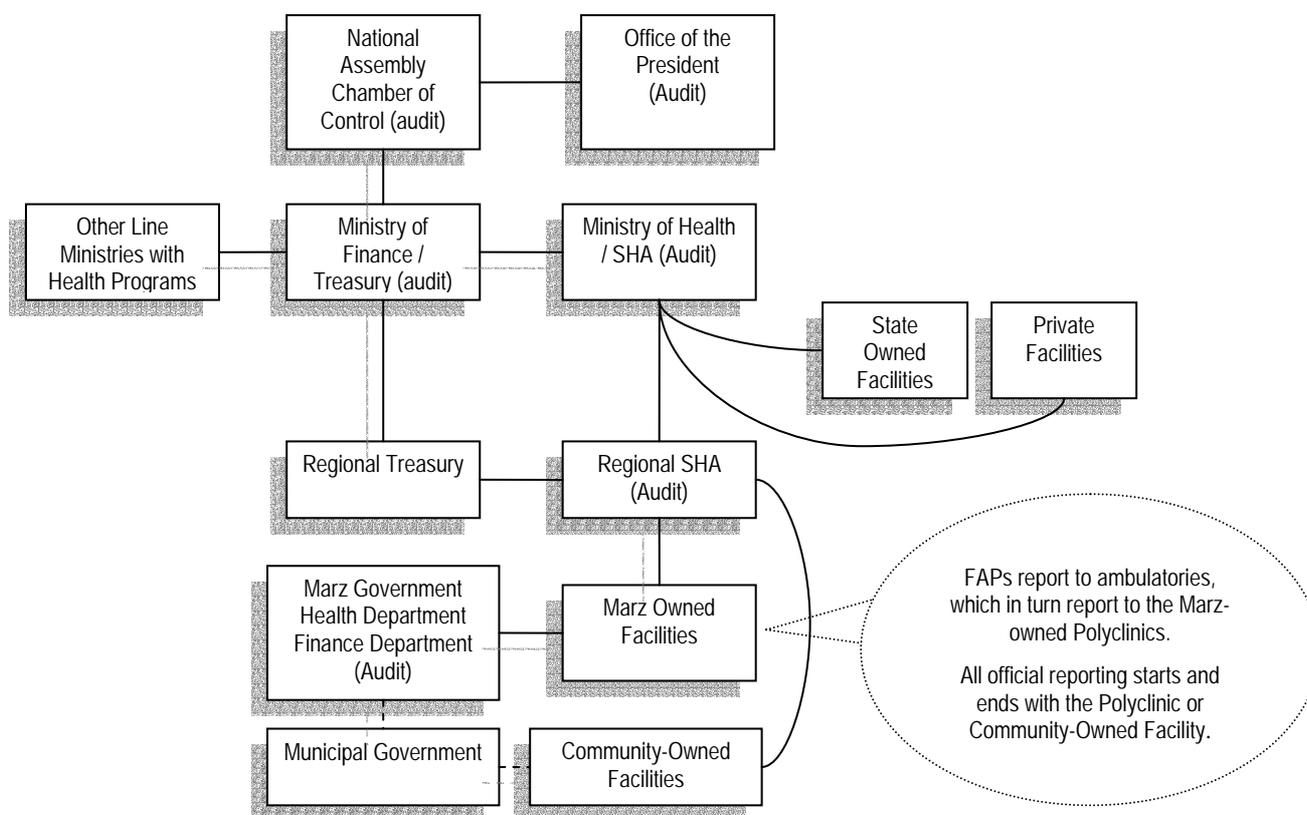
²⁴ MSH, “Decentralizing Family Planning Services.”

²⁵ Ibid.

Management Function	Degree of Decentralization (descriptions applicable to Armenia in bold)		
	Low	Moderate	High
Staffing	The central level hires and assigns staff to central or local-level posts. Terms and conditions of employment are set by the central level.	Staff are selected at the local level or assigned to local posts through the public service system. Terms and conditions of employment are set by the central or local level.	Staff are selected or appointed by the organization or entity. Terms and conditions of employment are set by the organization.
Staff Supervision	The central level sets performance objectives; supervision is done by the field level. (State Ordered quality objectives)	Local level sets performance objectives and supervises staff.	The organization or entity sets performance objectives and supervises staff.
Logistics/ Vehicle Management	Commodities and equipment are procured and stored at the central level. (some drugs and supplies might be arranged by the MoH) Ordering by requisition is done by the field units.	Commodities and equipment are procured, stored, and maintained locally. Local managers order through regional public or private stores.	The organization purchases commodities, equipment, and maintenance services through private sources. Ordering is done largely by private companies.
Quality of Care/ Service Standards	Standards of care are set and monitored by the central level. – Only BBP services monitored at the central level	Standards of care are set by the central level and monitored by the local level.	Standards of care are set and monitored by the organization.
MIS/Reporting and Program Monitoring	Data-collection requirements are set at the central level. Local level submits reports to the central level. Program monitoring is performed by the central and local levels.	Data collection and reporting requirements are differentiated to serve the needs of the central and local levels. Program monitoring is performed by the local level.	Data collection, reporting, and monitoring requirements are determined and performed by the organization. Data may be reported to the government to fulfill national-level information requirements.
Program Evaluation	Central-level staff or consultants conduct evaluations.	Central-level staff, or consultants hired by local-level managers, conduct evaluations.	Staff or consultants are hired by the organization to conduct evaluations

A final illustration of the decentralization of the Armenian health sector is the following organizational chart. The details depicted in the chart were pieced together through various meetings and reports and should be considered a starting point for future decentralization mapping.

Exhibit 4: General Organizational Structure for the Armenian Health Sector



Looking only at the information presented above, one can believe that Armenia has managed to effectively decentralize its health sector, in line with countries such as New Zealand, which is considered a global model for public sector reform. New Zealand has transformed its health system over the last two decades, moving from a highly centralized “welfare state” system to its current decentralized structure. In those two decades, the Government of New Zealand introduced new reforms, modified them based on weaknesses and gaps, and retracted other reforms that failed. The decentralization efforts were introduced gradually over the 20 year period, allowing for administrative and management systems to adapt and strengthen before pushing more advanced concepts. The Government continues to examine new reform options to increase utilization and quality of care for its population.

Decentralization of any government function is complex and even when initiated with good intentions, it often takes years to elaborate corresponding normative acts supporting enforcement of adopted laws, and to develop the necessary skills and support from all levels to achieve the objectives of decentralization.²⁶ According to Richard Bartley, quoted in the World Bank study, *Public Management and the Essentials of Public Health Functions*, “many countries, some of them encouraged by technical enthusiasts in the donor community, jump directly into complex second generation public sector reforms (provider –purchaser splits, contracting out, etc.) without strengthening administrative and management skills first. These reforms typically fail”.²⁷

²⁶ Ibid.

²⁷ Peyvand Khaleghian and Monica Das Gupta. “Public Management and the Essentials of Public Health Functions.” World Bank Policy Research Paper 3220 (February 2004), pg 15.

The description provided in the World Bank study reflects the situation in Armenia's health sector. Armenia has jumped ahead in public health reform before establishing the necessary regulatory framework, strengthening the management capacity of facility managers and regional and community leaders or putting in place administrative systems. Suddenly, head physicians were transformed into semi-autonomous medical facility directors. The facilities became Joint Stock Owned Companies owned by various levels of government, but managed by head physicians and now subject to corporate profit tax. Marzpeteters and the community became owners of medical facilities yet had no budgetary or financial management authority or any role in the implementation of the National Health Policy. Facilities began contracting directly with SHA for services, versus receiving government budget funds each month for all service delivery. It is understandable why there is confusion about the roles, responsibilities, and authority of all the parties. The disconnect between paper and practice, however, may actually enable corruption because when roles and responsibilities are not clearly defined and administrative systems are not in place to monitor transactions, it is easy to abuse authority for private gain.

Law on Joint Stock Companies

In 1997, medical facilities were changed from State Enterprises to "State" Joint Stock Companies. Government bodies have responsibilities defined in the healthcare legislation that conflicts with the responsibilities they possess as owners of the Joint Stock Companies (both of which are supported by legislative acts). Therefore, there is not a clear definition of the relationship between the facilities and their owners.¹

In addition, despite being Joint Stock Companies, Decree #226 of RA Government On *Determination of the Official Rates of Employees of Budgetary Institutions* treats state medical facilities as budget organizations. This classification restricts the financial authority of the facility over its resources and subjects the facility to ministerial and government mandates on funding priorities such as the 2001 decision requiring facilities to pay all salary arrears.²

¹ PADCO, ASTP Report No 86, pg. 9

² *Ibid.*, pg 10

It was interesting to ask head physicians what it meant to be "Marz-owned" or "Community-owned." Most simply did not know. They knew that it related to the facilities becoming Joint Stock Companies, but they did not see any change in the day-to-day operations. One facility Director thought it may mean that the land that the facility was located on was owned by the community. One FAP nurse did not know which facility she was linked to for support, supplies, etc. Many facility staff interviewed knew only to whom they needed to report without understanding why or what role that body played in the larger health sector and/or government. Others knew that they needed to receive approval from the Marz Health Department in order to procure equipment, but assumed it was because they were within the local government oversight. The same confusion about decentralization and the various roles and responsibilities was echoed by representatives in the international community. Everyone has a general idea about how things are supposed to operate, but when questioned about detailed interactions or specific oversight or transactional links, no clear picture emerged.

The audit function is a good example of the complexity of decentralization in Armenia. Financial audit functions are essential and the SHA audits medical facilities' accounts for both paid services as well as state-reimbursed services. However, note that in Exhibit 4 above there are five separate bodies with audit authority: 1) Control Chamber under the National Assembly, 2) Supervisory Body under the President, 3) Audit Body under the Ministry of Finance, 4) Audit Division in the State Health Agency, and 5) the Financial Department of the Marz Health Department. Only the last three would likely be involved in auditing the medical facilities, but even with three separate audits, overlaid with the prevalence and acceptance of bribes and the lack of administrative controls it is easy to see how corruption could occur in this environment.

In addition to financial auditors, facilities can be visited by national and local tax authorities, sanitary inspectors and marz or national level technical specialists. All of these were cited by facility staff and international representatives as potentially soliciting bribes or seeking other types of favors in exchange for overlooking inaccuracies in records, mistakes, or other administrative gaps.

As well as facilities, citizens too are adversely affected by ambiguity and lack of accountability within the system. When decentralization does not clearly delineate the roles and responsibilities of the facilities versus the local government versus the State Health Agency versus the Ministry of Health, it is easy for each to blame the other for inefficiencies and the inability to provide quality services consistently and for either free (per the BBP) or for a set official price.

Armenia's health reforms are not failing, as predicted in the World Bank Study quoted above, because the Government and the donor community continue to address reform shortfalls and initiate new programs to address the needs. However, the complex and confusing decentralization is providing an enabling environment for corruption. Armenia, with the help of the donor community, needs to focus on filling in the administrative systems, controls, managerial capacity, and a clear definition of roles and authority in order to prevent a collapse in health reforms and a further loss of public confidence in the health system.

C. Societal Tolerance

Why does Armenia rank so high in the prevalence of informal payments? One explanation is that there is a societal norm of providing gifts to the medical staff for successful services. The gifts could be a box of chocolates, flowers, alcohol, or a nominal amount of money. According to interviewees, these gifts used to be customary, but voluntary, and were always provided after the service was delivered.

The nature of informal payments changed in the 1990s with the collapse of the Soviet Union and the war with Azerbaijan, when government funding and other types of pre-payment virtually collapsed, and health care was predominately covered by out-of-pocket payments.²⁸ The societal norm of paying the informal payment did not change, and the practice is still widely tolerated and is not recognized as outright corruption by many. Interviewees gave the following reasons justifying informal payments:

- **Low salaries of medical staff:** Interviewees indicated that informal payments are justifiable because physicians and medical staff do not make sufficient salaries to support their families. This mentality is magnified in rural communities, where patients and physicians know one another well and know the financial burdens each possess.
- **Fear of receiving poor care:** An overwhelming majority of people consulted indicated that informal payments were required to ensure that quality care was provided. There is a sense that if one does not pay the informal payment (or the full amount that is requested), the patient may be ignored, mistreated, or receive mediocre service. One interviewee mentioned that some of the best facilities are also the ones that require the highest informal payments. In essence, informal payments help guarantee quality, and people are forced to accept that scenario to ensure that they or their loved ones receive the best medical care possible.
- **Rewarding the physician and medical staff:** The original concept of gift-giving is still a prominent explanation for informal payments. Despite the fact that informal payments are not really voluntary and often do not occur after the service is provided, many individuals still believe that the informal payment is a gift to the medical staff, particularly for deliveries and surgeries with successful or joyous outcomes like the delivery of a male baby.
- **Lack of government funding:** Many Armenians also attribute the need for informal payments with insufficient government funding. They believe that Armenia is a poor country and no matter what is done, there will not be enough money to provide all of the services. In essence, they are helping subsidize the system through informal payments. Ironically, most interviewed (including international and government representatives as well as facility staff) did not believe that BBP services should be limited in order to fully finance SOME services versus partially financing ALL services. In fact, most people interviewed believed that the BBP should be expanded to cover more of the population and more services.

²⁸ Ibid, 58.

- **Poor workforce planning, resulting in too many physicians (particularly in Yerevan city and the surrounding areas):** As per Mr. Samvel Hovhannisyan, Chairman of the Family Medicine, NIH, in Armenia there are too many educational establishments preparing specialists of all levels (physicians, nurses, and technicians) for the healthcare sector. Many graduates cannot find jobs which results in increased bribery and patronage and ultimately, increased costs of healthcare. This is a peculiar phenomenon of the health care system: with an increase in the number of health care providers, unlike other branches of the economy, prices for health services inflate and the quality of the service worsens.²⁹
- **Lack of public awareness of BBP eligibility and services:** According to a recent UNDP study, only 38.7 percent of families interviewed were aware of the governmental decrees making them eligible for government-funded services under the BBP. Furthermore, 43.5 percent of the uninformed portion of the population in need of healthcare would not seek health services because of the belief that they would have to pay for services, and 24 percent of the uninformed paid for services that were supposed to be free of charge.³⁰

Regardless of the justification, the fact that such a large portion of the population within Armenia and the region³¹ believe that informal payments and corruption, in general, are “par for the course,” makes it difficult to attack corruption through only public awareness campaigns and community outreach programs. The practice is deep rooted and culturally accepted, not only in the health sector, but also in education, taxation, business operations, law enforcement, etc. The societal tolerance combined with an absence of civil society creates an environment where individuals do not feel empowered to demand accountability and transparency from the medical facilities or government bodies or to challenge culturally tolerated practices.

²⁹ Health Care: Why Costs are so High, by Bob Carbaugh, Department of Economics, Central Washington University, <http://www.cwu.edu/~carbaugh/Health%20care%20costs.htm>

³⁰ Silva Abelyan, UNDP, “Are the RA Government Decrees Applicable” Annex 2-1.,pg 1.

³¹ Taryn Vian, *Corruption and the Health Sector: Sectoral Perspectives on Corruption*, November 2002, pg 1. 81 percent of respondents in Central Europe reported having to pay informal payments to physicians in order to receive treatment.

4. RECOMMENDATIONS FOR PROJECT NOVA

The following section provides recommendations for Project NOVA to combat corruption in rural RH/MCH care and contribute to broader anti-corruption activities in the health sector generally. Recommendations are provided for each of the Project's components and presented in order of greatest potential impact.

A. Improve RH/MCH Policy Formulation and Implementation

I. WORK TO RECONCILE STATE ORDER FOR FAPS WITH STATE FUNDING

Currently the state order funding envisages head facilities “supporting” connected FAPs. However, there is no provision that requires the obligation of a certain percentage of the funding, or any standards for what “support” means. There is a disconnect between the legislation and the funding, leaving FAPs 100 percent reliant on the “good nature” of the head physician. It is recommended that Project NOVA 1) research what is necessary for a FAP maintenance; 2) conduct research on various facilities in target marzes to compile information on how FAP maintenance varies from facility to facility; 3) prepare a policy paper or lobbying approach to ensure funding for proper FAP functioning and reconcile the legislation with state funding³².

Local Counterparts:

- 1. Ministry of Health Medical Services Department*
- 2. Marz authorities*
- 3. Facility Directors*

II. UNDERTAKE POLICY WORK TO DEFINE CAPITATION ESTIMATES (IN RELATION TO THE MAINTENANCE OF FAPS)

Currently capitation estimates are based solely on the size of the population. These estimates are used to formulate the facility plans for reimbursement and ultimately the reimbursement available to the facilities. However, two facilities that serve the same size population will receive the same plan, despite the fact that one may have no FAPs, and another six (as is the case in Desegh). Facilities required maintaining FAPs are not receiving any additional funding to support the infrastructure, additional medicine, or equipment.³³ Project NOVA should 1) conduct further research on various facilities with similar (or the same) capitation rates and the responsibility for FAPs (and/or other lower level care facilities); 2) based on this research, prepare a lobbying approach or policy recommendations to address the discrepancy in the current system and have FAPs maintenance included as a variable in the creation of the reimbursement plans and rates.

Local Counterparts:

- 1. Ministry of Health*
- 2. State Health Agency*
- 3. Marz authorities*
- 4. Facility Directors*

³² It may be helpful to meet with Eleanor Valentine, Chief of Party of the USAID Armenia Legislative Strengthening Program, to discuss how that project is dealing with issues where legislation and state funding do not match.

³³ The State Health Agency indicated that this year facilities with FAPs will receive additional funds to cover the nurses' salaries.

III. RESEARCH ECONOMIC AND SOCIAL JUSTIFICATION FOR FAPS

Per recommendation 4.A.II concerning the financial support and maintenance of FAPs, Project NOVA could conduct additional research to determine 1) if there is legislation mandating when a FAP is required (per population), 2) if there is legislation preventing or permitting FAPs to accept fee for services (if so, is this being done and how are the finances monitored), 3) if there is an economic rationale for closing FAPs, and 4) if so, then how does that improve and/or affect service delivery in rural communities. If, for example, it is determined that a health center or polyclinic is within a close distance to the community, then it could be recommended that the money for FAPs remain within the supporting facility to serve the community versus allocating a portion of the funding for a FAP that is either underutilized or duplicates services that could be provided at the supporting facility.

Local Counterparts:

- 1. State Health Agency*
- 2. Facility Directors*

IV. EXPLORE THE USE OF COMMUNITY TAX REVENUES

Armenian municipalities were just granted the right (via the Law on Local Self Governance) to collect property and land tax. Project NOVA should research this law and determine if there are restrictions on how the revenues can be used. If there are no restrictions, Project NOVA should create a lobbying agenda for the community groups to attempt to have a portion of the community tax revenue earmarked for the health system. According to the Director of the State Health Agency, there is an ideal goal of having community revenues contribute to, if not entirely cover, the cost of FAPs maintenance. Project NOVA's emphasis on FAPs makes this issue relevant and one that should be investigated further. This recommendation could be pursued later in Project NOVA's implementation given other Project priorities and the time required for municipalities to determine how they will implement the new law.

Project NOVA could conduct a similar activity at the national level, but assistance must first be given to the facilities to correct the "report fixing" practice and to accurately budget and forecast financial needs. A follow-on recommendation would be to work with the facilities to raise awareness of the impact of inaccurately reporting health statistics (no additional funding for the health sector from the national budget is being allocated because the reports make it appear as if everything is fine; capitation plans are being miscalculated because incorrect data is being used; audit risks and corresponding fines and bribes increase, etc).

Local Counterparts:

- 1. Municipal Governments*
- 2. Coordinate with USAID Local Governance Program*

V. FACILITATE COST ESTIMATES FOR RH/MCH SERVICES.

Virtually everyone interviewed, with the exception of the State Health Agency, indicated that a fundamental problem with service delivery and quality of service (leading to the need for, and acceptance of informal payments) is that the BBP reimbursement rates are severely underestimated. According to the interviews, the SHA reimburses facilities at best 50 percent of the actual cost of the service. However, despite these assertions, no one interviewed knew of any attempt to actually estimate the real cost (including indirect costs of operations: administration, utilities, rent, salary of employees that are not directly related to the service, but required for the functioning of the facility, etc). It is highly recommended that Project NOVA conduct financial analysis of the RH/MCH services in conjunction with budgeting exercises with facility staff to determine the actual cost of these services.

It is important to provide hard data in order to change policies, redirect government funding, and raise awareness both within the medical circles and the community as to how much these services actually

cost. Project NOVA could collaborate with a more micro-level health initiative on this activity in order to prepare a more comprehensive analysis of the actual costs of services versus the BBP reimbursement rates.³⁴

It is recommended that Project NOVA select a specific RH/MCH service that is earmarked for all the population, such as antenatal care, so that figures can be compared across different levels of care. Project NOVA could compare the cost of antenatal care at an urban polyclinic, a rural health center, and a family medicine center. In addition, the comparison could include the cost of the role of the FAP nurse in coordinating pregnancy care for the women in their community. A mean cost can be derived by analyzing the costs at the various levels. The results may also provide additional support for expanding the role of primary care providers if quality antenatal care can be performed for lower costs.

Local Counterparts:

1. Ministry of Health Finance Department
2. State Health Agency Economic Department
3. Facility Directors

VI. CONTRIBUTE TO DECENTRALIZATION ANALYSIS AND MAPPING

Decentralization of the health sector began in the late 1990's, yet there is significant confusion among the donor community, facilities, and even government officials as to 1) the extent of decentralization, 2) the function of different levels of government in theory and practice, and 3) how primary care facilities interact with different supervising bodies. The confusion surrounding decentralization efforts has real consequences on the delivery of quality health care throughout the health sector, but particularly in rural areas. Rural facilities indicated that they were unsure of the role of the Marz Health Departments,³⁵ and Marz Financial Department, the functions of the Ministry of Health versus the State Health Agency, and Community officials. A secondary tier then emerges with sanitary inspections, tax inspections at various levels, and financial audits from both the SHA and Marz Financial Departments. The third level could be seen as the linked facilities such as polyclinics responsible for ambulatories or FAPs. The confusion embodied in the current status of decentralization increases the vulnerability for gross corruption and ultimately justifies petty corruption at the facility levels. In other words, if government funding is not being controlled or spent according to national intentions, then the facilities are not receiving adequate funding for their operations and the physicians use this fact to justify requiring informal payments. The status of decentralization and the confusion within the health sector about the new roles and responsibilities enables corruption and justifies a lack of accountability at every level (government to the facilities, facilities to the lower level facilities, facilities to physicians and nurses, physicians to patients).

It is recommended that Project NOVA contribute to the creation of a decentralization map that clearly lays out the intended responsibilities of each level, in comparison to what is actually occurring. The immediate utility of the exercise is that facility managers will understand their rights and responsibilities vis-à-vis the various levels of government and the facilities under their control. A larger objective, however, is to work with the international community responsible for the decentralization efforts and the GoA to streamline and clarify the decentralization process. It is

³⁴ The European Health Observatory, *Learning from Experience*, notes that a contributing factor to the failure of basic benefits packages in other countries is the costly and exhaustive effort to obtain cost-effectiveness data on interventions (pg. 66). Armenia has elected to continue with the Basic Benefits Package and continues to expand the population and services included without regard to the cost or current under-funding of the system. Given the operating context, it is the author's opinion that economic data from the rural facilities would provide the baseline for the cost of service provision assuming that costs are lower in rural areas than urban facilities.

³⁵ Some Marz officials approve head medical staff, approve the number of staff in facilities, and approve the "paid service" fees. Confusion arises because it is difficult to determine if these activities permissible because the Marz health department is serving as an arm of the MoH or because the Marz is the single state owner of the facility?

important to note that it is recommended that NOVA contribute to this activity, not lead it. Decentralization of the health sector spans far beyond the scope and responsibility of the NOVA Project. Either USAID directly or a macro health project (perhaps the follow-on to ASTP) could lead the exercise with NOVA contributing by providing input from the communities and facilities they work with as part of their ongoing tasks.

Project NOVA could also do an assessment specifically on the decentralization of RH/MCH services – for example, state-ordered care, FP, and STI.

Local Counterparts: To Be Determined by Lead Project

VII. PARTICIPATE AND CONTRIBUTE TO THE UNDP MONTHLY ANTI-CORRUPTION MEETINGS

The UNDP “Support Civil Society in Anti-Corruption Initiatives” Project focuses on anti-corruption in the health and education sectors. The project will organize monthly discussions on policies and legislation in education and health sectors and report on progress of implementing their monitoring methodology. It is highly recommended that Project NOVA attend and contribute to these monthly discussions.

B. Strengthen Management & Supervision of Rural RH/MCH Facilities

I. STRENGTHEN UNDERSTANDING OF GOVERNMENT REIMBURSEMENT POLICIES AND PROCEDURES

The greatest weakness identified in the health facilities was facility managers’ ubiquitous lack of knowledge and understanding of the government reimbursement policies and procedures. In rural areas, the majority of services provided are covered by the BBP either because of the services themselves (ie: antenatal care, deliveries, vaccinations, etc) or because the individuals served are classified as “vulnerable.” Therefore, the facilities are virtually 100 percent reliant on government reimbursement to operate, yet those visited could not clearly or concisely articulate the way in which they interact with the SHA. In fact, many did not know if reimbursement occurred on a monthly, quarterly, or annual basis. Those interviewed were unsure of whether the money came through the Treasury, regional SHA, or central SHA, or how the reports they prepared were utilized by the government. Later recommendations will cover improving facility level budgeting, reporting and accounting to potentially increase funding, however, before that can even occur, it is critical that the facilities understand how the reimbursement system is supposed to function, what and when they need to report, and how, why, and for what portion they are being reimbursed. The fact that some rural facility managers do not understand the system does not make them corrupt, but it does make them unaccountable to the citizens because if they are not accessing the system correctly, the quality and availability of services will be limited.

Similarly, the facilities need to be educated on how the national budget is determined for the health sector and how the reports they are (or are not) providing could contribute to the overall health budget and allocations. There are deficiencies in the budget preparation process since it relies heavily on metrics,³⁶ inaccurate reports, and population statistics versus budget projections from facilities, official population estimates, and appropriately estimated reimbursement schedules.

It is recommended that Project NOVA create seminars and materials (flow charts depicting the report flows leading to funding; forecasting leading into MOH budget requests, and reimbursement steps, etc) to the facilities it works with throughout the life of the project. At a minimum, the facilities should be educated on how reimbursement operates, the steps it needs to follow to get reimbursed, and the consequences of doing so inaccurately. These materials can be prepared by Project NOVA in conjunction with the SHA as part of the ongoing collaboration with SHA. If possible, the regional SHA branches would provide seminars (coordinated by Project NOVA) for facilities. The direct

³⁶ Metrics refers to the use of formulas instead of actual financial projections. For instance, the budget estimates for a facility are based on X amount for an adult and 2X for a child under 7.

contact with SHA will ensure that all information is accurate and all questions are answered fully as well as establishing direct links between the facilities and the SHA.

Local Counterparts:

1. *Ministry of Health Finance Department*
2. *State Health Agency*
3. *Facility Directors*

II. CONDUCT A BUDGETING AND ACCOUNTING EXERCISE (INCLUDING TAX OBLIGATIONS)

The most common concern conveyed during interviews was the lack of funding. Yet, nobody interviewed had participated in a budgeting exercise at the facility level to ascertain the actual cost of operations. Keeping the situation theoretical, it is easy for facilities, physicians, and the government to avoid transparency and accountability to the public.

A facility cannot determine how much funding it requires a priori and cannot plan its spending without a forecast. Budgeting and finance decisions should be based on data. In addition, running a facility requires financial management and planning in order to guarantee that there are enough funds for utilities, salaries, medicine, and equipment. The quality of services suffers when there is inadequate financial and resource management because there is no reliability or constancy. It allows some facility heads to claim that they never received funding from the government and therefore cannot provide state-ordered services for free. If operating month-to-month with sporadic and inconsistent resources, even well-intentioned facility managers will be unable to provide free, high-quality services.

Facilities would be greatly empowered if they were to participate in a budgeting exercise with Project NOVA. Decentralization efforts transformed head physicians into independent managers and medical facility administrators. The leap is not intuitive and it is reasonable to believe that there are major skills gaps that need to be filled in order 1) for the facilities to run efficiently, 2) for the facilities to understand the level of funding they require in order to operate effectively (including tax obligations), and 3) to obtain economic data on the actual costs of services reimbursed by the government in order to advocate for increased reimbursement rates.

Facilities may claim that they know how much money they require and they do not need assistance. In order to achieve “buy in” for this intervention, Project NOVA and the marz authorities should carefully select target facilities. For example, the facilities must be 1) willing, 2) selected as part of the initial selection process for participation in other NOVA-funded activities, and 3) accompanied by a memorandum of understanding between the Project and the facility clearly delineating the responsibilities of each party in the exercise.

The Project NOVA team should work with the facility(ies) to 1) calculate the facility’s fixed costs, 2) establish indirect rates (overhead, social security contributions, paid vacations – anything that the facility incurs that is not a direct cost), 3) estimate the revenue (including reimbursement) on a monthly basis, 4) determine what and how much revenue is guaranteed on a monthly basis, 5) determine the value the humanitarian aid (including medical supplies, medicine, etc. donated by charitable or donor organizations) that will eventually be the property of the facility, 6) estimate variable costs based on the previous year’s services and expenditures (assuming this data is available), 7) review the SHA reimbursement plan for the facility, 8) estimate tax obligations (and educate the facility on the tax obligations), 9) create an annual or quarterly budget and train the financial manager and the accountant on how to monitor and account against a budget and how to use the budget for forecasting. A budget should be considered a living document and should be directly linked to and monitored against the accounting practices of the facility. The Project NOVA team should strive to institutionalize budget formulation, forecasting, and accounting as a recurring process.

One facility head indicated that if she were to receive this type of intensive assistance and could really understand her resources (and felt comfortable that the facility could actually operate with the funds available legitimately), that she would be willing to institute a policy banning informal payments in

her facility. Even if Project NOVA were only to provide this type of extensive assistance to a single facility, it would be worth the investment in order to demonstrate, through an actual case study, that a facility can run legitimately and the physicians and nurses still receive the same salaries, the same services can be offered, and the same population served with quality care (within the existing resources). If the Project NOVA team find in the course of the budgeting and accounting exercise that, in fact, the facility could not run without accepting informal payments, then that information could be used for policy leverage to show through data that the current financing levels and service delivery expectations are not compatible and the system needs revisions. Either way, Project NOVA will have economic evidence to test the system and perhaps even obtain a success story that can be replicated.

Local Counterparts:

- 1. Facility Directors*
- 2. Tax Administration (for confirmation of tax obligations)*

III. INCREASE AWARENESS OF INACCURATE REPORTING

Facilities have to be aware of the consequences and impact “report fixing” has on their own facility as well as the Health Sector in general. The interviewees in the facilities revealed that there is a misunderstanding of the use of the reports prepared. For instance, one facility head indicated that her capitation/reimbursement plan included only 10 visits for children. She actually saw and treated 30 children, but only reported 10 because that was what she was entitled to for reimbursement. This simple example exposes so many of the problems the facilities are facing. In this situation, the facility did not report the extra 20 children. Therefore, there is no consideration for reimbursement – the facility now has a funding gap that has to be filled through either reallocating money from other line items, or more likely, informal payments. In addition, the next year’s reimbursement plan is drawn from the previous year’s performance and service delivery. Not reporting the additional 20 children means that the facility will have the same capitation/reimbursement plan the next year despite actually seeing additional patients. The report was “fixed” to match the plan so when the Ministry of Health/SHA reviews reports, it appears as if funding exactly matches service delivery so there is no need to increase or adjust resource allocation (both for that facility as well as in the national budget). Therefore, national programs and associated funding are based on inaccurate information.

Several NGOs and donor projects interviewed believe that the “report fixing” phenomenon is encouraged by the Ministry of Health and is linked to available funding. According to those interviewed, the Ministry of Health is likely to reject a report that exceeds the plan because it would implicitly mean that the facility is asking for additional reimbursement. There is also an element of misunderstanding. The facility that provided the example above legitimately did not think that it was allowed to report any additional cases. Other facilities indicated that they did report more cases in a separate report and those additional services would be considered at the end of the year for reimbursement if there was extra money. Fixing reports may make facilities look like they are efficient because they are “meeting plan,” but the practice actually has serious consequences for the health sector. In order to combat this problem, Project NOVA could do the following:

- As recommended above, have facilities attend seminars with the SHA that clearly outlines the reimbursement process, associated reports, and procedures.
- Create a “flow chart” and schedule for each facility that graphically and simply lays out the schedule and process.
- Include a section about reporting and report accuracy in the Management Handbook.
- In facilities receiving more intensive assistance, ask the facilities to collect data on the number of patients (and what type of patients and the service provided) for one month. Compare that data with the report submitted to the SHA. This type of “spot checking” can be used to show the facility with their own data the implications of the report. If the data matches, then the management team can explain the reimbursement process and how that report will feed into the

next year's plan. If the report is inaccurate, then the management team can explain the chain of events that a single inaccurate report can spur.

- If the Management team finds through its work at the facilities that report fixing is as prevalent as the anecdotes seem to reveal, then Project NOVA should initiate meetings with the Ministry of Health (including the SHA) to discuss the practice and the perceived problems associated with this behavior on the whole health sector.

Local Counterparts:

1. *Ministry of Health Finance Department*
2. *State Health Agency*
3. *Facility Directors*

IV. PROMOTE INTERNAL CONTROLS (INCLUDING MEDICAL SUPPLY INVENTORIES)

Internal controls can simply be described as separating responsibilities to increase transparency and accountability. For instance, a physician should not also be serving as the cashier. Internal control is a very effective anti-corruption tool because it makes it difficult for a single person to gain enough control to divert financial resources. The more people involved in completing an activity (ie: processing a patient from registration to payment), the more people who have to know about and agree to participate in something illegitimate. Internal controls alone will not stop corruption, particularly in the Armenian health sector where informal payments are the predominant sources of corruption. However, complicating corruption through internal controls is a necessary step to contributing to other systemic changes. Internal controls are also good management practices so do not need to be presented as anti-corruption measures, but rather management tools to improve efficiency (for example, keeping separate cashier and patients records facilitates audits, etc). At a minimum, the NOVA team should work with the facilities to put in place basic internal controls such as:

- Having patients sign-in at a reception desk (where a record or encounter form is created or obtained for them³⁷)
- Having a separate cashier with separate financial records
- Requiring that receipts be provided for all services rendered by the cashier (as a practice, not at the request of the patient)
- Having the medicines inventoried and either “checked out” by physicians or issued from a separate person responsible for maintaining the drug inventory
- Having an accountant and/or financial manager that is not the head physician³⁸

Other systems that should be taken into consideration are:

- **HR Systems:** such as supervisory structures, job descriptions (linked with pay scales), employment contracts (with termination clauses for poor performance, unethical behavior, etc), and a clarification of roles and responsibilities vis-à-vis marz and community officials and staff.³⁹
- **Accounting Procedures:** auditable accounting records must be maintained delineating state-ordered versus paid services, valued inventory of supplies and medicines; salaries paid in accordance with legislation; tax obligations understood and paid per legislation; BBP

³⁷ BBP 2005 Methodological Guidelines have already set up such a provision.

³⁸ This is a requirement of the Law on Accounting (the new law was adopted in December, 2002) unless the facility is too small (staff consisting of 1-2 persons) for having different people to perform these duties.

³⁹ Head Pediatricians, for example, have to report separately to the Marz Health Department not via the Head Physician.

reimbursement reports prepared and justified by account records; and assistance with financial management (with Head Physician and/or Finance Manger).

Local Counterparts:

1. Facility Directors

V. REINFORCE THE CONCEPT OF A CODE OF ETHICS

Ideally there would be a board of ethics for the health community. Establishing such a board is outside of the scope of Project NOVA; however, the Project can contribute to the idea of ethics in medicine by introducing the concept of a code of ethics to its beneficiary facilities. It would be a significant accomplishment if the Project NOVA team were able to work with several facilities (perhaps the facilities that will be receiving more intensive assistance from the project) to draft codes of ethics that will be issued for the facility, enforced by the Head Physician, and include disciplinary actions and termination clauses for violation. The code of ethics could be adapted over time and include increasingly more articles. The key is to ease the facilities into the idea of a code of ethics, get a simple code in place, and then provide guidance on, and rationale for, expanding the scope of the code. Project NOVA could include a code of ethics as part its human resource management initiative.

Draft codes of ethics are available from international literature and could be adapted to the Armenian context. It is recommended that the willingness of the facility to adopt a code of ethics (that they develop, not that is imposed) is part of the selection criteria for facility inclusion in Project NOVA assistance programs.

Local Counterparts:

1. Facility Directors

VI. INVITE UNDP ANTI-CORRUPTION INTO FACILITY(IES) TO USE THE 20 ANTI-CORRUPTION TOOLS

The UNDP “Supporting Civil Society in Anti-Corruption Initiatives” Project is creating 20 anti-corruption monitoring tools for the health sector. The project is utilizing the “Law on Freedom of Information” to access public institutions and use its tools to gauge corruption within the facilities. The project is not only seeking to catch corruption, but also to highlight exemplary institutions for good management and accountability to the public. It is recommended that Project NOVA notify the facilities with which it is working closely that after a certain period of assistance, the Project will invite the UNDP teams into the facilities to apply the tools. The idea, of course, is that Project NOVA will provide sufficient training and assistance to these facilities (ie: putting in codes of ethics, internal controls, etc) that the facility will have a “clean bill of performance” and can be highlighted as an example within the health community and in the media, which is part of the UNDP approach.

Project NOVA must approach this recommendation with care. As all public institutions are subject to review by the UNDP project, Project NOVA should promote partnership with UNDP monitoring groups as part of on-going work with the facility to strengthen transparency, trust and accountability, which will result in improved client interest in using services.

Local Counterparts:

1. Facility Directors

VII. WORK WITH POLICY PILLAR AND COMMUNITY PILLAR ON RECONCILING THE STATE ORDER(S) FOR MAINTENANCE OF FAPs WITH FUNDING

One of the policy recommendations is to reconcile the State Order for FAPs maintenance with government funding. Project NOVA will require the assistance of facility managers to gather the necessary data to formulate a policy approach. Specific assistance could include collecting data on the facility-level allocation for FAPs versus the cost of maintaining FAPs, reviewing facility budgets and government funding to determine how much money is being reserved for FAPs, documenting the facility manager’s interpretation of the State Order requiring the maintenance of FAPs in relation to

the funding allocated, and helping raise awareness of the facility managers on the need for FAPs and the required resources to adequately serve the population.

Local Counterparts:

1. Facility Directors

C. Increase Consumer Demand for RH/MCH Services through Community Education and Mobilization

I. DISSEMINATE THE BBP “FREE SERVICES” INFORMATION

It is recommended that the Project NOVA Health Action Groups (HAGs) help expand the current dissemination channels to the public on which medical services are free and to which portion of the population. The ASTP initiative to have a poster in each medical facility is a start and should be included in all of NOVA-assisted facilities; however, people have to be in the medical facility to see that information. That would assume that people are seeking care regardless of the price. A 2004 UNDP study found that members of the population who are aware of the free health services are more likely to use services and not pay informal payments.⁴⁰ The interviews and reviewed documents actually indicate that individuals, particularly in rural areas, do not seek medical attention beyond FAPs because they are afraid of the high cost of care. This phenomenon is leading to the deterioration of the health of the population and the increased need for specialized care and serious medical attention once the illnesses become severe. A wider distribution of the BBP service information in community centers, markets, churches, etc. combined with continued education of the public through the FAPs and community groups could contribute to increased utilization and heightened awareness. Project NOVA may consider creating a simplified version of the information in a graphic format (similar to the Entrepreneur Roadmap prepared by the USAID MEDI Project).

Local Counterparts:

1. Community Groups

2. Coordinate with USAID MEDI

II. PROMOTE BUDGET AWARENESS AND MONITORING

Government funding should be public information, however, based on interviews with the international community, facility heads, and nationals, government funding information is not readily available and is not provided upon request (at least not easily). There are numerous stories of individuals who are eligible for free services going to medical facilities only to be told that the facility did not receive money from the government for such services or that the facility has not been reimbursed by the government yet so the service cannot be offered for free. Not understanding the budget process, the patient is more likely to comply when asked for informal payment for the service. It cannot be assumed that rural populations care to know or understand the government budgeting procedures or funding flows; however, it would be immensely empowering and effective if Project NOVA could engage its Health Action groups to obtain the government budget numbers for the community facilities, work with facility managers (and lobby if necessary) to ensure that the community’s needs are met with these funds (i.e., FAPs are maintained), and serve as a receptacle for citizen complaints.

In a meeting with Ara Ter-Grigoryan, Director of the State Health Agency, he questioned the usefulness of making the government funding allocations public, but made a wager of sorts. He agreed to post the government funding allocations for each facility that Project NOVA is working with in the facility. However, because he does not believe it will make any difference to the public, he would monitor and report on the effectiveness of the exercise. This offer to list the funding by facility

⁴⁰ “Human Poverty and Pro-Poor Policy in Armenia”, UNDP/Government of Armenia, Yerevan, 2005

in the facilities is significant, but if Project NOVA is not prepared to work aggressively with the community groups to make the budget numbers useful and understood, then this offer should not be pursued at this time. Eventually budget allocations will need to play a role in community awareness and activism to make facilities and physicians accountable to the citizens and to combat the prevalence of informal payments. If the SHA posts the budget numbers now and reports that, in fact, there was no impact on citizen awareness, reduction in informal payments, and/or accountability, then all future initiatives in budget transparency will be crippled. Project NOVA could prepare a lobbying approach or policy recommendations to have the facilities required to post their Contract with SHA in a public place (eg: entrance hall) at the facility.

Local Counterparts:

- 1. Ministry of Health Finance Department*
- 2. State Health Agency*
- 3. Facility Directors*

III. COOPERATE AND COORDINATE WITH UNDP CIVIC GROUPS

The UNDP “Support to Civil Society in Anti-Corruption Initiatives” Project has created Civic Groups in 8 marzes and has plans for groups in all of the marzes. The Civic Groups are composed of community volunteers (selected on a competitive basis) with mixed backgrounds in finance, education, law, health, accounting, etc. These groups will carry out the monitoring of the UNDP program and implement the reviews of public institutions. Project NOVA should coordinate with these civic groups and leverage the activities of each to empower communities.

IV. ASSIST THE COMMUNITY ACTION GROUPS IN UNDERTAKING WATCHDOG FUNCTIONS

Project NOVA’s Health Action Groups could play a vital role in empowering civil society to demand accountability and transparency in rural health care. There are many activities that could be initiated depending on the interest and capacity of the HAG members. For example, as noted above, the Groups could monitor government funding to facilities in their areas and lobby to 1) ensure that the money is allocated as intended in the government budget, 2) that patients eligible for free services under the BBP receive them and are not rejected because the facility indicates that it did not receive government funding, 3) that national programs and funding address the community’s concerns and interests. In addition, the Groups could mediate between community members being asked to pay informal payments and facilities; publish stories about patients’ experiences (positive and negative) at facilities; and monitor and facilitate physician visits to the rural communities.

Local Counterparts:

- 1. Community Groups*

D. Improve RH/MCH Performance of Rural Health Facilities through Training & Equipment Provision

This component is focused on improving the clinical skills of the physicians and nurses. As such, there are limited recommendations for improving accountability and transparency.

I. CREATE AND PROVIDE TRAINING FOR PHYSICIANS AND NURSES ON ETHICAL BEHAVIOR

Training should cover the consequences (per the penal code) for criminal acts which currently do include bribe requesting and accepting, the difference between gifts and corruption, and methods for handling situations where physicians and nurses are either asked to partake in unethical behavior or witness unethical behavior, and where and how to report such incidences. As part of its work with the basic and retraining institutes for physicians and nurses on updating RH/MCH curricula, Project NOVA could develop training modules on ethical behavior.

Local Counterparts:

- 1. Facility Directors*
- 2. Universities*

ANNEX A: SCOPE OF WORK



Scope of Work

REPRODUCTIVE HEALTH SECTOR SYSTEM REVIEW

FEBRUARY -- MARCH 2005

Purpose

To conduct a system review detailing recommendations for how Project NOVA can address the issues of fiscal efficiency, transparency and accountability within its strategies and programs to improve access and quality of reproductive health/maternal and child health services in rural areas.

Background

USAID Armenia is committed to supporting the Government of Armenia's Anti-Corruption Strategy Paper. As such, USAID requires Project NOVA to address these issues in the reproductive healthcare sector. The project has outlined its strategies in addressing corruption in each of the four project areas (facility improvement, management and supervision, policy, and community partnership) through the best and final period of the contractual negotiations.

This assessment is envisioned to assist the project and USAID counterparts to more clearly articulate what actions within the sphere of anti-corruption are feasible and appropriate for the project to implement that will lead to the greatest impact on access and quality of care. A list of key questions to be addressed during the assessment is included as an attachment.

Proposed personnel	Specialty/Responsibility	Time requested
Alisa Pereira, EMG Consultant	Public financial management/public sector reform	Up to 25 days
Anna Benton, EMG Project Manager	Research and consultation on anti-corruption issues, assistance with writing of report.	Up to 4 days

Ms. Pereira will be paired with the Project Nova Health Systems Analyst once this person is hired, and will also work with Ms. Benton and EMG headquarters throughout the duration of the task.

Specific Tasks

1. Meet with Project NOVA staff to review scope of work, consultancy agenda and expected outcomes.
2. Identify and review a set of key source documents to better understand the environment for corruption within the health sector. Attached list of known documents. Others may be available.
3. Meet with USAID/Armenia representatives involved in the anti-corruption efforts to understand their cross-sectoral strategies and approaches to anti-corruption.
4. Hold informational meetings with key governmental and private sector organizations to clarify their perspectives, priorities and recommendations for strengthening the transparency and

customer-orientation of health care services. Attached is a list of individuals/agencies to interview.

5. Make site visits to selected PHC facilities to interview facility heads, providers and clients to determine their perspectives on the health system strengths and weaknesses (Lori and Tavush for minimum of 3 days).
6. Work with Project NOVA staff counterpart to summarize findings and make recommendations.
7. Prepare and make oral presentation to Project NOVA staff, and then to USAID and other key counterparts.

Outcomes

1. Assessment report that documents the major causes, consequences and nature of corruption within the health sector, with an emphasis on RH/MCH issues and outlines recommendations for Project NOVA to address them.
2. Presentation in Powerpoint given to USAID, Project NOVA staff and other key counterparts.

Key Resources (Known)

1. Government of Armenia anti-corruption strategy
2. The Poverty Reduction Strategy Paper, approved by Government of Armenia
3. USAID Strategy 2004-2008
4. Recommendations on How to Reduce informal Payments for medical Services in Armenia: ASTP, Report 86, August 2002
5. Corruption: From Cradle to Grave (Bars Media Documentary, 2004)
6. Lori Marz Community Assessment, August 2001, PRIME II
7. Recent World Bank assessment reports
8. Health Systems in Transition - Armenia, <http://www.euro.who.int/observatory>

List of Key Stakeholders to Interview

National Stakeholders

1. Ministry of Health Deputy Minister, MCH and PHC Department
2. State Health Agency
3. Lori and Tavush Marz Directors

International Agencies/Projects

4. World Bank, Susanna Hanrapetian
5. World Health Organization, Elizabeth Danielyan
6. Transparency International, Amalia Kostanyan
7. Center for Civic Dialogue Initiative (UNDP funded project)
8. OSCE, Chair of International Working Group
9. Armenia Legislation Strengthening Project (USAID)
10. Armenia Social Transition Project (PADCO/USAID)
11. Armenia Public Sector Reform Programme (PriceWaterHouse Coopers, DFID)
12. Oxfam (advocate for rural health care)
13. USAID, Karoly Okolicsanyi, EREO Economic Advisor (ext 4547)

National and Local Service Providers

14. Armenian American Wellness Center
15. Lori and Tavush rural PHC centers (heads, providers, clients)

Local Private Organizations

16. Association of Family Medicine
17. Nursing Association
18. Maternity Fund of Armenia, Susanna Aslanyan
19. Anna Consumer Rights Association, Melita Hakobyan, 520440
20. Drug Utilization Rights Group, Irina Ghazaryan, 237140
21. Investigative Journalists of Armenia hetq.am, Edik Bagdasaryan, 404624, 563149Onik Grigoryan; oneworld.am

ATTACHMENT A

Key questions to be addressed during the assessment include the following:

Problem Definition

- How does the money flow (in theory and in practice), from both the national budget (known value) and informal payments (estimated value), in the RH/MCH sector?
 - To what degree are different RH/MCH services vulnerable to corrupt practices (including tertiary level services: delivery, abortion; and primary health care (PHC) services: antenatal/postpartum care, infant care, family planning, STI treatment):
 - Reviewing the differences between services that are state-ordered (free) versus those that are fee-for-service
 - Reviewing differences between the costs of different services
 - The availability of different services at different levels of care
 - Understanding health care providers' perceptions/beliefs of the acceptability of corrupt practices.
 - How do health reforms (decentralization, privatization, contracting with SHA) contribute directly or indirectly to lack of accountability and transparency at the rural PHC level and how are rural PHC services differentially susceptible to corruption, looking specifically at dimensions of provider-patient relationships:
 - Informal payments
 - Absenteeism
 - Private practice in public facilities
 - Unnecessary referrals
 - Pocketing or misuse of official fees
 - Theft of drugs/supplies
 - Sale of drugs/supplies that are supposed to be free
- ...and relations/interactions with other levels of the system:
- State Health Agency (i.e. Reporting ghost patients, improper reporting, bribes to get funding)
 - Sanitary-Epidemiologists (vulnerability to excessive inspections)
 - Chief Specialists
 - Marz authorities
 - Communities
 - Facility licensing institution
- How does the current legal and regulatory environment adversely affect service delivery in terms of its vulnerabilities to corruption – looking at issues related to licensing, taxation, and sanitary inspections?
 - What existing anti-corruption activities in Armenia have proven effective and might be relevant (for expansion or collaboration) for the RH/MCH sector?

Proposed Solutions

- How might the project most effectively promote the best practices of accountability, transparency and efficiency given existing resources and project goals. Some best practices include:
 - Rigorous Internal Controls: Separation of duties, tiered approvals, whistleblower protections and supervisory oversight.
 - Sound Accounting Practices: Internationally accepted standard chart of accounts, policies and procedures, and reporting requirements.
 - Transparent Expenditure Management: Purchases and payments are well documented, within budget, and meet project goals and objectives.
 - Preparation for Audit: Staff is aware at all times of the requirements for compliance with future audits.
- What role, if any, might professional associations, national and local NGOs, and community structures play in corruption prevention, education and enforcement (Citizen Report Cards, hotlines, etc)?
- How might Project NOVA utilize interventions that focus on education of the health provider on government anti-corruption efforts or emphasis on code of ethics? How can project strategies and activities across the four focus areas be effectively integrated to promote the best practices as outlined above, the development of a code of ethics and enforcement mechanism for the code, etc?

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ANNEX D: INTERVIEW QUESTIONS

6 areas of vulnerability and corruption in the health sector / RH/MCH services	Provision of health services*	Education of health professionals	Medical research	Regulation of quality and product services facilities and professionals	Distribution and use of drugs and supplies in service delivery	Construction and rehabilitation of health facilities
Delivery						
Abortion						
Primary Health Care Services						
Antenatal / postpartum care						
Infant care						
Family planning						
STI treatment						

*Informal payments, absenteeism, ghost patients, unnecessary referrals, diversion of government budget, private practice in public facilities

Questions:

1. Where do you think that the RHMCH services are most vulnerable to corruption?
2. Which of these services under the basic benefits package are supposed to be free (state ordered) versus those which are fee for service?
3. In the fee for services what is the posted cost?
4. Where is the cost posted?
5. Despite the posted costs how much do they typically have to pay? For each of the services above (generally)?
6. How are clients notified about the additional costs? (examples in different levels of care, who do they pay, how many people (and who) do they have to pay)
7. Is there a difference between, in the categories above, between informal payments for free services or fee-for-service services?
8. What is the general perception about informal payments? What are the major impacts of informal payments on the poor (examples?)
9. Are people denied service if they do not provide the informal payment or is it just “less” service? Does it vary by physician to physician or is it so institutionalized that there is almost a price scale for informal payments (ie: X AMD for a c-section, etc).
10. Do people tend to not go to the physician because they do not have money?
11. What happens if a family does not have the money to pay the informal payments? (ie: no birth certificates, etc)
12. Do people know who are considered part of the vulnerable groups and/or do they know which services are supposed to be for free?

13. Does corruption occur in the rural areas in the same way as in urban areas or are the communities closer and therefore decrease the amt or frequency of informal payments? Is the perception that in rural areas (ie FAPs) that informal payments go to purchase supplies and supplement the BBP reimbursement vs going to the nurses, physicians, etc?
14. What do you think are the major root causes of corruption in the health sector? Low salaries? Slow reimbursement of SHA? Insufficient reimbursement of BBP? Tradition of gift giving?
15. How does this type of corruption affect the quality of care received by patients?
16. How do you believe providers view the practice of informal payments?
17. Are RH/MCH especially vulnerable to unnecessary referrals?
18. Do patients have to provide their own medicines? How do facilities receive medications and supplies? Do physicians tell patients where to get the drugs?
19. Does “patient hunting” primarily occur in hospitals or is it prevalent throughout the healthcare system?
20. The healthcare system has been decentralized. How did that occur? What legislation supports it? To what level has the decentralization taken place (ie: who is responsible for State Ordered Services? The marz, the facility, etc)?
21. What is the current status of health care facilities? Are they state-owned? Private? What does it really mean to be joint stock company but 100 percent owned by the government (what level of government)? Are rural facilities sometimes owned by the communities? If so, what does that mean and what kind of oversight does the “community” have?
22. Are medical staff civil servants? Who dictates their salaries?
23. Do all medical facilities receive a certain amount of money generally representing their population? How is that determined? Is there any reporting/auditing? How often is it recalculated? Can facilities bribe the census taker to increase the money by altering the findings?
24. How do medical facilities contract with SHA? Do they compete or is it blanket contracting? Is there any enforcement and/or reporting requirements?
25. Do you know of any examples where the SHA has not fully released funds to the facilities and/or they require payment to release the money? If so, what is the justification?
26. What is the relationship of the SHA to the MoH – is the head a Deputy Minister?
27. How is it determined how much money the SHA will handle out of the MoH budget? Or do they handle all of the MoH money?
28. Is there any tracking of these expenditures? It is considered government expenditure since it is government funding. Is there any type of reporting required by the facilities on services delivered?
29. Do you know of any cases where facilities create “ghost patients” in order to get reimbursed more money?
30. How was the BBP prices figured?
31. How does the SHA reimburse funds? Is it before the services or after services?
32. How many health facilities have been privatized? Approximately? What types of facilities?
33. What has the impact of the privatization been on RH/MCH? PHC?
34. Are most facilities a combination of fee for service (private), capitation, and BBP reimbursement? Are there any limitations on the fees that can be charged for “fee for service” or is it at the discretion of the facility?

35. Are most RH/MCH facilities public or partially public? Are they permitted to have private services in public facilities? If so, how do they separate supplies (ie: that were supposed to be used for BBP), account for these practices (financially), etc.
36. Do you think that decentralization, privatization and relations with the SHA make rural PHC more vulnerable to corruption or equal to urban facilities?
37. At the rural facility level, how many people are usually on staff?
38. What is the approximate size of the community these facilities would serve? Are there typically one or more facilities for each rural area?
39. Has there ever been any type of budgeting exercise to project what actual spending is required for the services/patients seen?
40. Are there any types of accounting systems in place (even pen and paper)?
41. Are there any internal controls?
42. Codes of Ethics?
43. HR Management Systems?
44. Audits (internal or external)?
45. Are supplies provided by the State, facility or patient?
46. When informal payments are paid in rural facilities, are they typically paid directly to the physician or also to the nurse? Is there any “check out” procedure where formal payments are made?
47. What role, if any, do the communities play in monitoring or tempering corruption in the rural health facilities? Or is it seen as supporting the local facility and therefore not corruption?
48. Do you think that these rural facilities are more vulnerable to State-imposed corruption (ie: bribes to the SHA, etc) because of their inability or lack of experience in working the system? (ie: keeping track of the patients they see, inventorying the supplies, etc)?
49. Are there occurrences of physicians stealing publicly provided supplies to use on private services? (misuse of government funding or supplied equipment)?
50. Are the rural PHC level services susceptible to excessive Sanitary-Epidemiologist inspections? If so, how do they handle these inspections? What body governs the Sanitary Epidemiologist inspections? What happens if they find a facility in violation of sanitary standards?
51. To what degree are the Marz level authorities involved in overseeing health service provision? Do requests for reimbursement go through the Marz or directly to the SHA? If it goes through the Marz, is there any direct connection btw the facility and the SHA?
52. Does the capitation funding come from the SHA, national, or Marz level budget?
53. Who licenses the facilities? What are the vulnerabilities to corruption in this area?
54. In PHC facilities, is there the assumption that the Chief Specialist will receive a portion of all of the informal payments received by the physicians and nurses? If so, how is the ration determined? What are the consequences for not providing enough payments?
55. In rural facilities with only one physician and a nurse, is there any arrangement where they would have to pay a portion of the money received to a higher level facility, community level leader, Marz official, etc. or is it confined to the facility?
56. How is the national budget derived? Is there budgeting at the Ministry level? At the spending unit level? At the facility level?
57. Is the national budget published in a public gazette? To what level?

58. Is the money controlled through a Treasury in the Ministry of Finance? Is money released on a monthly, quarterly, etc basis? Based on what? Reporting? Revenue generated? Or a simple division of the total budget divided by 12 months?
59. Is the money released by line item requiring reports on each line item?
60. Is there a supreme audit institution?
61. How much control does the Minister of Finance and line Ministers have to move money between line items once the government has approved the budget?
62. Does the MoH have the SHA handle all financing or just for service provision?
63. With decentralization, does the money for everything except BBP go to the Marz to be allocated from there? If so, are there reporting requirements?
64. Is the release of the money from the Marz then dependent on revenue generation or is the money allocated for capitation, etc. compulsory? By what law, decree, etc?
65. What is the general flow of money from the government approved budget down to the facility and then what reporting, auditing, etc. is required to support the financing?
66. How does the current legal and regulatory environment make service delivery more susceptible to corruption?
 - a. Taxes – profit tax, property tax, etc
 - b. Licensing – facilities, medical staff, etc
 - c. Sanitary Inspections
67. What anti-corruption activities have taken place in Armenia that have proven successful and could be relevant for NOVA?
68. What do you see the role of the communities, associations, and NGOs play in corruption prevention, education and enforcement? Whistleblower hotlines, citizen report cards, external controls?
69. Did PriceWaterhouse or ASTP create code of ethics?

ANNEX E: LIST OF INTERVIEWEES

Person's name	Title	Organization
Vahan Poghosyan	Head of the Organization of Medical Care Department	MOH
Karine Saribekyan	Head of the Maternity and Child Care Division	MOH
Ara Ter-Grigoryan	Director	State Health Agency
Greta Mirzoyan	Coordinator of the Health Sector Anticorruption Working Group	Anticorruption Commission
Marianna Stepanyan	Expert	Anticorruption Strategy Implementation Monitoring Commission
Robert Dilbaryan	Head of Health Department	Lori Marzpetaran
	Providers, nurses, midwives	Lori Marz FAPs
	Providers, nurses, midwives	Tavush Marz
Karoly Okolicsanyi	EREO Economic Advisor	USAID
Eleanore Valentine	Program Director	Armenia Legislation Strengthening Project, USAID
Tatyana Makarova	Health Team Leader	Armenia Social Transition Project, USAID
Brian Potter	Primary Health Care Advisor	Armenia Social Transition Project, USAID
Elizabeth Danielyan	WHO Liaison Officer	World Health Organization
Vahan Asatryan	Program Director	Center for Civic Dialogue Initiative (UNDP funded project)
Steven J. Avalyan Newton	Team Leader	Armenia Public Sector Reform Programme, PriceWaterHouse Coopers, DFID
Margarita Hakobyan	Program Manager	Oxfam
Hasmik Davtyan	Deputy Director	Armenian American Wellness Center
Susanna Aslanyan	Chairman	Maternity Fund of Armenia
Melita Hakobyan	Chairman	Consumer Rights Association

ANNEX F: DONOR ANTI-CORRUPTION ACTIVITIES IN ARMENIA

UNDP “Supporting Civil Society in Anti-Corruption Initiatives” Project

The Project developed an Anti-corruption Participatory Monitoring Methodology (APMM) for the health and education sectors. It established Civil Society Anti-corruption community groups and sectorial anti-corruption consultative groups in 8 regions of the country. The Project is creating 20 anti-corruption monitoring tools for the health sector, five are in draft form and the remaining 15 will be developed this year. The drafted tools include topics such as 1) the sale of drugs that are supposed to be free, 2) drug distribution (including humanitarian aid), 3) free services (are they being provided for free to the right individuals),⁴¹ 4) facility funding.⁴² The project is utilizing the “Law on Freedom of Information” to access public institutions and use its tools to gauge corruption within the facilities. The project is not only seeking to catch corruption, but also to highlight exemplary institutions for good management and accountability to the public. The Project has established a close partnership with the media. While the Project itself does not have any enforcement capability, it notifies the media of its findings and the media can opt to cover the case and report on it directly. If the media covers a story on corruption in a specific institution, that can trigger the public prosecutor to launch a criminal investigation.

DFID Armenia Public Sector Reform Program

The Program seeks to improve the efficiency, effectiveness, accountability, transparency, and responsiveness of the public administration. Specifically, the Program focuses on four components:

- Rationalizing and re-organizing organizational structures
- Increasing accountability, independence and effectiveness of the civil service
- Increased access to information for the citizens (including citizen monitoring of government plans)
- Assistance to the Government to coordinate donor support and implement the anti-corruption strategy⁴³

The Program is assisting three ministries, Health, Labour and Social Issues, and Education and Science to restructure and reorganize to provide better service delivery. The ministries just approved the reorganization plans, which are not public documents at this time.

⁴¹ The Project team indicated that the “free service” problem goes both ways. There is the issue of vulnerable groups or eligible groups not getting free services as well as non-vulnerable individuals paying bribes to receive eligibility status in order to obtain subsidized or free services.

⁴² The facility funding tool will focus on facility claims that they have not received government reimbursement and are not guaranteed to receive it and as such cannot provide BBP services for free.

⁴³ DFID, PriceWaterhouseCoopers, “Armenia Public Sector Reform Programme,” activity leaflet. 2004.