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Twinning Fiche

Project title: Support to implementation of Universal Health Insurance Reform in Armenia

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EU funded project

TWINNING TOOL

Contents

Acronyms

AMD	Armenian Dram
CEPA	Comprehensive Enhanced Partnership Agreement
EAP	Eastern Partnership
EIP	Economic and Investment Plan
EUD	Delegation of the European Union
GoA	Government of Armenia
GDP	Gross Domestic Product
MoH	Ministry of Heath
NCD	Non-communicable diseases
NDICI	Neighbourhood, Development and International Cooperation Instrument
PHC	Primary Health Care
PL	Project Leader
RTA	Resident Twinning Adviser
SDG	Sustainable Development Goals
SHA	State Health Agency
SOP	Standard Operations Procedures
UHC	Universal Health Coverage
UHIF	Universal Health Insurance Fund
WHO	World Health Organisation

1. Basic Information

1.1 Programme:

Annual action plan in favour of the Republic of Armenia for 2023, Reform and CEPA implementation facility, reference: NDICI-GEO-NEAR/2023/ACT-62369, financed under the Neighbourhood, Development and International Cooperation Instrument (NDICI-Global Europe).

1.2 Twinning Sector: HEALTH and CONSUMER PROTECTION (HE)

1.3 EU funded budget: *1 500 000,00 €*

1.4 Sustainable Development Goals (SDGs): this project contributes to Sustainable Development Goal 3 "to *"ensure healthy lives and promoting well-being for all at all ages"*. The associated targets aim to reduce the global maternal mortality ratio; end preventable deaths of newborns and children; end the epidemics of AIDS, tuberculosis, malaria and other communicable diseases; reduce mortality from non-communicable diseases; strengthen the prevention and treatment of substance abuse; halve the number of deaths and injuries from road traffic accidents; ensure universal access to sexual and reproductive health-care services; **achieve universal health coverage;** and reduce the number of deaths and illnesses from hazardous chemicals and pollution.

2. Objectives

2.1 Overall Objective(s):

The overall objective is to enhance the capacity of the Government of Armenia to implement Universal Health Insurance reform to provide all Armenian citizens with access to essential healthcare services.

2.2 Specific objective:

The specific objective is to strengthen the capacity of the Government of Armenia, in particular Ministry of Health of the Republic of Armenia ("MoH") in its reform of the healthcare system with the introduction of universal healthcare coverage mechanism and the establishment of a new structure required for implementation of the reform – a functioning Universal Health Insurance Fund (UHIF).

2.3 Elements targeted in strategic documents.

The EU-Armenia Comprehensive and Enhanced Partnership Agreement (CEPA), signed in 2017 and entered into force in 2021 provides a frame for cooperation in the areas of mutual interest, in particular in political, economic and social fields. The agreement highlights the need to promote health-in-all-policies and implementation of international health agreements and regulations (WHO namely).

The Government of the Republic of Armenia and the Ministry of Health have initiated a comprehensive healthcare system reform process committed to Universal Health Coverage and health as a human right.

The project is in line with the ongoing implementation of the Economic and Investment Plan for the Eastern Partnership (EaP) and its flagships for Armenia– a tool for advancing the recovery, resilience and reform agenda and enhancing CEPA implementation.

The EU cooperates with Armenia in the framework of the European Neighbourhood Policy and its eastern regional dimension, the Eastern Partnership, which supports the delivery of many global policy objectives, including the Paris Agreement on Climate Change and the UN 2030 Agenda and its Sustainable Development Goals. It contributes to the overall goal of increasing the stability, prosperity, and resilience of the EU's neighbours as set out in the Global Strategy for the foreign and security policy of the European Union.

3. Description

3.1 Background and justification:

The Concept of introduction of universal health insurance (hereinafter referred to as the UHI) was developed for the implementation of the activity set forth in Section 4.3 of Annex N 1 to Decision N 65-A, dated 8 February 2019, of the Government of the Republic of Armenia and point 1.1 of "Ministry of Health" section of Annex 1 to Decision N 1902-L, dated 18 November 2021, of the Government of the Republic of Armenia. UHI is an independent state-guaranteed system in the field of healthcare for the protection of population health, which provides compensation for the costs of disease prevention, treatment and routine control.

UHI system guarantees equal opportunities for the insured to receive high-quality medical care. UHI will be implemented on the principle of a single buyer/payer, through a Fund - a structure established by the state (hereinafter referred to as the Fund or UHIF), which must ensure the efficiency of calculating and spending the funds necessary for the health care expenses of the insured. The main goal of the introduction of UHI is to ensure financial access to basic health care services for all population groups and to improve the quality of medical care.

Accomplishment of the main goal of the introduction of UHI will contribute to the improvement of morbidity and mortality rates, increase of the average life expectancy, decrease of the number of persons with disabilities due to health problems, sustainable development of human capital and growth of the economy.

Current Situation and Challenges

International comparisons of the assessment of Armenia's healthcare financing system and observations regarding cost-effective programs show that increase in state funding leads to the improvement of the relevant capacities for its distribution and provision of

medical services, which is expressed in the form of non-financial indicators: increase in average life expectancy, decrease in maternal and infant mortality rates (Table 1).

Table 1: Dynamics of individual health indicators

#	**Health indicator**	**1998**	**2008**	**2021**
1	**Life expectancy at birth, of which**	**71.5**	**73.8**	**73.5**
1.1	*Men*	*69.1*	*70.0*	*68.4*
1.2	*Women*	*75.2*	*76.3*	*78.6*
2	Infant mortality rate per 1,000 live births	14.7	10.8	6.91
3	Under-5 mortality rate (per 1,000 live births)	18.4	12.1	8.7
4	Maternal mortality rate (per 100,000 live births)	38.8	23	22.0
5	Budgetary healthcare expenditures in state expenditures, %	6.4	6.1	5.4
6	Public healthcare expenditures in GDP, %	1,6	1,5	1,4
7	Private healthcare expenditures in GDP, %		2,5	7,8

However, when we look at the sources that finances the above mentioned indicators, it is noticeable that Armenia has low state funding compared to many countries in Europe and Central Asia, providing over the last 25 years 5.4% of the expenditures of the healthcare sector's consolidated budget, or about 1.4% of GDP, which is at least 4 times less than the average government healthcare expenditures of the countries in the same income group as Armenia.

Inadequate funding has led to fragmentation of the service delivery system, compensation being lower than actual costs and lack of specialised medical staff in the regions. For financial reasons 12,6% of the non-poor population, 24,5% of the poor and 49% of the extremely poor do not visit a PHC doctor. Lack of public funds for healthcare and the uncontrollability of out-of-pocket payments hinder the development of the system and improvement of the quality of medical care and service, contribute to the impoverishment of many families due to high healthcare costs, and hinder the improvement of access to medical care and service and financial affordability. With the indicator of spending over 10% of household income on healthcare (16.1%), Armenia exceeds the average global (12.7%) and regional (7.4%) indicators.

Strategy for the Introduction of UHI

The step-by-step increase in the level of financial protection of the population in accordance with the forecasted fiscal capacities is a primary goal for the introduction of UHI. In addition to increasing the level of financial protection, introduction of UHI also

aims to eliminate the fragmentation currently existing in state-funded programs, as well as to give compensations at prices calculated on the basis of normative costs, thereby ensuring appropriate standards of medical care quality.

Ensuring smooth introduction of UHI requires testing the functions and capacities of the insurance Fund, recruitment of specialised personnel, training, development and testing of information systems. At the same time, measures to improve the quality of primary health care, information systems, medical care, and the development of healthcare infrastructures initiated by the Ministry of Health will contribute to the effective introduction of UHI.

Description of Universal Health Insurance

Population

In the first, preparation phase of the introduction of UHI, the population groups to be included in UHI at each phase will be approved, their databases will be prepared, their identification with other databases will be carried out, as well as issuance of electronic insurance policies will be conducted.

During the 1st year of the phased introduction of UHI, the population groups defined by the state will be included in UHI, including members of the families included in the benefit system with 28.01 or more points, persons with disabilities, children under 18 years of age, socially disadvantaged and other persons included in special groups of population, beneficiaries included in the social package. During the 2nd year of the phased implementation, citizens aged 63 and older, as well as public sector employees, will join the population groups defined by the state. In the last year of the piloting phase, in 2026, all hired workers, self-employed persons and those employed in agriculture will have the opportunity to join UHI.

It is planned that in the final - implementation phase of UHI introduction, all the citizens of Armenia or their overwhelming majority (95% or more) will have the same package of services.

Depending on the fiscal capacities, the volume of state budget allocations and the actual annual indicators of the piloting phase, the number of inclusion of population groups in the piloting phase may be modified.

Table 2. Projected indicators of population inclusion by UHI implementation phases

	Population group	**No of beneficiaries by 2019 data**	**Preparation phase**	**Implementation phases**			**Final expected coverage**
			2023-2025	**2026**	**2027**	**2028**	**2029**
	Total	2,962,000	Statutory establishment of population groups and	1,364,282	1,722,366	2,307,068	2,868,488
1	Persons with disabilities	191,959		191,959	191,959	191,959	191,959

2	Persons aged 18 and older included in socially disadvantaged and special groups	489,924	their state co-funding amounts, formation of the register of insured persons, issuance of electronic policies	489,924	489,924	489,924	489,924
3	Employed population and self-employed persons, **of which**	641,802		120,000	269,900	641,802	641,802
3.1	*Employees of public sector, **including***	*269,900*			269,900	269,900	269,900
3.1.1	*Social package beneficiaries*	*120,000*		120,000	120,000	120,000	120,000
4	Pensioners (63 year and older)	208,184			208,184	208,184	208,184
5	Students	70,327					70,327
6	Unemployed persons	62,119					62,119
7	Job hunters	28,974					28,974
8	Children (0-18 year)	562,399		562,399	562,399	562,399	562,399
9	Persons employed in agricultural farms	212,800				212,800	212,800
10	Other population groups	493,512					400,000

Services

In the preparation phase of UHI introduction, the basic benefits and minimum service packages will be formed. The basic benefits package will be available in the piloting phase for the population set forth by the state.

As a result of UHI introduction, all insured citizens will have the same coverage, regardless of their ability to pay and social status, which will differ only in terms of age and gender-specific compensations. Voluntary health insurance will be in place in addition to the basic benefits and minimum service packages for insured and uninsured persons and will include services not included therein.

Costs

Coverage costs will include the compensation amounts for basic benefits and minimum service packages and risk supplements. The costs of UHI management will be calculated separately, taking into account the mandatory conditions for ensuring the implementation of the functions necessary for UHI management by means of professional specialists, modern technical and information technologies, planning for those expenses in the amount of no more than 2% of the total costs of coverage.

Calculation of the costs necessary to ensure the coverage (hereinafter referred to as the Coverage costs) will be carried out by the Ministry of Health in the preparation phase of UHI introduction, based on the methodology agreed with the Ministry of Finance. Calculation of the Coverage costs for each year will be carried out based on the scope of compensation of the basic benefits and minimum service packages of the previous period,

the predicted changes in the prices of the services compensated within the framework of the basic benefits and minimum service packages and the predicted changes in the terms of their compensation, the predicted changes in the gender-age structure and uptake by the beneficiaries, the factors as a result of changes in the healthcare policy that can affect the structure of the basic benefits and minimum service packages, the prices of services and conditions of their compensation, as well as on the predicted indicators of uptake by the beneficiaries.

Financial Resources for UHI

Financial resources required will generate from two main sources: the state budget and the insurance premiums. Funds from the state budget will be allocated on the principle of co-financing to cover the coverage costs, taking into consideration the social and health risks of the beneficiaries.

In the preparation phase of UHI introduction, the amount of co-financing of the coverage costs from the state budget will be determined according to the phases of introduction, as well as the periodicity of the allocation of these amounts, taking into account the fiscal area. At this phase, the costs of establishing the Universal Health Insurance Fund (UHIF) will also be realised.

Table 3. Projected benchmark amounts of financial resources required for UHI phasal introduction, billion AMD

	Preparation	*Piloting*			*Implementation*
	2023	**2026**	**2027**	**2028**	**2029**
Total, of which	*1.5*	*185,0*	*235,0*	*305,0*	*370,0*
State budget (partial and full subsidy)	*1.5*	*175,0*	*220,0*	*270,0*	*Target GDP 4 %*
Insurance premium		*Depending on the number of people joining*	*Depending on the number of people joining*	*Depending on the number of people joining*	*Depending on the proportion of subsidy*

The amounts presented in Table 3 are calculated based on the actuarial calculations made on the basis of the 2019 database and can be changed as per the introduction phases, in view of the risks caused by inflation, uptake and other factors, as well as the amount of coverage management costs. The expenditure of 1.5 billion AMD planned for 2023 includes the capital and operational costs for the establishment of the UHIF. During UHI introduction, the Government can channel the increases of the salaries, pensions, benefits and other monetary payments of beneficiaries paid in full from the state budget to the insurance premium payment. In addition, from the beginning of the piloting phase of UHI introduction - starting from 2024, beneficiaries of the social package of state institutions and organizations and other employees will be given the opportunity to redirect the amount of the social package as an insurance premium. The timelines, periodicity, procedure and conditions of information exchange for fundraising will be established by

law. Specifics of contributions by the citizens for co-funding will be established by the decisions of the Management Board of the UHIF.

Before the final implementation of UHI, management of the reserve fund will be carried out on a special treasury account. After the full introduction of UHI, management of the reserve fund can be transferred to pension funds. Contributions from the state budget will be collected on a monthly basis, based on the lists of beneficiaries formed in accordance with the amounts of the state co-financing. Participants will transfer their premiums through their employers or independently, depending on the beneficiary's status at the time of transfer.

Management

For the management of UHI, a universal health insurance fund (hereinafter referred to as the UHIF) will be established.

The Fund will have a Management Board, which will make key decisions. For effective decision-making during the management of the Fund, and for ensuring their participatory and transparent nature, two committees of strategic procurement and performance control will operate adjunct to the Management Board. Board members will serve in a voluntary capacity. Members of the Government, members of organisations representing the interests of employers, employees, consumers and the professional health sector may be involved in the Management Board with equal representation (50 percent participation per the Government and the other representatives). The committee's adjunct to the Management Board will have representatives from unions representing medical organisations, non-governmental organisations, and specialised associations. The composition of the Management Board will be appointed by the Prime Minister for a period of 1 to 3 years, and the Minister of Health, ex officio, will be appointed as the Chairman of the Management Board (the structure of the Fund is presented in Annex 4).

For the purpose of service procurement, the criteria and procedure for the selection of medical organisations shall be established by the Board of the Fund and should be the cornerstones that will ensure the financial sustainability of the Fund, the realisation of the goals of introducing the insurance, and the performance of the functions specific of a strategic buyer.

The principle of selective contracting should be applied not only to medical organisations, but also to the lists of services to be procured from these medical organisations, based on clearly defined criteria and a transparent process and should ensure physical (spatial) availability of services for the population and an appropriate level of quality.

The staff of the Fund should have the functions of monitoring the conditions of drawing up and executing contracts with representatives of medical organisations. Monitoring should be conducted through appropriate analyses on the basis of data obtained from medical organisations or surveys on the capacities of medical organizations, quality of medical care and service, financial discipline, patient opinions.

The use of contract amount is an important tool for efficient spending of financial resources, but its use should be very flexible, should not foresee constant amendments to the contracts due to changes in the contract amount, also should take into account evaluation of indicators characterising the quality of medical care and service.

The Fund is planned to use developed pricing tools to estimate the volumes of drugs and medical products used and potential costs. The Fund will use these tools when negotiating with local manufacturers and importers to agree on service prices, and the possibility of centralized procurement of drugs and medical products can be used as a tool in negotiations with domestic manufacturers and importers. Distribution of humanitarian and charitable goods and their subsequent expense recording must be agreed with the Fund. The Fund can also act as a joint programme implementer with the MoH.

Payments

By Law regulatory documents on payments will be developed in the preparation phase of UHI introduction. In the preparation phase, the amounts of stabilisation/reserve funds for UHI will be determined.

Payment mechanisms are important for the effectiveness of the introduction of UHI. The principle of mixed payment mechanism will be applied for the payment of the essential services included in the insurance packages.

In case of chronic diseases in outpatient settings, compensation for drugs will be carried out on the basis of prescriptions, by submitting a public offer on the maximum reimbursable size of drugs defined by the Fund for drugs included in the List of Essential Medicines and subject to compensation, which can be joined by any organisation operating in the area and having a relevant license. In case of chronic diseases in outpatient settings, when purchasing drugs at a price higher than the maximum reimbursable size set by the Fund, the principle of surcharge will apply and the citizen will pay the difference between the approved maximum reimbursable size and the selling price. In order to compile the list of drugs to be reimbursed, a review and assessment of the List of Essential Medicines, as well as evaluation of its effectiveness based on the structure of the main diseases and groups of beneficiaries will be carried out.

The prices of medical care and service calculated on the basis of the new methodology approved by the MoH will be used for payment. Moreover, the normative costs underlying the calculation of service prices, in terms of drugs and MP, laboratory-instrumental examinations, surgical interventions, professional consultation provided during diagnosis and treatment, should be the minimum technical standards of service provision. In the preparation phase, the minimum salary thresholds of the medical staff will be established by specialties. Establishing the amounts of overhead costs is also important. The Fund should also publish the minimum technical conditions, including preconditions for laboratory-instrumental examinations also.

For significant as well as periodic violations of the conditions provided for in the contract, measures of liability will be established for both medical organisations and healthcare professionals, up to termination of the contract or application to the MoH to revoke the license. The technical standards and normative costs of payment will be combined with the service quality requirements.

Financial Sustainability of UHI

Starting from the piloting phase of UHI introduction, the Government will ensure a gradual increase of the financial resources allocated from the state budget, ensuring at least 15% of the state budget expenditures or a minimum of 4% share of GDP for the year of the final implementation of UHI (2027) and the following years. The financial flows of the Fund will be ensured on a monthly basis, at the expense of the state budget, through transfers to the Fund's treasury account.

The Government will deliberate the draft annual budget of the Fund at the level of the main financial indicators, such as planned income and expenditures, projected deficit or surplus, proportion of administrative expenses, etc., and will present it to the National Assembly for approval as an integral part of the state budget. The Fund, for each fiscal year, based on the methodology approved by the Government's decision, will calculate the amount of co-financing and Coverage costs per beneficiary, compare it with the planned revenues and submit recommendations to the Board of the UHI Fund regarding the sources of filling the deficit or the directions of spending the surplus. The Fund will also present mid-term and long-term cost and income estimates. During each year of introduction, starting from the third quarter, the Fund must present to the Board the financial indicators of the current year, the amount of surplus or deficit, as well as recommendations on the expansion of the package of services or the implementation of restrictions.

For each year, the executive director of the UHI Fund will calculate the administrative costs of the Fund and submit it to the Management Board for approval. Introduction of insurance can be seen by medical organisations as a source of attracting additional funds by providing unnecessary services and receiving compensation for them. This phenomenon is known as bad faith risk. In order to mitigate such risks, compensation mechanisms should be applied, which will limit the provision of unnecessary services to the insured by medical organisations. On the other hand, incentive mechanisms will be applied for the beneficiaries for little consumption of services. Mechanisms for activation of the package will also be applied for mandatory preventive exams, as well as mandatory conditions for ensuring their dynamic control in case of chronic diseases. The emerging restrictions related to the introduced clinical guidelines, protocols and cost norms should contribute to the improvement of the quality and availability of medical care and service and should not have a nature of subjective, expert level or purely financial limitation. For the purpose of mitigating such risks, limitations on the amount of compensation for some services and some groups of the population can be effective. Besides, at least in the initial period of UHI introduction, the principle of applying the maximum contractual amount

of compensation for the services provided by medical organizations will be applied, which will be combined with the mechanisms of quality evaluation indicators and routine analysis of performance and will be a mechanism of restraining the temptation to provide unnecessary services.

It is projected that at the beginning of the introduction of UHI, in 1-2 years, an increase in the volume of services is possible, due to the increase in the number of beneficiaries who previously had certain health problems but failed to consult a doctor. Therefore, when calculating the insurance premiums, the potential risk of increased uptake should be taken into consideration.

Accountability, Monitoring and Oversight

UHI will provide an opportunity to ensure receipt of comparable data on the provision of medical care and service and compensation, which will serve as a basis for the transparent implementation of the insurance process. In that regard, standard formats of reports containing financial and non-financial data should be approved:

1) for external users: Government, Prime Minister, National Assembly;
2) for UHI management: the Fund's Management Board;
3) for internal use: structural divisions of the Fund;
4) public reports.

The reports should include all the indicators that can reflect the realisation of the short-term goals of UHI, as well as evaluate the results of the measures implemented during that time.

Monitoring implementation regulations should be developed, lists of necessary data should be drawn up, which should be combined for the purpose of control of the services.

For the purpose of identification of the insured persons, the lists of databases submitted to the Fund by various agencies, the frequency and format of their submission will be established by law or Government decisions.

The structure of the Fund will include an internal audit unit, which members will be appointed directly by the Board. That unit, along with other functions, will also be responsible for monitoring the performance of contracts signed by the structure with medical organisations, and will regularly report to the Board on the results.

The Fund will undergo an external audit. The Audit Chamber will conduct budget performance evaluations, and the financial audit of the Fund will be conducted by a reputable international auditing organisation.

The Fund will regularly, at least on a three-year basis, present information on the goal of UHI introduction and the results presented in the set of result indicators of the activities, which will serve as a basis for the evaluation of the UHIF's activity.

The conditions for the introduction of UHI are directly related to the implementation of the main functions of healthcare. Therefore, it is expected that the MoH will implement the activities that ensure the conditions for the introduction of UHI within the timelines set forth for their implementation.

From that perspective, great importance is attached to consistent implementation of PHC reforms, health care quality improvement, health information system development strategies, and infrastructure development programmes already approved by the MoH.

3.2 Ongoing reforms:

Since 2021, several measures and actions related to the modernisation of healthcare have been implemented in line with CEPA Chapter 16 Healthcare (articles 91 and 92) and with WHO regulations. Health is a cross-cutting issue and is mentioned in labour and social protection, environment, education, or civil protection chapters of CEPA.

The CEPA roadmap, which is the leading document of the Government of Armenia to implement reforms lists as priority actions: fight against cancer, cross-border threats to health, modernisation of laboratories, vaccination, promotion of a healthy lifestyle (including measures against tobacco consumption, modernisation of nursing, prevention on non-communicable diseases, mental health and primary healthcare. This goes with an extensive programme of training of health professionals and modernisation of infrastructures.

Reduction and prevention of health damage by tobacco laws and by-laws entered into force mostly in 2021. The development of nursing work was adopted in 2022 through a strategy to be implemented until 2026. In 2022, the action plan for mental health maintenance was drafted, including children's mental health. In 2023, a few new strategies for the period 2023-2026 were adopted on Health System, Laboratory systems, antimicrobial drug resistance control, and revised Public Health security.

The Primary Health Care reform which is an important step for the efficiency of universal coverage has shown some progress with the upgrading of health professionals (physicians, paediatricians, nurses, etc.) and on staffing regional health facilities (MoH order dated September 2023).

Some progress is also noted in the management and care of certain diseases (non-communicable diseases -NCDs) like cancer (new register of patients started in September 2023), breast cancer-free scanning and palliative care (which is operational for paediatric care and half implemented for adults. Standards for cardiovascular diseases, chronic obstructive pulmonary disease, laboratories, or infectious diseases have been deployed but not yet fully implemented. A decree for smallpox vaccination has been approved in November 2023 and will be implemented in 2024 through the training of health workers, procurement, and vaccination guidelines. Another major regulation is the one concerning

the quality of drinking water as of EU directive 2020/2184 which has been covered by MoH order in November 2023.

The E-Health platform has been implemented in 2017 but is not yet fully operational.

The strategy for Health System Development 2023-2026 (GoA decision N 174-L of 9 February 2023) addresses the health of each individual from birth maintenance, disease prevention, treatment, medical service -provision and access, quality of life and well-being to the questions. The strategy promotes existing public health care improving mechanisms, processes, relationships by developing and reforming them.

Universal Health Coverage and Strengthening of the Primary Health Care system are at the centre of the health reform agenda coupled with the implementation of cross-cutting strategies on quality of care and e-health as stipulated in the 2021-2026 Action Plan of the Armenian Government.

The introduction of the Universal Health Insurance system in Armenia by 2027 was approved by Decision #133-L on 02 February 2023. The law is accompanied by a conceptual document on UHI as well as a detailed List of Activities for Phased Introduction of Universal Health Insurance for 2026-2028. It is foreseen that a special Universal Health Insurance Fund (UHIF) will be established, following international best practices. The Charter of the Universal Health Insurance Fund was drafted. It contains a description of the principles on which the Universal Health Insurance is based. It is annexed to this fiche as annex 2. The draft law establishing the UHI system as well as the UHC Fund. The draft law is annexed to this fiche as annex 3.

Justification

Since 1998, the main model of healthcare financing in Armenia was implemented by the state healthcare agency (SHA). Back then, that agency was formed with the aim of becoming a mandatory medical insurance fund. The functions of SHA, the relations with healthcare providers, the information system were built with the logic of being ready for the introduction of insurance. However, over time, the mandatory medical insurance system was not introduced, and the state order system is still in place. In the course of time, the functions of the SHA were somewhat limited, as it became a division of the Ministry of Health. However, the functions of SHA, in terms of concluding contracts with medical organizations, accepting reports, and subjecting them to expertise, continue to this day.

The implementation of the UHIF is planned to be phase-by-phase. In other words, it is anticipated that starting from 1st January 2026, more than 50% of the total population will be insured, in 2027 this number will reach 70% of the population, in 2028 - 86%. and from 2029 it is planned that more than 90% of the population will be insured. At the same time, it should be taken into account that although the number of the insured population

increases year by year, the insurance model should start working from the first year. That is, all the functions that are assigned to the Fund, must be implemented starting from the first year of insurance investment. Nevertheless, it is clear that due to the number of beneficiaries, staffing of the departments performing certain functions should be carried out gradually, according to the indicators of the projected increase in the number of beneficiaries in the years of insurance implementation. In addition, the functions of individual units of the Fund are determined by the beneficiaries' belonging to one or another population group, the Fund's priorities defined by law. For example, in the first two years, it is planned to insure those groups of the population who are currently beneficiaries of the budget financing or State Order programmes in Armenia and who are mainly informed about the organisation of free or preferential services, their rights and responsibilities. In addition, the insurance fee for the majority of them will be paid from the state budget, therefore, for the latter, access to information on the order of payment of insurance premiums and their amounts may be more limited.

It is expected that after the formation of the Fund, the employees of the SHA, who have the relevant experience and capabilities, will express their desire to be involved in working under the conditions of the new model. Even if the voluntary medical insurance system is not so popular in Armenia and according to the data of 2022, the number of its beneficiaries is about 120,000, there are 6 insurance companies operating in the insurance market, which also offer voluntary medical packages in their portfolio. It is expected, that after the formation of the Fund, the employees of the insurance companies, who have the relevant experience and capabilities, will also express their interest to be involved in Fund staff.

The step-by-step approach to implement UHI in Armenia justifies this Twinning Project. The introduction of the UHI in Armenia will have a large impact on both the State finances and the healthcare in the country. The Ministry of Health and the UHIF could benefit therefore from experiences in EU Member States on a large scale to effectively implement universal health insurance.

3.3 Linked activities:

- The EU Initiative on Health Security aims to set up a regional competent workforce for the prevention and control of challenges posed by transferable diseases and to enhance regional cooperation to tackle cross-border health security threats. The overall objective is to contribute to health security by protecting EU Neighbours' citizens against cross-border health threats posed by communicable diseases. The specific objectives are as follows: strengthen partner countries' skills and institutional mechanisms to respond to health threats; support cross-border cooperation between the EU and partner countries on health security threats of common interest through exchange of information, best practices and lessons learned. Implementation: 01.01.2020 to 31.12.2024.

- WHO Armenia partners with the Ministry of Health in their reform efforts: creating a strong Quality Management System (QMS) in Armenia's #Tuberculosis (TB) laboratory network to improve the quality of care for patients with TB, as well as establish Information System to leverage digital technologies to find, treat, and reduce TB cases in the country. Upgrading of regulations and protocols for a successful QMS setup and further certification and accreditation of the TB National Reference Laboratory. Updating TB diagnostic cascade skills to reduce TB incidence, deaths, and easing financial strains on TB patients and families.
- WHO provides technical support to the Government of Armenia for the development of its second National Strategy on Prevention and Control of Hospital Acquired Infections for 2024-2028.

- EU funded bilateral project entitled «Rights, Services, and Participation: Fostering a Comprehensive Mental Health Framework in Armenia" is dedicated to improving the existing legislative and policy framework, which does not fully correspond to fundamental human rights and the international agreements ratified by Armenia. It aims at producing clinical guidelines and adopting practices in the sphere of mental health. The action targets the needs of specific groups, such as mothers-to-be in times of high pregnancy and women with postpartum depression by enhancing the capacity of maternity hospitals to provide mental health care. The project aims also at upgrading school psychologists will be trained to recognize common conditions among school-age children and respond properly. Implementation: 01.01.2024 - 31.12.2026

- A loan agreement between Armenia and the World Bank (International Bank for Reconstruction and Development) was signed in July 2024 and ratified by the National Assembly on 18 April 2025. This results-based agreement provides a €102 million loan, mainly for the Universal Health Coverage Implementation Programme.

- On 8 September 2025, the Health Care Quality Improvement Programme Loan Agreement between Armenia and the Asian Development Bank (ADB) was debated at the National Assembly. It foresees a € 45 million loan for projects related to digitalisation, licensing and quality of services inter-alia.

3.4 List of applicable *Union acquis*/standards/norms:

- Directive (EU) 2016/97 of the European Parliament and of the Council of 20 January 2016 on insurance distribution;

- Directive (EU) 2009/138/EC of the European Parliament and of the Council of 25 November 2009 on the taking-up and pursuit of the business of Insurance and Reinsurance (Solvency II);

- Directive 2012/52/EU of 20 December 2012 laying down measures to facilitate the recognition of medical prescriptions issued in another Member State.

- Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare

- Directive 2012/52/EU of 20 December 2012 laying down measures to facilitate the recognition of medical prescriptions issued in another Member State.

- The EU's public health strategy post-COVID-19 European Parliament resolution of 10 July 2020 on the EU's public health strategy post-COVID-19 (2020/2691(RSP)

- Regulation (EU) 2021/522 of the European Parliament and of the Council of 24 March 2021 establishing a Programme for the Union's action in the field of health ('EU4Health Programme') for the period 2021-2027, and repealing Regulation (EU) No 282/2014

- Regulation (EU) 2022/2371 of the European Parliament and of the Council of 23 November 2022 on serious cross-border threats to health and repealing Decision No 1082/2013/EU

- Regulation (EC) No 1338/2008 of the European Parliament and of the Council of 16 December 2008 on Community statistics on public health and health and safety at work

- Universal Health Coverage Partnership with the World Health Organization (WHO), to which the EU announced a new contribution of EUR 125 million for the period 2023–2027

3.5 Components and results per component

The Twinning project will strengthen the capacities and provide advisory assistance to accompany the establishment of the Universal Health Insurance Fund.

Component 1: Strengthening the governance and management of the UHIF

Result 1: Legal and organisational frameworks of the UHI system are strengthened to ensure adequate, qualitative and preventive health care to people

Result 1.1 The legal framework, governance structure and management mechanisms are reviewed and recommendations are implemented.

Result 1.2 Capacity building of the Fund management team is increased and allows the Fund to function effectively.

This component will improve legal, institutional and management capacities of the UHIF. As it is complex to foresee the hindrances that this important reform may bring during it implementation, it will be necessary to finetune the structure and functioning of the UHIF from an organisational point of view but also, if necessary, on legislative aspects (by-laws). This component regards therefore the strengthening of the institutional capacity of the Fund.

Component 2: Capacity building of the UHIF staff

Result 2: The operational capacities of the staff of UHIF to implement methodologies and procedures are strengthened and allow efficient functioning of the structure.

Result 2.1 A HR development plan is set-up and training programmes and curriculum prepared after a training needs analysis. This includes the definition of work processes, job descriptions, internal and external interrelations.

Result 2.2 The training plan is implemented by categories and specific units; capacity is increased c to ensure efficient functioning of the UHIF.

This component regards the necessary upgrading of the staff of the Fund, under the condition it is sufficiently staffed. The main functions of the Fund are conditioned by the introduction of cost-effective mechanisms for the services provided to the insured persons and the reimbursement of the medicine, it will be therefore necessary to ensure training on all mechanism, methodologies and procedures required by the UHIF.

It is expected that after the formation of the Fund, the employees of the SHA, who have the relevant experience and capabilities, will express their desire to be involved in working under the conditions of the new model. It is also expected that many specialists from the insurance companies can also join the workforce of the Fund. In other words, the Fund will have capable staff in terms of basic functions to carry out current works. However, for the full and effective implementation of the Fund's functions, it will be necessary to organise the exchange of experience for key positions, and organise initial and on-the-job training for at least the following units: actuarial calculations, risk management, contracting. Other units may receive ad hoc training (see draft in Annex 5).

Component 3: Development of UHIF procedures and methodologies

Result 3: Contracting and actuary procedures are in place and respond to international standards

Result 3.1 Standard Operations Procedures for procurement is developed and/or improved for hospital, primary care providers and pharmacies. Contracting procedures are developed and tested.

Result 3.2 Actuarial Methods in Health Insurance Provisioning, Pricing and Forecasting are implemented and tested.

Result 3.3 Financial analysis, ensuring accountability, reporting and transparent accounting methods and forms are implemented and tested.

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This component concerns the core functions of the UHIF.

- Contracting and procurement procedures have to be implemented and tested (drawing up contracts, preconditions, monitoring…) according to the types of providers: hospitals, ambulatory care, laboratory services, supply of drugs and medical goods. Large volumes of data will be obtained, which must be standardised and made dynamically controllable with key indicators and measures of liability with sound financial management.
- The UHIF envisages the position of Actuary, who will mainly carry out the calculation of insurance package costs, calculation of reserves, and assessment of the amount of the insurance premium. The improvement of the professional abilities and of the actuary is therefore essential and will help to minimize risks. It will be necessary to get acquainted with the features of the applied actuarial models and approaches to risk assessment in similar systems.

- One of the most important functions of the UHIF is the implementation of financial analyses, the preparation of financial reports, because as a public institution, the Fund is obliged to present its activities transparency and accountability.

Component 4: Development of the IT environment

Result 4: Electronic tools are developed and implemented

Result 4.1 The IT environment is assessed in order to set up tools for actuarial calculations, service costs and medicine reimbursement size calculation, insured persons register database, statistics and forecasting.

Result 4.2 Technical specifications are drawn for the implementation of an efficient and friendly-user digital tool

This component is dedicated to electronic tools introduction, which will facilitate the efficient functioning of the Fund and allow different scenarios of forecasts.

Component 5: Development of the Communication environment

Result 5: the Communication department is operational

Result 5.1 The UHIF's Communication Department is strengthened: dedicated staff is trained through specific a training programme and operational procedures. Educational programmes for the management teams of medical organisations are developed and delivered.

Result 5.2 Based on the Communication Strategy developed by the World Bank, actions plans are set-up for communication activities with beneficiaries (media, citizens) and partners (medical, governmental institutions, private sector…). Messages are developed to relevant audiences and relevant communication tools and channels, and tested. Budgeting, impact analysis and monitoring are included.

Result 5.3 A communication campaign concept is drafted to disseminate to the population and stakeholders' information on insurance coverage, conditions for receiving services, registration etc. Assistance to the creation of visual animations and infographics is provided. The campaign is launched by the Beneficiary.

This component focuses on building capacity and in putting in place tools/channels for communication with the public and insured individuals, as well as communication with medical organisations. The main objective is how to communicate on complex health insurance issues and contribute to greater transparency in the health and insurance sector. A particular attention is to be put on visualisation tools to ensure the upmost visibility.

3.6 Means/input from the EU Member State Partner Administration(s):

The project will be implemented in the form of a Twinning between the Beneficiary Country and EU Member State(s). The implementation of the project requires one Project Leader (PL) with responsibility for the overall coordination of project activities and one

Resident Twinning Adviser (RTA) to manage the implementation of project activities, Component Leaders (CL) and a pool of short-term experts within the limits of the budget. It is essential that the team has sufficiently broad expertise to cover all areas included in the project description.

The RTA will be supported by a full-time project assistant performing general project duties, handling administrative arrangements for conferences, training, seminars, etc., and providing translation and interpretation services as necessary. When the nature of the project suggests that the volume of translation and/or interpretation requested would be considerable, a language assistant can be hired in addition.

Proposals submitted by Member States shall be concise and focused on the strategy and methodology and an indicative timetable underpinning this; the administrative model suggested the quality of the expertise to be mobilised and clearly show the administrative structure and capacity of the Member States entities. Proposals shall be detailed enough to respond adequately to the Twinning Fiche but are not expected to contain a fully elaborated project. They shall contain enough detail about the strategy and methodology and indicate the sequencing and mention key activities during the implementation of the project to ensure the achievement of overall and specific objectives and mandatory results/outputs.

The interested Member State(s) shall include in their proposal the CVs of the designated Project Leader (PL) and the Resident Twinning Advisor (RTA), as well as the CVs of the potentially designated Component Leaders-(CLs).

The Twinning project will be implemented by close cooperation between the partners aiming to achieve the mandatory results in a sustainable manner.

The set of proposed activities will be further developed with the Twinning partners when drafting the initial work plan and successive rolling work plan every 6 months, keeping in mind that the final list of activities will be decided in cooperation with the Twinning partner. The components are closely interlinked and need to be sequenced accordingly.

3.6.1 Profile and tasks of the PL:

The Project Leader is expected to be an official or assimilated agent with a sufficient rank to ensure an operational dialogue at political level.

Basic Skill Requirements:

- University degree in public administration, public health, health economics or other relevant discipline or equivalent professional experience of 8 years in public administration, public health or other sectors relevant for this twinning.
- Minimum 3 years of specific experience, at a senior management level, in public health, health economics or health insurance functions in EU MS relevant national administrations;

- Very good spoken and written English (at least level 2 on a scale of 1 [excellent] to 5 [basic]).

Assets:

- Experience in EU funded project management, institution building and/or peer exchange
- Specific professional experience in healthcare reform.

Tasks to be completed:

- To supervise and coordinate the overall project preparation;
- To supervise, guide and monitor project implementation towards the timely achievement of the project results;
- To liaise with the Beneficiary Counterpart (BC) administration at the political level;
- To ensure timely availability of the expertise;
- To prepare the project progress report with the support of the RTA;
- To co-chair the project steering committees;
  To take into account the work of relevant EU bodies and agencies and establish links where appropriate.

3.6.2 Profile and tasks of the RTA:

The Resident Twinning Adviser will be based in Yerevan (Armenia) to provide full-time input and advice to the project for its entire duration. She/he will be in charge of the day-to-day project implementation and coordination of project activities according to a predetermined work plan and liaise with the CHI Fund counterpart in Armenia. (S)he should co-ordinate the project and have a certain level of understanding of all the components.

Basic skill requirements

- University degree in health economics, public health, public administration, health law or other relevant discipline or equivalent professional experience of 8 years in the public health sector;
- Minimum 3 years of specific experience in healthcare insurance related regulatory functions in EU MS relevant national administrations;
- Very good spoken and written English (at least level 2 on a scale of 1 [excellent] to 5 [basic]).

Assets:

- Experience in project management, in institution building projects or peer-to-peer exchanges.
- Experience in implementation of relevant EU legislation and EU instruments related to the project components.

Tasks:

- To coordinate and assure project implementation and implementation of all project activities;
- To prepare the initial and subsequent work plans and project progress reports, together with the PL;
- To assure the coherence and continuity of the successive inputs and the on-going progress;
- To coordinate the activities of all team members in line with the work plan;
- To assess continuously project progress to assure its timely implementation;
- To prepare material for regular monitoring and reporting;
- To liaise with MS and Beneficiary Country (BC) PLs and maintain regular contact with the BC RTA;
- To provide technical advice, support and assistance to the Beneficiary institution in the areas specified in the work plan;

- To liaise with the EU Delegation Project Manager & Team Leader;
- To liaise with other relevant institutions in Armenia and with other relevant projects.

3.6.3 Profile and tasks of Component Leaders*:*

The Component Leaders will work in close cooperation with the RTA and the Beneficiary administration in order to meet the mandatory results. Their main task is to plan and coordinate activities under their respective areas of responsibility in collaboration with the partner institutions.

Basic skill requirements

- University degree in relevant discipline or equivalent professional experience of 8 years in a sector relevant to the component of the twinning for which the candidate is proposed;
- Minimum 3 years of professional experience at an operational level in relevant EU MS health administration or mandated body in a field relevant to the component for which the candidate is proposed
- Very good spoken and written English (at least level 2 on a scale of 1 [excellent] to 5 [basic]).

Assets:

- Experience in capacity building, institutional building or peer-to-peer exchanges
- Tasks:
- To provide component coordination, guidance and monitoring in close cooperation with the BC component leader, RTA and RTA counterpart;
- Continually monitor the achievement of objectives related to their component and comparing actual progress with the specified benchmarks and time-frame;
- Support the RTA in preparing the interim, quarterly and final reports related to their component;
- To provide practical expertise and technical advice, as well as coaching to the relevant staff in the Beneficiary administration for the execution of activities relevant to their project components;
- To analyse policies and practices in the thematic area relevant to the respective component;
- To support the drafting of action plans, training plans, studies;
- To prepare and conduct training programs, to facilitate stakeholders' dialog;
- To support the BC counterparts drafting technical documents relevant to their component's results;
- To suggest improvements of relevant procedures and systems.

3.6.4 Profile and tasks of other short-term experts*:*

The STEs should be identified by the Project Leader/RTA and will be agreed with the Beneficiary Administration during the negotiation phase of the Twinning contract and following these indicative (but not exclusive) areas: health economics, public health, insurance and actuary, (administrative) law, audit and accountancy.

Basic Skill Requirements:

- University degree or equivalent professional experience of 8 years;
- At least 3 years of professional experience in a respective field related to the purpose of the mission foreseen in the work plan;
- Very good spoken and written English (at least level 2 on a scale of 1 [excellent] to 5 [basic]).

Assets:

- Experience in delivering capacity building activities;
- Experience in providing inputs to policy/regulatory documents, methodological guides and/or handbooks.

Tasks:

- To provide advice, expertise and/or coaching to the relevant staff of the Beneficiary administration for the execution of specified project activities;
- To plan and deliver capacity building activities (workshops, study tours, trainings);
- To suggest improvements of relevant procedures and systems including suggestions to the revision of regulatory framework;
- To provide support in drafting action plans and roadmaps;
- To report on the results of the missions;
- To liaise with RTA and BC counterparts.

4. Budget

1 500 000 €

5. Implementation Arrangements

5.1 Implementing Agency responsible for tendering, contracting and accounting

The Delegation of the European Union to Armenia (EUD) in Yerevan. EUD will work in close cooperation with the Beneficiary.

Address: 21 Frik street
AM Yerevan 0002
DELEGATION-ARMENIA@eeas.europa.eu

The person in charge of the project at the EUD are:
Ms Tatevik DAVTYAN
Health Contact Point
Tel. +374 54 64 94
Tatevik.DAVTYAN@eeas.europa.eu

5.2 Institutional framework

The beneficiary institution of this project is the Ministry of Health. The Universal Health Insurance Fund (UHIF) will be directly involved in project implementation.

At the time the Twinning Project will start, the UHIF should have just started its functioning, and the implementation of the Universal Health Coverage will be in the first phase. During the Twinning Project both the Fund and the UHI system will develop further. It is foreseen that the UHI Fund will be an administrative organisation with a professional staff of around 220 in the year 2027 (see distribution in annex 4). The UHI Fund will be organised into five departments with strategic functions[1] and four staff functions.

5.3 Counterparts in the Beneficiary administration:

[1] Actuarial Department, Contract Development and Performance Control Department, Information Technologies and Information Analysis Department, Financial Department and

The PL and RTA counterparts will be staff of the Beneficiary administration and will be actively involved in the management and coordination of the project.

5.3.1 Contact person:

Ministry of Health

Ms.Maria Hovakimyan, Deputy Director of Health Projects Implementation Unit Government Building 3 Yerevan 0010

5.3.2 PL counterpart

Ministry of Health

Mr.Samvel Kharazyan, Director of the State Health Agency

Government Building 3 Yerevan 0010

5.3.3 RTA counterpart

Ministry of Health

Mr. Armen Melkonyan, Head of International Relations Department

Government Building 3 Yerevan 0010

6. Duration of the project

Execution period of the project shall be 27 months. The implementation period of the Action will last 24 months. The execution period of the contract shall enter into force upon the date of notification by the Contracting Authority of the contract signed by all parties, whereas it shall end 3 months after the implementation period of the Action.

7. Management and reporting[2]

7.1 Language

The official language of the project is the one used as contract language under the instrument is English. All formal communications regarding the project, including interim and final reports, shall be produced in the language of the contract.

7.2 Project Steering Committee

A project steering committee (PSC) shall oversee the implementation of the project. The main duties of the PSC include verification of the progress and achievements via-à-vis the mandatory results/outputs chain (from mandatory results/outputs per component to impact), ensuring good coordination among the actors, finalising the interim reports and discuss the updated work plan. Other details concerning the establishment and functioning of the PSC are described in the Twinning Manual.

[2] Sections 7.1-7.3 are to be kept without changes in all Twinning fiches.

7.3 Reporting

All reports shall have a narrative section and a financial section. They shall include as a minimum the information detailed in section 5.5.2 (interim reports) and 5.5.3 (final report) of the Twinning Manual. Reports need to go beyond activities and inputs. Two types of reports are foreseen in the framework of Twining: interim quarterly reports and final report. An interim quarterly report shall be presented for discussion at each meeting of the PSC. The narrative part shall primarily take stock of the progress and achievements via-à-vis the mandatory results and provide precise recommendations and corrective measures to be decided by in order to ensure the further progress.

8. Sustainability

Both the Ministry of Health and the UHI Fund as beneficiary institutions are fully willing and committed to ensure the sustainability of the present twinning project. A number of strategies will be put in place, including transferring knowledge by the staff trained from this project through peer-to-peer training in the workplace. The training programmes and arrangements will be discussed and agreed at high level of the Ministry of Health to create a culture of peer-to-peer learning approach.

The sustainability of the project results is dependent on sufficient number of personnel from the Beneficiary administration to be assigned to work in the implementation of and benefit from the project. This implies commitment by Ministry of Health to avail sufficient budget and human resources to the authority, to fulfil its regulatory mandate linked to the implementation of the Universal Health Insurance Fund.

9. Crosscutting issues

The overall objective of this project is to support the Republic of Armenia in building its capacity to organise a mandatory healthcare insurance system and implement it.

Universal Health Insurance means, by nature, that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. As such, it contributes to advancing gender, equal and inclusive treatment, fight against discrimination and in general human rights policies. The Twinning Partners will ensure that these aspects are constantly implemented.

Equal opportunity in the project will be assured in accordance with EU standards and equal opportunity policies. Equal treatment of women and men will be observed in the project staffing, implementation and management. In particular, attention to the equality principle will be given to the selection of personnel for training and capacity building activities.

Furthermore, the principle of implementation of this partnership project will minimise paper use during project implementation (paperless work).

Relevant project information and all communication and visibility materials must be updated and approved by the EU Delegation through the EU's project communication database 'EU DIGITOOL'. All visibility and communication material will be kept up to date throughout the lifetime of the project. **The use of the 'EU DIGITOOL' approval system is a mandatory requirement.**

10. Conditionality and sequencing

The precondition of this Twinning Project is the effective enforcement of the UHIF with sufficient staff to co-implement the project, absorb and own its benefits. There is no other preconditions or prior activities for this Twinning project. Nevertheless, it is important that Armenian authorities remain committed to achieve the envisaged results and objectives, throughout the duration of the project. The Armenian authorities will ensure operational and logistical support to the RTA and the Twinning experts, as well as provide effective coordination with the other Armenian institutions involved in the project.

11. Indicators for performance measurement

The specific objective is to strengthen the capacity of the Ministry of Health of the Republic of Armenia ("MoH") in its reform of healthcare with the introduction of universal healthcare coverage and the establishment of a functioning Universal Health Insurance Fund (UHIF).

Overall, Twinning performance measurement will be based on the quality and timeliness of expert inputs (reports, mappings, training manuals, presentations etc.) provided as well as beneficiary satisfaction with the collaboration in response to the expressed needs for human resource and institutional capacity development.

RESULTS	SUB-RESULTS	INDICATORS
Component 1: Strengthening the governance and management of the UHIF		
Result 1: Legal and organisational frameworks of the UHI system are strengthened to ensure adequate, qualitative and preventive health care to people	Result 1.1 The legal framework, governance structure and management mechanisms are reviewed and recommendations are implemented.	UHIF technically in place and in line with international standards • Number of legal/technical documents drafted/reviewed with recommendations (approx.5)
	Result 1.2 Capacity building of the Fund management team is increased and allows the Fund to function effectively.	Enhanced skills for effective management • Number of managers trained/ number of training events • Participants satisfaction and progress evaluation

Component 2: Capacity building of the UHIF staff		
Result 2: The operational capacities of the staff of UHIF to implement methodologies and procedures are strengthened and allow efficient functioning of the structure	Result 2.1; A HR development plan is set-up and training programmes and curriculum prepared after a training needs analysis	• Training Needs Analysis completed • Training plan and curricula prepared and approved • Work processes drafted and approved
	Result 2.2 The training plan is implemented by categories and specific units and increased capacities ensure efficient functioning of the UHIF.	Enhanced staff skills on Fund methodologies/procedures • Number of staff trained • Number of capacity building activities organised
Component 3: Development of UHIF procedures and methodologies		
Result 3: Contracting and actuary procedures are in place and respond to international standards	Result 3.1 Standard Operations Procedures (SOP) for procurement is developed and/or improved for hospital, primary care providers and pharmacies. Contracting procedures are developed and tested.	Contracting procedure developed Number of SOP and contracts
	Result 3.2: Actuarial Methods in Health Insurance Provisioning, Pricing and Forecasting are implemented and tested.	Number of methods
	Result 3.3: Financial analysis, ensuring accountability, reporting and transparent accounting methods and forms are implemented and tested.	Financial analysis completed Full method tested and implemented
Component 4: Development of the IT environment		
Result 4: Electronic tools are developed and implemented	Result 4.1 The IT environment is assessed in order to set up tools for actuarial calculations, service costs and medicine reimbursement size calculation, insured persons register data-base, statistics and forecasting.	IT technical assessment completed
	Result 4.2 Technical specifications are drawn for the implementation of an efficient and friendly-user digital tool	Technical Specifications drafted
Result 5: The Communication Department of UHIF is operational	Result 5.1 UHIF's Communication department is strengthened. Educational programmes for medical organisations are developed.	PR operational procedures are developed and documented. Specific training programme for the PR staff is developed and delivered. Training for the management teams of medical organisations delivered
	Result 5.2: Communication actions plans are developed.	Targeted comprehensive communication actions plans are set-up including budget, impact and monitoring tools. Targeted messages and communication tools are tested.
	Result 5.3: The concept for a communication campaign is drafted and the campaign launched.	Campaign is approved: financial means are allocated for its implementation Visual animations and infographics are created.

Annex 1 Logical framework includes a more detailed overview of project specific targets and indicators for performance measurement, complementing the results and sub-results enumerated in Chapter 3.5.

12. Facilities available

The Beneficiary commits itself to deliver the following facilities:

- Adequately equipped office space for the RTA and the RTA's assistant (and interpreter) for the entire duration of the secondment.
- Supply of the office room including access to internet, computer, printer, photocopier, telephone (TBD).
- Adequate conditions for the short-term experts to perform their work while on mission.
- Suitable venues for the meetings and training sessions that will be held under the project.

The Beneficiary will also guarantee the availability of staff who will be involved during the twinning project implementation.

Full coordination and transparency is expected among all key players involved.

Annexes to the Twinning Fiche

1. Simplified Logical framework matrix as per Annex C1a
2. Charter of the UHIF
3. Draft law on the UHIF as of 14.02.2024
4. Organigramme and Staff distribution of the UHIF
5. Draft training plan for the UHIF

Electronically signed on 05/11/2025 12:51 (UTC+01) in accordance with Article 11 of Commission Decision (EU) 2021/2121