POLICY BRIEF

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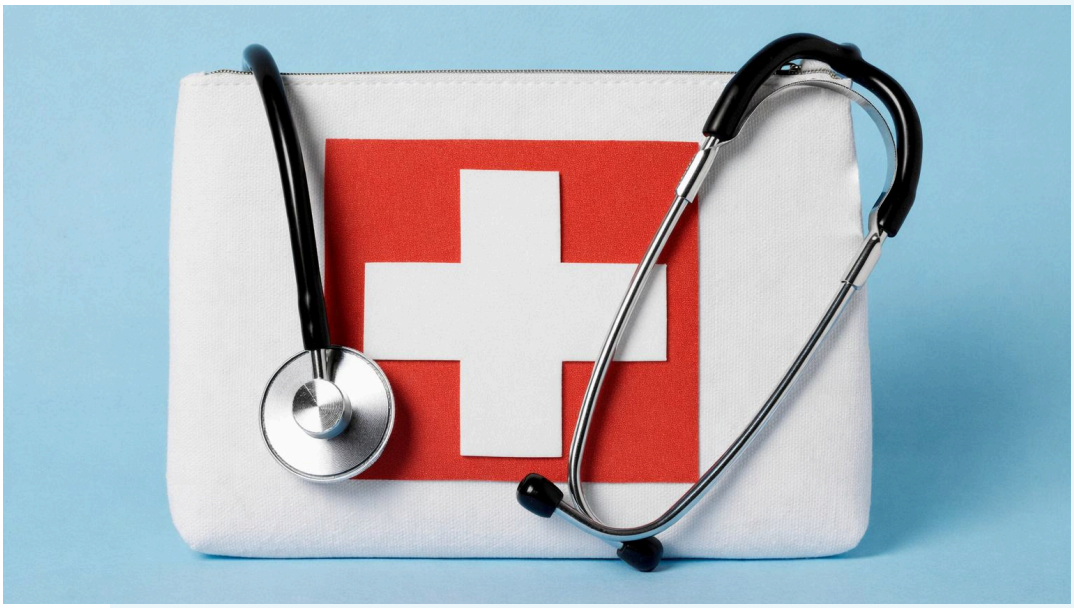
Towards Universal Health Insurance: Prospects and International Experience

The first promises to introduce a comprehensive health insurance system in Armenia were made back in 2018, in the pre-election program of the ruling political force. However, the first draft of the concept, which promised to introduce a comprehensive health insurance system by 2022, received negative feedback during public discussion and was temporarily shelved, partly due to the COVID-19 crisis and war. An improved draft of the concept was presented and adopted in 2023, followed by the presentation of the resultant law to the public; the latter, with amendments, was submitted for public discussion in the first half of October of 2025. On November 13, 2025, the RA Government approved the third version of the bill. This version envisages not comprehensive, but universal insurance, which is more consistent with its content. The draft of the legislative package was submitted to the National Assembly on December 2, 2025, adopted in second reading on December 17, and entered into force on January 1, 2026.

In this policy brief, we will discuss the specifics of Armenia's universal health insurance system, its expected prospects, and their economic effectiveness based on international experience.



Source: freepik.com

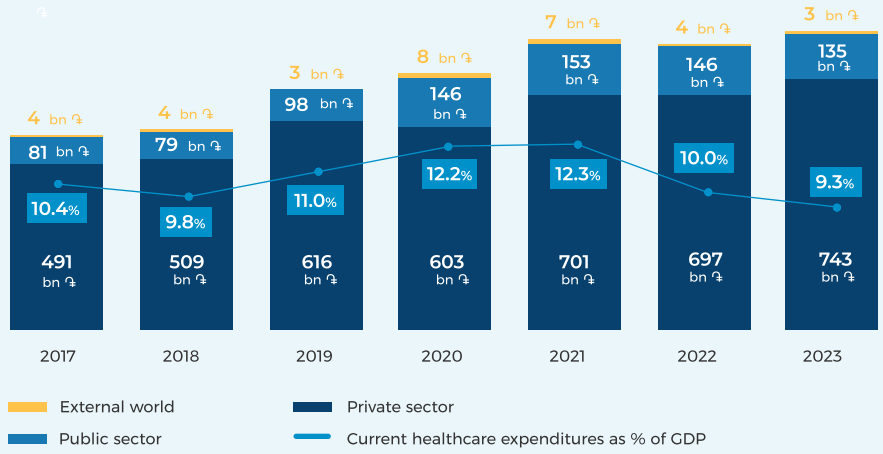
The need for universal health insurance

According to official data, in 2017-2023 current healthcare expenditures in Armenia increased by about 1.5 times, exceeding AMD 882 billion, which is equivalent to 9.3% of GDP.

This indicator for Armenia is comparable to the global average of around 10% (2023).

In Armenia, the public sector covers only 15% of current healthcare expenditures.

Figure 1. Dynamics of current healthcare expenditures, 2017-2023

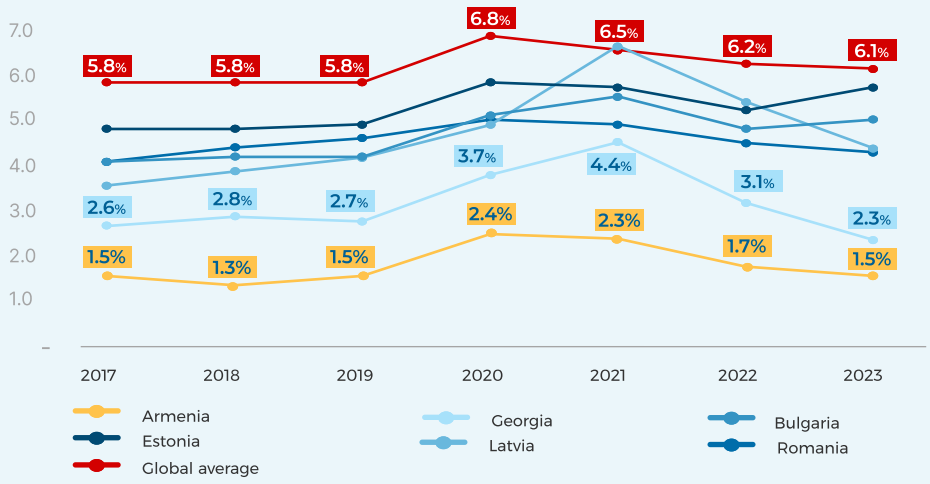


Source: National Healthcare Accounts of Armenia

Notably, the lion's share in the structure of current expenditures - more than 84% - belongs to the private sector (direct payments of households and payments of employers, payments and transfers to private insurance companies), while the public sector covers only 15% of the current spendings compared to the global average of 62% (2022). Similarly, according to the World Bank, the share of these expenditures in GDP is also significantly lower (1.5%), compared to the global average, which was 6.1% in 2023.

Source: policyadvisor.com

Figure 2. Share of government's healthcare expenditures in GDP

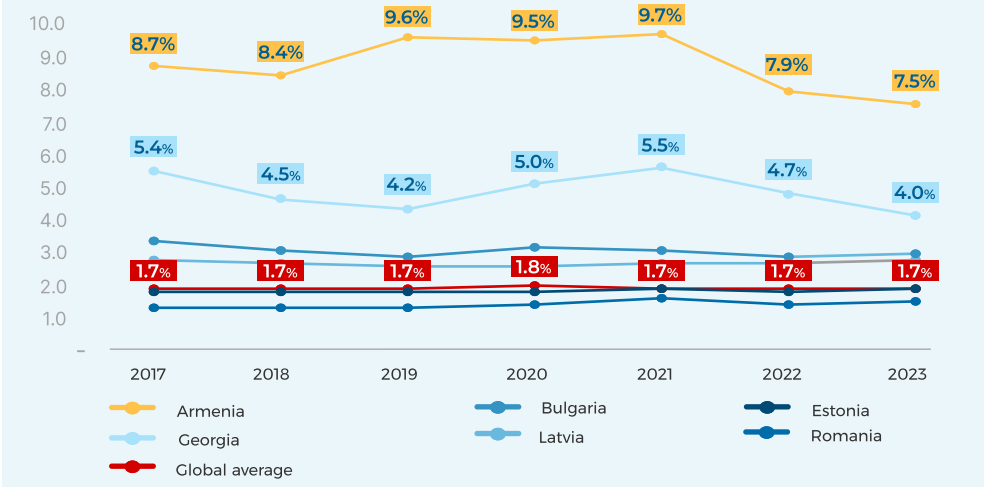


Source: ArmStat, WHO

Although the number of people with private health insurance has increased in recent years, direct out-of-pocket payments by households continue to have the largest share in the private financing structure (96%). In 2023, current out-of-pocket healthcare expenditures amounted to about 7.5% of GDP, which significantly exceeds the global average of 1.7%, as well as the indicators of a number of Eastern European countries.

According to the National Institute of Health, in 2023 current out-of-pocket healthcare expenditures in Armenia amounted to 7.5% of GDP, significantly exceeding the global average of 1.7%.

Figure 3. Share of out-of-pocket healthcare expenditures of households in GDP



Source: National Healthcare Accounts of Armenia, WHO

According to the concept, insufficient financing leads to under-reimbursed prices, huge out-of-pocket expenses and unmanageability. More figuratively speaking, households in Armenia spend 16.1% of their income on healthcare, which exceeds both the global (12.7%) and regional (7.4%) averages. As a result, due to financial reasons, 12.6% of non-poor population, 24.5% of the poor and

49% of the extremely poor do not visit primary healthcare (PHC) doctors.

By introducing a prepayment model of income collection for healthcare financing, the government promises to make basic medical services accessible to the population and reduce out-of-pocket costs.

International experience of universal health insurance

William Beveridge, source: Wikipedia

In the case of the Beveridge model, low service tariffs are usually formed, but also a high dependence on political decisions and the size of state revenues.

There are many prepayment systems for universal health coverage, but they can be divided into two main models: Beveridge and Bismarck.

According to the model developed by the British economist and reformer **William Beveridge**, health services are financed from tax revenues of the state budget and implemented mostly by state institutions. Even if there are private hospitals, they receive their funding from the state. This model is based on the idea of health as a human right, the protection of which should be the task and, in fact, monopoly of the state.

The Beveridge model operates in the homeland of its founder - Great Britain, in Italy, Spain, Portugal, Scandinavian countries, etc. The application of this model typically leads to formation of low service tariffs, but also high dependence on political decisions and the size of state revenues. Lack of competition can also lead to inefficiency of the healthcare system, including in terms of infrastructure, quantity and quality of medical personnel.

The Beveridge model does not prohibit the activities of private insurance companies, but the state-owned fund has an exceptionally strong competitive position vis-à-vis the private sector, which typically leads to inefficiency in the management of the system.

Otto von Bismarck, source: Wikipedia

The Bismarck model was introduced earlier in Germany by **Otto von Bismarck**. In this model, the main source of financing are regular payments by employers and employees-insurance premiums, which are channeled into multiple non-profit foundations, the so-called "sickness funds".

Unlike the Beveridge approach, the Bismarck model offers greater

Great Britain

Source: 1tv.ge

The Beveridge model in the UK provides free healthcare for all. However, as the insurance package offered by the state is not comprehensive, out-of-pocket costs are significantly high; in particular, as of 2023, 15% of expenditures per person are out-of-pocket costs. Due to low funding, there is poor quality of services and frequent long queues, while dependence on the decisions of the ruling political power leads to social and financial instability.

opportunities for the formation of free competition.

The Bismarck model operates in Germany, the homeland of its founder, as well as in Austria, Switzerland, Israel, Japan and elsewhere. In these countries, non-profit foundations operate as former “sickness funds”, and private for-profit insurance companies act as providers of additional services. Such systems are more difficult to manage than systems with the Beveridge approach, but competition between multiple insurers stimulates the diversity of products and packages offered, urging market players to pursue innovative approaches to attract beneficiaries.

A special case of the Bismarck model is the **"single payer" model,** where citizens direct their insurance premiums to a single fund. Such a model operates in Estonia, France, Greece, Korea, Turkey, and elsewhere.

In the case of the Bismarck model, problems may arise such as the flow of workers from formal to informal sector, the desire to hide the real amount of wages to avoid insurance premiums, and in countries with aging population - decrease in the amount of collected insurance premiums, to name a few.

Source: New York Times

In addition to these two main approaches, there are also various **hybrid models,** which can have different manifestations.

Competition between multiple insurers in the Bismarck model stimulates the diversity of products and packages offered, urging market players to pursue innovative approaches to attract beneficiaries.

The model implemented in Armenia is more similar to the one operating in Estonia.

Estonia

Source: Sputnik Armenia

In the "single payer" model in Estonia, the source of financing is mainly targeted payments by employees. Only hired employees pay healthcare contributions, while those who do not pay contributions but are insured (minors, pensioners, etc.) make up almost half of total beneficiaries. With a single fund, prices are not formed in free market conditions, but in a controlled manner, and private players cannot compete with the single payer. There is insufficient funding in the system, one of the consequences of which is a decrease in the number of healthcare workers in Estonia: in particular, in 2024 there were 3.5 doctors and 6.6 nurses per 1,000 population, compared to the OECD average of 3.9 and 9.2, respectively. The level of out-of-pocket payments is high: in 2021 they accounted for about 22% of healthcare expenditures.

One of these hybrid models is the so-called **regulated competitive model,** where health insurance is mandatory and the service is provided by multiple insurance companies operating in a highly regulated competitive market.

In general, there is no perfect model. However, satisfaction surveys in countries with one or the other model show that, nevertheless, there are certain systems that ensure a higher level of satisfaction, such as the hybrid model used in the Netherlands.

Source: Estonian Health Insurance Fund

The Netherlands

The population is required to be insured by private insurance companies, the diversity of which makes the choice somewhat difficult. However, the system is quite effective: the healthcare needs of almost the entire population are fully and timely met (in 2024, only 1.9% of the population over 16 years of age had their healthcare needs unmet, of which only 0.6 percentage points were due to high cost, distance, or queues). There is an effective risk-balancing system: due to active government intervention and regulation, almost the same insurance premium applies to all insured persons, regardless of risk level, while insurance companies receive compensation for taking on high-risk policyholders.

Source: stock.adobe.com

In the Netherlands, where a hybrid model is in place, the satisfaction level of the population is 83%.

Table 1. Description of mandatory health insurance models in the selected countries

Country	Satisfaction level	Unmet needs	Share of mandatory health insurance in healthcare expenditures	Model	Market players
Germany	81%	0.9%	78%	Bismarck (social health insurance)	Non-profit mandatory health insurance funds + private insurance companies
The Netherlands	83%	0.7%	75%	Bismarck (universal health insurance)	Mandatory insurance provided by private insurance companies
Czech Republic	75%	0.4%	73%	Bismarck (social healthcare)	State health insurance funds
Sweden	75%	-	0%	Beveridge (national healthcare service)	A unified state system financed from the state budget
France	60%	4.5%	80%	Bismarck (social health insurance)	Unified state body + private insurance companies
Finland	61%	-	12%	Beveridge (national healthcare service)	State-funded system + national health insurance mechanism
Spain	62%	1.8%	4%	Beveridge (national healthcare service)	Unified state-funded system + private insurance companies
Estonia	62%	8.2%	67%	Bismarck (social healthcare)	Unified health insurance fund
Portugal	58%	-	3%	Beveridge (national healthcare service)	National state-funded health service
Italy	44%	1.5%	0%	Beveridge (national healthcare service)	National state-funded health service

Country	Satisfaction level	Unmet needs	Share of mandatory health insurance in healthcare expenditures	Model	Market players
Latvia	54%	6.9%	0%	Beveridge	Unified state-funded system
Lithuania	53%	3.7%	60%	Bismarck (social health insurance)	Unified health insurance fund
Poland	51%	-	67%	Bismarck (social health insurance)	Unified fund
Hungary	41%	0.8%	62%	Bismarck (social health insurance)	Unified state fund
Greece	27%	6.1%	32%	Hybrid	Unified national healthcare organization

Source: OECD, "Health at a Glance 2025"; Eurostat, Population and social conditions database; European Commission, Country Health Profiles 2025

Note: (1) Dark blue and dark azure indicate countries where a system is in place similar to the one introduced in Armenia on January 1, 2026. In the Netherlands, marked in dark blue, where insurance is also mandatory, it is provided through private insurers. The latest available figures for 2023 are presented. (2) "-": data missing.

Universal health insurance system in Armenia

The health insurance model in Armenia is essentially a Bismarck model with the "single payer" variant. According to the Armenian Law "On Universal Healthcare", **all insurance operations will be entrusted to a single fund,** which will be responsible both for the establishment of contractual relations with hospitals and pharmacies, and for collection of insurance premiums and payment of reimbursements, as well as for determination of reimbursement ceilings for medical services and medications. However, unlike the classic Bismarck model, in Armenia there is no talk of social solidarity, when financially secure individuals pay also for socially vulnerable individuals; instead, the state will pay for certain social groups (e.g. the elderly, children) (see Table 2). The insurance premiums of the azure-colored groups of insured persons are transferred to the fund by the state.

Payments for other groups are contributed by beneficiaries on a monthly or annual basis. The rate of insurance premiums is **AMD 129,600 annually or AMD 10,800 monthly;** in the case of hired work-

The health insurance model in Armenia is essentially a Bismarck model with the "single payer" variant.

ers, the employer, as a tax agent, will be responsible for withholding mandatory payments and transferring them to the treasury account. In addition to all resident citizens of Armenia, insurance coverage also includes certain groups of foreigners, for example, hired workers, individual entrepreneurs, notaries, etc. with the right of residence in Armenia.

Unlike previously circulated drafts, the current law also introduces the principle of co-payment for medical care, services, and medicines, which allows medical institutions to set a price for a given medical service or medicine up to 2 times higher than the maximum reimbursement rate set by the government, with the negative difference to be paid by the patient.

The universal healthcare system in Armenia will be introduced in phases during 2026-2028.

Table 2. Social groups subject to universal healthcare in Armenia

1. Children under the age of 18, including persons left without parental care, if they are 18-23 years of age or up to 26 years of age but are taking a full-time education course.
2. Persons of the age 65 or higher
3. Persons with up to 3rd group disabilities
4. Participants of disaster relief works of the Chernobyl nuclear power plant
5. Former servicemen receiving a military disability pension
6. Mothers (adoptive parents) caring for children under two years of age
7. One of the parents (guardians) taking care of three or more minor children
8. One of the parents (guardians) of a child with a disability
9. Participants of World War II
10. A member of a family with family vulnerability score
11. Hired workers
12. Workers under civil law contracts
13. Individual entrepreneurs, notaries
14. Recipients of rent, interest, dividend, royalty payments
15. Persons engaged in individual agricultural activities
16. Persons affiliated with an insured persons, on a voluntary basis

Note: the insurance premium for azure-colored groups will be fully paid by the state.

The system is scheduled to be implemented phase by phase over the period 2026-2028 (Table 3).

It should be noted that in order to reduce the financial burden certain revisions have been made.

For example, the actual burden of mandatory insurance payments for persons receiving salaries between AMD 200,000 and AMD 1,000,000 has been mitigated due to the reduction of the stamp duty rate.

Table 3. Phases of implementation of universal healthcare in Armenia

	1-st phase (2026)	2-nd phase (2027)	3-rd phase (2028)
1.	Children under 18 years of age	Hired workers receiving a salary or salary-equivalent payments of up to AMD 200,000	All other beneficiaries
2.	Persons of age 65 or higher	Persons working under a civil law contract	
3.	Persons with 1st to 3rd group disabilities	Persons receiving passive income	
4.	Citizens included in the social support system (including family members of deceased servicemen)	-	
5.	Hired workers with gross salary exceeding AMD 200,000 in November 2025 or in any month in 2026		
6.	Individual entrepreneurs and notaries whose annual revenue turnover in 2025 exceeded AMD 2,400,000	-	

Beneficiaries with salaries above 1,000,000 AMD will pay the full insurance premium of AMD 10,800 in 2026, as well as continue to allocate AMD 15,000 to the "Zinapah" fund, but a year later they will be able to get a refund of up to AMD 4,000 per month through social credits obtained within the framework of the income declaration system. In total, about **1,600,000 people** will be insured in 2026.

From January 1, 2029, that is, after the full implementation of the system, a bonus system will also begin to operate.

Bonuses can be utilized to pay insurance premiums and use other additional services. They are accumulated if a person has used exclusively preventive services during the year. If the beneficiary becomes a blood donor, or if a doctor registers an improvement in the beneficiary's healthy lifestyle indicators (related to body weight, smoking or use of alcohol), additional ratios are applied to the bonuses.

In 2026, approximately 1,600,000 people will be insured in Armenia, for whom transitional provisions have been introduced to ease the financial burden.

Conclusions and Recommendations

- ✓ Financial calculations show that the system introduced in 2026 **will cover, at best, about 23% of healthcare costs**, which is lower than the indicators of all the countries considered (the lowest is in Greece, at 32%).
- ✓ By giving the quasi-state universal health insurance fund the right to set maximum reimbursement rates and maximum co-payment rates, an **efficient mechanism for intervening in market prices is created**. The problem is exacerbated when we consider that this market is dominated by one large buyer and many sellers. In the event that a significant gap arises between the maximum reimbursement/co-payment rates and actual prices, due to fiscal or policy considerations, the problem will become even more pronounced.
- ✓ The implementation of this universal healthcare model poses hazards for the **long-term investment attractiveness of the sector**.
- ✓ The establishment of actual prices and maximum reimbursement/co-payment rates may in some cases also lead to an increase in shadow turnover, in particular, when the actual **price exceeds the established reimbursement amount by more than twice**, citizens will have to pay the difference in cash.
- ✓ International experience shows that under the proposed model, low level of healthcare infrastructure and financing, client **satisfaction is likely to be below the average for the countries considered**, which could overshadow the reform.
- ✓ Given the common practice on the labor market, when the agreement between employer and employee is about net salary, **in some cases employers will bear the financial burden**, which is an additional expense for them and prevents beneficiaries of the universal healthcare system from presenting claims.
- ✓ It is proposed, to hold discussions with the banking system to implement a mechanism whereby **mandatory insurance payments are automatically charged to beneficiaries' bank accounts upon receipt of income**. This will, on the one hand, resolve the issue of payments for people with passive income, and on the other hand - increase beneficiaries' engagement with the system and neutralize the potential burden for employers. Such mechanisms are in place in Switzerland and the Netherlands.
- ✓ While preserving the already established fund, transition to a **regulated competitive market model**, within the framework of which beneficiaries can choose the insurance company every year, to which the fund will transfer the amount on a monthly basis. Price competition between insurance companies will be limited, as all of them will be obliged to offer the services determined by the government at a fixed price. The involvement of such intermediaries will allow to form competition in the medical services market, increase the quality of service for beneficiaries, reduce the risk of fraud and the burden on primary health care institutions.

ACSES
Address: 48/1 Nalbandyan Street, Yerevan 0010
Tel.: (+374 33) 200 882
www.acses.am
info@acses.am

Friedrich Naumann Foundation for Freedom
www.freiheit.org