Draft

The Health Sector in Ukraine

Discussion Paper on
Selected Health Care Reform Options

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Executive Summary

Ukraine faces a number of challenges in respect to its health care services. That reform is required is widely appreciated and the Government of Ukraine is giving earnest consideration to a range of initiatives. These initiatives include: (i) alterations to the financing system; (ii) the introduction of a minimum guaranteed package of services; (iii) changing the way resources are allocated; (iv) increasing the role of the private sector; and (v) restructuring the secondary care delivery system. Many of these are eminently appropriate and have proven to be extremely beneficial when introduced in other countries facing similar problems of constrained affordability and relatively inefficiency.

The intention of this paper (the topic areas within having been agreed with the GOU) is principally to raise awareness and to comment upon some of the matters and options being contemplated by the Government. Notwithstanding this, it is apparent that certain additional initiatives could be commenced now, which would assist the longer term health reform requirement, and the paper therefore also makes recommendations in this regard. Key challenges which need to be addressed include the aforementioned constrained affordability and inefficiency, poor health status, system misalignments and sub-optimal integration, and sub-standard and excessive infrastructure.

A major constraint in addressing these challenges is a restrictive clause (Article 49) within the Constitution which guarantees every individual, free of charge, the right to medical treatment, and also stipulates that the existing network of medical institutions shall not be reduced.

A further constraint is the lack of a clear pathway for the future. Many of the Ukrainian reform proposals in this paper have been placed before parliament but remain without universal, or even a sufficiency of, support. For example within the government the Ministries of Finance and Health have differing opinions on the current draft version of the health insurance law.

One of the characteristics of the Ukrainian healthcare system is inadequate public sector financing and high levels of informal payments. Health expenditure has therefore become a significant poverty risk factor. In an attempt to address this situation, several new sources of financing have been proposed: a payroll tax, official user fees, and voluntary health insurance. Coupled with this, it is contemplated that government derived revenues would be used to finance a “base program”, or minimum guaranteed level of services, which would be offered free of charge. User fees and voluntary insurance would be used to finance services that exceed the basic quality standard of the base program, and state and local budgets would finance “targeted health programs.”

Consensus appears to exist that Ukraine will develop a social insurance health system with an associated purchasing agency and in consideration of this reforms designed to improve efficiency by allowing selective contracting and to introduce the private sector into the “market” are being contemplated. It is also envisaged that the introduction of a more defined purchasing function will
reduce the current levels of inefficiency and may potentially also lead to a reduction in the surplus infrastructure.

The Bank’s Position

The Bank compliments the GOU on its endeavors to address its fiscal and health related challenges. The analytical process being undertaken by the government prior to determining which of the myriad of reform options it will formally pursue is appropriate and the avoidance of “soft-options”, short-term and ad hoc ‘solutions’ is commendable.

Multi-channel financing is common elsewhere in the world and, provided that the fragmented revenue sources can be consolidated at the purchaser level, can be decidedly advantageous. A heavy reliance on payroll taxes however might prove problematic in the future given that their success is usually strongly correlated with high formal employment rates. Without overcoming the collection difficulties typically associated with less formal and un-employment the GOU may be unable to significantly reduce the current rate of informal payments.

Even without introducing health insurance (i.e. awaiting the outcome of the current debate over financing models), Ukraine could move quickly to a system of improved purchasing, and eventually, selective contracting. This has the potential to greatly enhance both the efficiency and quality of the delivery of health care services. Evolutionary development of the purchasing function, in tandem with co-terminus strengthening of information systems and management capacities, has proven to be extremely beneficial in similar environments.

While the Bank supports, in principle, the concept of governments enunciating a basic benefits package (BBP) as a critical component of their fiscal management strategy the bridge between theory and reality in respect to such packages is a notoriously tenuous one. Few successful examples of a ‘reductionist’ BBP can be found in the world and the determination of relative service cost-effectiveness is inherently problematic without exceedingly sophisticated data collection and analysis systems. Accordingly the Bank does not recommend that the GOU rely upon this initiative to address its fiscal challenges and proposes that any introduction of such a package should be subsequent to the undertaking of robust cost and demand analysis and to the introduction of germane provider and insurer regulation.

Despite the relatively low percentage of GDP expended upon health services in the country and the considerable reductions in both hospitals and hospital beds over the past decade, the Government of Ukraine recognizes that it may still retain a surplus of supply, in terms of both hospitals and hospital beds. Further evidence that the Government is aware of potential efficiency gains within the sector is apparent in the Minister of Finance's recent public advocacy for a restructuring commission.

The Bank agrees that recommended strategic planning at a macro-level would facilitate the reduction of surplus capacity and that such an approach is essential to ensure the ongoing congruency of all the component parts of the envisaged reform. It is similarly critical that the macro-level planning be resource-realistic and that it highlight the associated policy pre-requisites. Finally improved governance within the hospital sector would also be of added value vis a vis the current degrees of inefficiency and in contemplating more targeted roles for private sector involvement.
I. INTRODUCTION

The main objective of this paper is to provide feedback to the Government of Ukraine (GoU) on health sector reform proposals that are currently under debate in Parliament. These proposals include: (i) changing the way the system is financed, moving away from a budget financed system to one with multiple sources of revenue, including a new tax on wages; (ii) changing the way resources are allocated, including explicitly rationing services by introducing a new priority package of services to be publicly financed; and (iii) restructuring the delivery system by emphasizing primary health care. These specific areas were chosen as topics of this discussion paper at the request of the GoU.

While fewer resources are available in a declining growth environment and the percentage of GDP expended on health is relatively low by international standards, substantial resources are still devoted to health care in Ukraine. For FY 2000, 16.1% of the consolidated budget ($800 million or Hr 4.5 billion) or about 3.0% of GDP – 3% being about average for the region - has been allocated to health care. However, the overall health of the population is deteriorating; life expectancy is decreasing; and the incidence of diseases is increasing sharply. For public sector health care expenditures, few quality returns are received in the form of efficiently delivered health care services that effectively reach those who deserve and need them.

This note begins with a brief overview of some of the important characteristics of the Ukrainian health care system and some of the major strengths and weaknesses of the Ukraine health system are identified. (International comparisons for Ukraine on health outcomes, financing, and delivery are included in the appendices to the paper). The next part of the paper outlines the Government reform proposals, particularly the main elements of the draft medical insurance law, and then looks more closely at the reforms related to funding/financing, resource allocation and purchasing, and restructuring the delivery system. The paper concludes with a list of potential areas of future assistance from the World Bank.

II. OVERVIEW OF THE HEALTH SYSTEM

- Health services in Ukraine (ambulatory and hospital) are provided predominately by the public sector.
- In 2000, Ukraine spent approximately 4-6 percent of its GDP on health.
- Total public spending was US$42 per capita in exchange rate based dollars and US$169 in purchasing power parity-adjusted dollars.
- 13 percent of public spending on health is the central government’s share and the rest goes to lower tier government – 39% to 27 oblasts, 27% to 600 rayons, and 34% to the 170 mistos or cities.
- Lower tier governments receive about 85% of their financing from the center via fiscal transfers and derive only about 15% of their financing from own-source fees and taxes.

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1 Information for this section was obtained from the following documents: IMF, Ukraine – Implementing Public Expenditure Reform, March 2000;
• Of the amount the central government financed in 2000, 45% went to the Ministry of Health, 19% to Ukrainian Railways, and 16% to the Academy of Sciences. Health facilities maintained by the Ministry of Defense are not included in the health sector budget.
• There are 3329 hospitals in Ukraine and 94% are operated by the MOH and local health administrations.
• Hospital bed numbers are high (9.6/1000) and ALOS long (15.2)
• Hospitals are accredited by the Head Accreditation Commission of the MoH, Oblast, or City health administration in accordance with the three grade scale.
• The health sector employs over 1.1 million workers: 19% are doctors, 38% middle level staff, 21% junior level staff, and 22% low level staff.
• 77% of health personnel work in hospitals, 8% in policlinics, 9% in obstetric, emergency and anti-epidemic stations, and 6% in other locations.
• Average health sector wages in 1999 were 129.3 UAH. This is 43 percent of the average salary. In 1997 health workers earned on average 65 percent of the average salary.
• Approximately one third of total health expenditures is for pharmaceuticals. Approximately 75 percent of pharmaceutical expenditures are out-of-pocket.
• Estimates of private spending as a percentage of total health care spending range from 50 to 90 percent but there are no reliable surveys to make a precise estimate.

III. HEALTH SYSTEM PERFORMANCE

Strengths of the System:

Unfortunately, in the deteriorating economy, many of the traditional strengths of the Ukrainian health care system are no longer present. Perhaps one of the greatest strengths today is the leadership role the Government is taking in health policy formulation. This is evidenced by a large number of significant policy documents that have been approved including the Concept of Health Sector Development and Measures to Introduce Family Medicine.

Strengths Regarding Health Outcomes

• Health outcomes are very good relative to GDP.
• Very low infant mortality relative to GDP.

Strengths in Health Finance

• Deficit as a percentage of GDP has fallen from 5.3 percent in 1997 to 1.1 percent in 2000.
• Health sector is putting less pressure on the economy – or at least it is causing less of the problem with the arrears. The share of the health sector budget arrears was 21.5 percent of total social budget arrears in 1998, after declining from 41 percent in 1996. Health sector wage arrears as a share of total wage arrears were 26 percent in 1996 and declined to 16 percent in 1998.
• Resources are allocated to the oblast and rayons using a per capita allocation formula.
Strengths in the Health Delivery System

- There is substantial delivery system capacity in terms of physicians and hospital beds.
- The Ministry of Health has initiated a hospital accreditation and quality improvement program.
- The right to health is constitutionally guaranteed.
- The government has demonstrated its commitment to Primary Health Care by issuing a decree.
- Drugs are available in both urban and rural areas.

A Key Challenge Facing the System:

One of the major challenges that needs to be addressed in the health sector today that has been identified by everyone is the very restrictive Article 49 of the Constitution. Specifically, the clause places constraints on both charging fees for services or closing health facilities. The precise wording is:

Everyone has the right to health protection, medical care and medical insurance. Health protection is ensured through state funding of the relevant socio-economic, medical and sanitary, health improvement and prophylactic programs. The State creates conditions for effective medical service accessible to all citizens. State and communal health protection institutions provide medical care free of charge; the existing network of such institutions shall not be reduced. The State promotes the development of medical institutions of all forms of ownership. The State provides for the development of physical culture and sports, and ensures sanitary-epidemic welfare.

There is recognition on the part of Ukraine that this is a constraint. Efforts to address have included: a campaign to provide a new interpretation of the article launched by PULSE, a physicians lobby; argument of a case before the Constitutional Court; several legal opinions and studies by local and outside consultants.

IV. OPTIONS FOR HEALTH SECTOR REFORM

Today, Ukrainian officials believe the main issue is how to provide the population with adequate medical care free of charge. They are concerned about the growing financial burden on the population and the constraints imposed by Article 49. Reform initiatives being considered are therefore multiple and wide-ranging and include funding and financing reforms; purchasing reform; the introduction of a minimum guaranteed package of services (i.e. a basic benefits package [BBP]); widening private sector participation, and restructuring the delivery system. Many of these possibilities are encompassed within the August 2000 Presidential decree on “Additional Activities Aimed at Improving Ukraine’s Health Care” (#963/2000).

The reforms can be divided into three groups: those relating to potential funding initiatives (i.e. how to raise the requisite revenues); those concerning allocation and/or purchasing reform (i.e. how to disperse the revenues); and those concerned with restructuring the delivery system (i.e.
introducing primary health care and reducing the number of hospital beds). In the first group are issues such as the introduction of mandatory social insurance and the consideration of facilitating additional supplemental insurance. The second group includes establishment of a minimum guaranteed level of service (a basic benefits package [BBP]), ‘selective contracting’ and private sector participation. The final group, restructuring the system by reducing the size of the hospital sector, imposes a special challenge for Ukraine given the constraints of Article 49. Other important sectoral reforms are part of the overall strategy, particularly those relating to the introduction of primary health care and the strengthening of public health programs, particularly in TB and HIV/AIDS, but are not highlighted in this document.²

A large number of these concepts were also presented to donors at a Donor’s conference on December 7-8, 2000 where the GoU requested assistance to implement the reform program. It should also be noted that, while at this time many of these potential initiatives are being considered individually, the GoU is conscious of the likely need for the application of multiple policy levers and for the need to ensure congruency between any such reform measures introduced. Consistent with such recognition, the President of Ukraine has recently endorsed a Health Concept for Ukraine that has been prepared by a Health Care Reform Task Force that had representatives of the Government of Ukraine, the Ministry of Health, the Academy of Sciences, Parliament, and health care providers.³

A. FUNDING/FINANCING REFORMS

Many of the reform proposals discussed below are contained in the draft Law on Compulsory State Medical Insurance. This draft was prepared by the Ministry of Health and had been put forward to the Parliament for a second reading. However, it should be noted that the law does not have universal support within Ukraine (or the Parliament) and that there has been lively debate on many of the provisions. Within the Government, the Ministry of Finance has expressed strong reservations with the current version of the health insurance law because of the payroll tax and financial provisions. Members of Parliament have expressed concerns with the breakdown of responsibilities between the center and regions. PULSE of Ukraine, a group of physicians who are very active in the public policy debate have differences in how exactly services should be rationed. The unions have also clearly played a large role in the drafting of the legislation. The discussion below attempts to identify some of these specific points of debate.

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² One area which is discussed later in the note, though not strictly an issue of health care financing, is that of restructuring the delivery system, particularly hospitals. This is at the request of the GoU and reflects their awareness of how important this issue is to overall fiscal sustainability.


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## Table 1: Main features of the Ukraine Draft Medical Compulsory Insurance Law

| Contributors | Local self-government bodies pay contributions for: pensioners, pupils & students, unemployed (unemployed on the dole, out of work mothers with 3+ children below 18; caregivers for disabled; children and youth below 18 years who do not work)  
Employers & Employees (including self employed) pay contributions for employees  
The Fund of Social Insurance Against Accidents at the Workplace and Occupational Diseases will pay for out-of-work disabled  
The State and local bodies covers cost of health care services of the uninsured.  

| Beneficiaries | All of the above. Unclear the number of uninsured. Estimated 4 million unemployed who are not getting social assistance (MOF). Children are covered by local government contributions, implying that other family members may not be covered with the main contributor. Beneficiaries will be required to show a certificate at the point of service.  

| Financing | Primarily contributions from payroll tax and budget allocations for local self government bodies. Contribution rates unspecified in the law. Responsibility for rate setting is unclear.  
Some room is left open for Government financing under Article 3: “budget health-protection allocations shall be earmarked for financing medical, sanitary and preventive programs and medical service of special social importance including immunization, provision of medicines to privileged populations groups in accordance with legislation and emergency measures to control epidemics according to a list which is specified by the Cabinet of Ministers”  
Government guarantee of right to free medical care.  

| Benefits | “Base program”, developed annually by MIF jointly with MoH with participation of trade unions and then approved by the Cabinet of Ministers  

| Organization | Medical Insurance Fund to be located in Kiev and its funds will not be incorporated into the State Budget. Branch offices and departments. Number not specified. Legally independent, but heads will be appointed by MIF Director and law says the departments and branches shall “fulfill the tasks assigned thereto in collaboration with local executive power bodies”  

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5 The exact meaning of this article is not clear. Article 5.3 “Those are not included in the foregoing list shall be provided medical service within the extent as offered by governmental and public health care institutions for the account of the funds from the state and local budgets. The mentioned persons may be insured on a voluntary basis by the Medical Insurance Fund.”  
6 Note that later in Article 6 (1) it says that the MIF shall act as an economic guarantor for the medical services provided under the Base program and territorial programs. First, why should the MIF guarantee what is offered in the territorial program? This removes the risk from the territorial fund and provides no incentive for them to control costs. Second, the law must be clear as to who will be the residual claimant. Elsewhere the law implies the State is the ultimate guarantor. But the state and the MIF are not the same. Recall the Board of the MIF has members who are not state employees and they would presumably be accountable for the actions of the MIF?
Governance

Non-profit, self governing which acts on the grounds of Statute approved by its Board.

3 Levels of Governance: Supervisory Board to control fulfillment of statute tasks and use of MIF funds. 12 members, 6 year term. Equal representation from Government, Trade Associations, and employer associations. Rotating chair. The MIF Board to direct and supervise the activities of the MIF, including appointing the Director and deputy, establish procedures for size of contributions, approve budgets. Approximately 45 members, equal representation of state, employers, employees. State representatives appointed by the Cabinet of Ministers. Executive Directorate to permanently run the MIF. Appoints heads of Departments and branches of MIF, with approval of MIF Board.

There is also provision for “Governmental Supervision “ of Compulsory State Social Medical Insurance. This provides right to MoH, MoF, and authorized local officials to have some “control”. The relationship of this group is to be defined by the Cabinet of Ministers.

Effectiveness

The law would become effective in January 2004

The proposal:

The theme of the financing reforms proposed in Ukraine is “multi-channel financing.” This implies mobilizing other resources in addition to the central and local budgets which currently comprise most of the public financing and out-of-pocket payments which currently are believed to be the largest source of financing. Several new sources of financing are proposed: a payroll tax, official user fees, and voluntary health insurance.

- Funds from local and state budgets and compulsory state medical insurance (primarily the payroll tax, but other sources as well – see above) would be used to finance a “base program” offered free of charge.

- User fees and voluntary insurance would be used to finance services that exceed the basic quality standard of the base program.

- State and local budgets would finance “targeted health programs” (ie, priority public health). Currently, only the payroll tax has been officially proposed as part of the draft medical insurance law before Parliament.

Experiences from the Region

There are several issues to consider. First, what has been the experience with payroll tax financing for health care in the region? Second, what has happened if funds from a payroll tax are mixed with budget funds when forming an “insurance” system. Third, what has been the experience in developing the institutions to implement a social insurance system?

Payroll taxes:

All countries in ECA had to cut real public spending for health in the first years of the transition and did so roughly in proportion with GDP decline. (Belli, 2000). Payroll tax-based social health insurance has emerged as a standard part of a diversified source of health care financing in the region, supplementing dwindling general tax revenues. Of the region’s 26 countries, 14 have
introduced payroll taxes — 9 as a predominant mechanism of financing and 5 as a complementary resource to general tax revenues and out-of-pocket payments. (Preker, Jakob, and Schneider, 2001).

Contribution rates range from 4% in Georgia to 18% in Croatia. The contribution rate depends on factors including the cost of the benefit package, size of the covered population, the desirable level of redistribution toward the non-working, and other available sources of financing. (see table 2). In most countries, the contribution rate was not synchronized with a detailed actuarial analysis of expected costs and revenues for the insured population (Ensor 1999). Instead, the rate-setting process reflected a combination of optimistic “eye-ball-ing” of desired revenues and guesses about the political acceptability of adding to the already heavy tax burden on employers and employees. This has resulted in frequent changes in the setting of the rates.

Another common problem seen in many countries is when the source of transfer for the non-working population is the central and/or local government budget, the subsidy often does not fully cover the cost of care provided for the target population in question. This is especially true for pensioners who use health services more than other segments of the population and whose care is often the most expensive due to the seriousness of their illnesses.

In general, the countries of the FSU have faced considerable difficulty in collecting payroll taxes for health. Payroll taxes generally work best in countries with high formal employment rates and relatively stable economies. The difficulties using payroll taxes to raise revenue for the health sector are well documented. (See Schieber and Maeda). Consequently, countries are often advised to maintain central budget financing by the IMF and the World Bank. However, experience in the region has shown that because of economic stagnation, transfers from the budget to the health sector have often been erratic and shrinking in real terms. Substantial arrears have continued to accumulate in the system and only a small fraction of the budget assignments to health approved by Parliament at the beginning of each year are actually transferred.

> **Multi-channel financing:**

While multiple channels of public financing is the most common system of financing, one of the main problems witnessed has been that these sources are not pooled. These fragmented revenue sources are often further splintered during the budget allocation process to multiple purchasers and providers. A single purchaser may receive revenues from one or several insurers, the national budget through MOH, one or more local budget through various local governmental levels, and patients’ out-of-pocket payments. Each of these purchasers is prevented from realizing the potential benefits of its purchasing power because of overlaps in coverage and unclear specification of the benefit package.

However, even in countries with the highest collection rates for payroll taxes, it is clear that the payroll taxes and other mandatory contributions will not be sufficient to cover the entire cost of the health care system. Therefore, managing the merger of public funds with the social insurance system or charging fees is essential.

One of the impacts of low levels of payroll contributions and public sector financing has been large amounts of out of pocket expenditures for health care. This raises obvious issues of equity as well as problems with splitting the risk pooling. The fact that many of these payments are illegal or “informal” presents another set of problems. One of the most disturbing implications of informal payments is that it fuels corruption and the growth of the “gray economy,” undermining...
Table 2. Characteristics of Health Insurance Contribution Revenues

<table>
<thead>
<tr>
<th>Country</th>
<th>Year introduced</th>
<th>Payroll tax rate, 1999</th>
<th>Nonactives</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Salaried</strong></td>
<td><strong>Self-employed</strong></td>
</tr>
<tr>
<td><strong>Year introduced</strong></td>
<td><strong>Employer:employee</strong></td>
<td><strong>Payroll tax rate, 1999</strong></td>
<td><strong>Self-employed</strong></td>
</tr>
<tr>
<td>Croatia</td>
<td>1993</td>
<td>18% (18:0)</td>
<td>18% of declared income</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>1993</td>
<td>13.5% (9:3.5)</td>
<td>13.5% of 35% of net pretax income</td>
</tr>
<tr>
<td>Estonia</td>
<td>1992</td>
<td>13% (13:0)</td>
<td>13% of declared income</td>
</tr>
<tr>
<td>Hungary</td>
<td>1990</td>
<td>14% (11:3)</td>
<td>14% of declared income but at least the minimum. Wage plus hypothecated tax of US$170 per person</td>
</tr>
<tr>
<td>Slovakia</td>
<td>1994</td>
<td>13.7% (10:3.7)</td>
<td>13.7% of declared income</td>
</tr>
<tr>
<td>Slovenia</td>
<td>1993</td>
<td>13.25% (10:3.7)</td>
<td>13.25% of declared income</td>
</tr>
<tr>
<td>Albania</td>
<td>1995</td>
<td>Public: 3.4% (1.7:1.7)</td>
<td>7% of statutory minimum wage</td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>1996</td>
<td>Private: 3–5% (3:0)</td>
<td>3% of declared income</td>
</tr>
<tr>
<td>Latvia</td>
<td>1998</td>
<td>28.4% of personal income tax (7.3% (3:0))</td>
<td>28.4% of personal income tax</td>
</tr>
<tr>
<td>Poland</td>
<td>1999</td>
<td>7.5% (7:7)</td>
<td>7.5% of declared income</td>
</tr>
<tr>
<td>Romania</td>
<td>1999</td>
<td>14% (7:7)</td>
<td>7% of declared income</td>
</tr>
<tr>
<td>Russian Federation</td>
<td>1993</td>
<td>3.6% (3.6:0)</td>
<td>3.6% of declared income</td>
</tr>
<tr>
<td>Azerbaijan</td>
<td></td>
<td>No payroll tax</td>
<td></td>
</tr>
<tr>
<td>Georgia</td>
<td>1995</td>
<td>4% (3:1)</td>
<td>4% income tax</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>1997</td>
<td>2% (2:0)</td>
<td>2% of declared income</td>
</tr>
<tr>
<td>Moldova</td>
<td></td>
<td>No payroll tax</td>
<td></td>
</tr>
</tbody>
</table>
government efforts to improve accountability and public sector management. It also is lost tax revenue for the economy. It also makes it difficult for government to influence public policy and resource allocation because it has a distorted perception of the real flow of resources into the system. (Lewis 2001, Belli 2000).

Organizational Issues:

In addition to the financial issues involved in introducing social health insurance, one of the biggest challenges countries have faced has been to establish semi-autonomous parastatal organizations to implement the new social insurance programs. The main dilemmas included whether to establish social insurance on a competitive or single-payer basis, adopting national versus decentralised revenue collection, pooling, and/or purchasing systems, building institutional capacity relevant in the new health system context, and clarifying the roles and responsibilities of these new organizations vis-à-vis the ministry of health, finance, and local governments. One option several countries in the region have taken is to develop the institution of a health agency that performs the purchasing functions of a social health insurance fund, adding gradually or at a later time to its contribution base.

Implications for Ukraine

There appears to be consensus that in the long run, Ukraine will have a social insurance health system and this has been indicated indirectly in several documents. However, today as the most recently drafted health insurance law is under consideration, timing once again becomes an issue and there are debates as to primarily when, not if, a payroll tax should be introduced.

Current taxation in Ukraine on employers is 37.5%, with 32% for pensions, 4.4% for disability, and 1.1% for unemployment. There does appear to be agreement that additional tax on employers is not feasible at this time and even the main supporters of the medical insurance law emphasize that implementation will likely need to be delayed until the economy improves. Discussions have been more around reallocation within the existing taxation levels, but that also seems unlikely given current opposition to take part of the disability funds and put them into unemployment.

The draft Law on Compulsory State Social Medical Insurance envisages health care to be financed by the budget and partly by additional revenue from a payroll tax. The rate of the tax is unspecified, but MoH officials have reported that it would need to be 5 percent.

Another concern raised with introducing a social insurance system is the additional administrative cost. The Ukrainian Ministry of Finance estimated that to implement the MoH version of the draft compulsory state social medical insurance law would require an additional 5000 staff and 150 million UAH for the funds as well as 2000 staff and 5 m UAH to cover additional requirements of health care facilities under a new system. First, if these estimates are true, this would be a remarkably low level of administrative cost for the health funds, assuming the total budget were either 8,250 million UAH (1.5% administrative cost) or 4,380 million UAH (2.85% administrative cost). But more importantly, there is no reason to bring additional people into the

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7 For example, there exists a framework law on social insurance that envisages five types of funds, one of which is medical. (cite)
8 Add source
sector for these positions. Instead, these positions are perfect candidates for re-trained redundant medical staff to assume. This was the case in Bulgaria, for example, and worked very well.

Another explanation for increasing costs is that many systems have decentralized too much, creating a bloated bureaucracy. Decentralization is often a goal of the reforms, but in terms of health funding, it can create unnecessary layers and fragment the risk pools. As a result, the trend has begun to change and some countries have begun to centralize. For example, in Estonia, the 17 pools have been merged into 8 and in Hungary, the 19 regional health insurance branches have been merged into a single national fund with most administrative functions centralized.

The draft health insurance law tries to address this by increasing the amount of funding going to the health sector and ensuring a base program of services. However, this is based on the assumption that the overall envelope will increase. If the payroll tax merely replaces current budget financing, no improvements in equity will be seen.

Currently, informal payments are a problem in the health sector in Ukraine. This was highlighted by a study of corruption among consumers, which found that respondents listed health care second only to automobile inspection as the most corrupt of public services (Ukraine Legal Foundation 1998). Lack of accountability is evidenced by the low probability of getting caught and of minimal sanctions for those who are—punishments for accepting illegal payments are virtually nonexistent.

In Ukraine (and Poland), focus groups identified the low wages of physicians and wage arrears as important factors behind informal payments—without patient payment, the system could not function. (KIIS 1999; Lewis et al. 2000). There is some empirical evidence to support the hypothesis that with higher salaries, the level of informal payments will decrease. In the Czech Republic, the number of physicians has declined somewhat and earnings have exceeded or kept pace with growth in overall wages. Side payments to physicians appear much less common than in the other countries in Eastern Europe (World Bank 1999a and 2000b). In Poland, one study compared the average informal payment required by different public providers; only the capitated primary care physicians— who had the highest earnings— did not charge additionally. (Chawla et al. 1999). This would imply that the recent salary increases improved in the Ukrainian 2001 budget are a step in the right direction to solving the problem. However, these increases could be used much more effectively if they were accompanied with a decrease in the supply of health providers, as was the case in the Czech Republic, as well as tied to provider performance. (see discussion below).

It would seem that Ukraine’s alternatives lie in either identifying an alternative earmarked tax for health care and/or supporting pilots to experiment with other voluntary insurance schemes. All countries have had difficulties collecting their payroll tax revenues, due to rising unemployment, informal sector growth, and increased liberalization of employment arrangements in the formal sector. However, this should not preclude the establishment of some sort of purchasing agency that could collect resources and, over time, become an insurance fund. In the meantime, the Fund could gain experience in such important areas as contracting, quality assurance, and financial management. Experience from the region shows that the difficulty is setting up these institutions has been underestimated.
B. RESOURCE ALLOCATION AND PURCHASING

Ukraine has already moved to a system of per capita funding from the center to oblast, and then from oblast to rayons. Per capita funding based upon appropriately weighted variables is supported by the Bank as a means of improving equity and increasing transparency. In isolation, however, it does little to assist affordability and is most advantageous when introduced in conjunction with a dedicated purchasing function.

GoU is also considering the following potential reforms: 1) to limit the amount of services the population can receive by specifying a mandatory “base program” that would be publicly financed; 2) improving efficiency by allowing selective contracting; and 3) introducing the private sector into the market and allowing it to compete with the public sector.

1. Minimum guaranteed levels of service

The proposal:

The draft health insurance law envisages a “base program” that will be developed by the Medical Insurance Fund every year jointly with the Ministry of Health, with participation of trade unions. The “base program” will be approved by the Cabinet of Ministers. (Article 6)

On the basis of this “base program”, the Council of Ministers of the Autonomous Republic of Crimea, oblast, Kyiv, and Sevastopol City Administration shall develop and approve draft territorial programs which will then be approved by respective Radas. The extent, level, and terms of medical services under the territorial programs may not be lower than those specified by the Base program.

Under the general provisions, it reiterates that the goal of the compulsory state medical insurance is to protect citizen’s rights to receive free of charge medical aid on the basis of social equality and availability with no regard to age, sex, state of health, at the expense of the medical insurance fund in the amounts determined by the program.

Experiences from the Region:

The establishment and introduction of a minimum guaranteed level of service, sometimes called a ‘basic benefits package’, is nearly always considered by countries facing service affordability issues. The logic behind this is if provision of all services is unaffordable then prioritization must take place to determine which services the government should finance with public funds.

According to public finance criteria, any proposed public expenditure should demonstrate its ability to meet efficiency and/or equity criteria. In analyzing efficiency and equity, the focus is on the specific nature of the market failure and why the private sector is not able to achieve an efficient and equitable outcome. The common types of market failure with regard to goods and services include: public goods, externalities, competition failures, asymmetric information and missing markets. The particular nature of health goods and services makes them prone to market failures. For example, health care activities such as ensuring sanitation, and information,
education and communication (IEC) campaigns to influence lifestyle choices are pure public goods. Others such as immunization, HIV/AIDS prevention and tuberculosis control are activities with large externalities. Information asymmetry and missing markets are also problems in the health sector. For example, the vulnerable (the poor and the very sick) may not be optimally served through private markets, and there are various market failures (moral hazard and adverse selection) associated with health insurance. All of these issues create a rationale for public expenditures for certain goods and services in the health sector.

Problems, however, invariably arise in both designing and implementing a basic package. Comprehensive and accurate cost-based modeling in association with accurate volume identification are naturally critical pre-requisites to the establishment of financially sustainable packages yet, in many instances due to the very resource deficiencies that are driving the need to introduce service limitations, it is impossible to get the necessary baseline data. Even more difficult to quantify and cost, which is necessary so that the new ‘package’ can incorporate them, are the service interdependencies and/or the common clinical co-morbidities associated with the services included within the basic package.

Many countries, even if they are able to overcome such data-hurdles, find the necessary process of establishing relative cost-effectiveness extremely problematic. While international initiatives such as the Cochrane Collaboration have provided us with much more useful data on matters such as relative cost-effectiveness, these issues remain highly contentious. Priorities must naturally also be locally customized which, given that it involves inter-disciplinary debate, is often challenging. It is somewhat of a concern from a political economy perspective that in Ukraine the draft health insurance law envisages the base program being annually determined and politically ratified. Potential annual package variability is also problematic from both patients and providers perspectives due to the inherent reduction in certainty.

Such difficulties often lead to governments establishing a minimal ‘excluded services’ list as an alternative to a basic package as this is more easily achievable and inevitably more clinically supportable. Such politically pragmatic options however fail to overcome the initial problem of a lack of affordability and, in fact, frequently result in the identification of the excluded services increasing consumers expectations in respect to those services not excluded.

The other often utilized ‘fall-back’ position in respect to basic packages is for governments to enunciate broad service areas, such as health protection, emergency care and acute surgery, rather than explicitly identifying all ‘covered’ services. As with the ‘excluded services’ option outlined above the utilization of the broad service areas option is a progression (affordability-wise) on unfettered access and is of a lesser political risk, but it usually also fails to prove financially sustainable.

The difficulties surrounding the design and implementation of a basic package often give rise to the adoption of broader service prioritization as an alternative. Under such an option a government will enunciate service expansion and contraction priorities which can be done by contrasting current service expenditure percentages with desired downstream service percentages, thereby demonstrating which service areas the government wants priority given to and also enabling, via this guidance, local managers and clinicians to respond to the promulgated directions while still retaining the ability to make local resource-consumption decisions that most appropriately fit the local circumstances and needs. For example, several countries in the region have specified spending levels for primary health care. This option is also more likely to be favored by parties that believe the route to more cost-effective health care provision is via increased strategic planning coupled with sophisticated, and accountable, purchasing.
Should GoU continue pursuing the introduction of a minimum services package – the Bank has advised the government of its concerns in respect to BBPs and that it does not believe it to be optimal to attempt the introduction of such an initiative given, amongst other factors, the absence of a robust database upon which to make the rationalization decisions - one technical issue to consider is who will be responsible for determining what is in the package and how that decision will be made. In some ECA countries, the process has become very politicized as it has been tied to the budget process and Parliament has gone in and added responsibilities for the health insurance fund without providing additional funding. Over time, this grew, to the point where what the government can actually afford to pay for is a small portion of what they are requiring to be universally provided. The easiest way to avoid this would be to depoliticize the process as much as possible. But if the health insurance funds are not entirely financially independent of the budget, that is a difficult thing to do and there is little international evidence that the process can ever, in fact, be constructively depoliticised.

Another problem can arise if the package is broken up in such a way that parts can be financed by different financiers. What many countries have considered is leaving the responsibility for financing of health care to the local level. This has several problems. First, it fragments the risk pool. Second, if these local providers receive financing from more centralized sources, say for secondary care services, it places an extra administrative burden upon them as they now have two groups to work with. If financing from the local level is desired, it is probably best to find some way to have all of the funds pooled in one place, whether it is central money allocated down or municipal money flowing up.

**Implications for Ukraine:**

It is important to reinforce that while in principle, the concept of governments enunciating a basic benefits package as a critical component of their fiscal management strategy is supported, and there is no doubt that if the difficulties outlined above, together with the associated political economy challenges, are able to be successfully overcome, then a soundly derived basic package would contribute in an enormously positive manner to the ongoing fiscal sustainability of the Ukrainian health service, The Bank is not universally supportive of BBPs simply because they invariably prove politically problematic and either non-implementable or fail to remain financially sustainable.

Current debate in Ukraine is an interesting one, and demonstrates a familiarity with many of these issues. While one perspective advocates the more typical truncation approach, another is looking more at a “Cochrane” type initiative whereby all services would be free, but the definition of all is defined by what is clinically effective. Essentially the two approaches can be crudely categorized as one under which quality would be limited, but with wider service access and another wherein quality would be heightened but with narrower access.

The Bank believes that engaging in the debate concerning the strengths and weaknesses of BBPs and attempting to conceptualize a potential pathway towards the possible eventual introduction of such a system of service rationing is constructive, however, it is firmly convinced that introduction of a BBP at this point in time would be premature and that definitive decision making in such a politically sensitive area requires considerable analysis of data which currently does not exist.
2. **Contracting**

*The proposal:*

The GoU, as implied earlier, recognizes that the introduction of more data and opportunity-cost driven purchasing, as distinct from a population or historical expenditure based allocation system, could be of significant assistance in overcoming its affordability challenges. Accordingly, earlier drafts of the medical insurance law had an entire article devoted to contracting. This has however been removed since details of this type are more appropriately placed in regulations rather than in laws. However, the right to selective contracting is still implied under Article 22 where it says that, “medical institutions having no medical service contract” is one reason to terminate payment for medical services and the introduction of a dedicated purchaser remains under consideration.

The term ‘selective purchasing’ is usually used to refer to the situation wherein a purchaser makes a conscious decision not to enter into contracts with all providers, thereby being ‘selective’. Under such circumstances purchasers frequently end up being cast as the points of primacy in health service rationalization exercises. Utilization of the term in its common usage is therefore challenging in the context of Article 49 of the Ukrainian constitution.

Selective purchasing could of course also be usefully envisaged as the situation where a purchaser elected to contract for the provision of only a predetermined number of procedures rather than effectively funding a provider via block-grants or input driven criteria such as physical beds.

*Experiences from the Region:*

Over the past decade insufficient attention in health reform exercises has been paid to the function of purchasing. Many governments have reformed only their service delivery mechanisms and/or their financing methodologies and, as a consequence, continue to face ongoing affordability crises linked to structural inefficiency.

Without the introduction of a sophisticated and accountable purchasing function under which clear product-choice decisions are made on the basis of price/cost, volume and quality in such a way as to reflect the government’s strategic priorities, optimal benefits from even the most advanced and technically proficient reform projects will not be achieved. Critical questions relevant to the establishment of an added-value purchasing function include: what is the nature, if any, of the competition the government wishes to inject into the system; at what level within the system does government want such competition to be maximized; given the geographical and clinical spread of services and the overall population numbers and density what purchaser configurations are optimal; is appropriate information in existence to enable informed purchasing to occur, and, given current levels of managerial capacity how would the most cost-effective purchaser-provider split be configured?

Equally important as establishing ‘where’ the purchasing activity will be located within the system is the determination of the purchasing currency. A number of different purchasing mechanisms are in existence in countries facing similar challenges to Ukraine such as prospective and retrospective case-based systems; fee-for-service; and fixed/minimum volume global budgets. [Input based resource allocation systems such as those wherein hospital receive the income based on things such as their bed or staff numbers are generally seen as allocation systems not purchasing systems]. Each of the purchasing systems has differing pros and cons the
majority of which correlate closely to the incentives inherent within the system and which can be maximized or minimized by management of their external environment (for example, by increasing or decreasing the hospital’s residual rights and/or management’s ability to hire and fire).

A common problem occurs when governments attempt to use only one purchasing system as differing systems are more or less useful in differing ways to differing service areas. Case-mix based prospective purchasing, for example, is not ideally suited to specialist care of the elderly or to the provision of mental health services due to the wider case variations that tend to be apparent within those specialized areas. Governments therefore need to pay particular attention to the interfaces between differing purchasing systems prior to their implementation.

The move in contracting has been from inputs based and historical budgeting to cost per case, fee for service, or some other sort of activity based payment scheme. Problems of expenditure blow-out have arisen when service volumes have not been “capped” and on other occasions the introduction of a case-mix-based inpatient payment system has resulted in excessive hospitalization and an inappropriate reduction in ambulatory care funding.

**Implications for Ukraine:**

Even without introducing health insurance, Ukraine can move quickly to a system of improved purchasing and eventually selective contracting. This has the potential to greatly enhance both the efficiency and quality of the delivery of health care services by facilitating economies of scale and skill. Added-value purchasing is not, however, without its political challenges as it will likely lead to service reductions and job losses in certain institutions.

Optimal purchasing is also contingent upon pooling of available resources, so work will need to be undertaken on purchaser configurations as well as on the identification of the most advantageous purchasing currencies. While it is debatable whether the requisite data currently exists within the Ukrainian system to enable the introduction of a, by international standards, sophisticated purchasing system, such a system could evolve in due course based upon an initial block grant / guaranteed volume interim model.

3. **Private Sector Participation**

*The proposal:*

The draft medical insurance law opens the door for private sector participation in the health sector. Specifically, Article 4 (5) says “Medical care under compulsory state social medical insurance can be provided by health care institutions of any ownership forms that are accredited and licensed in the procedure established by the legislation of Ukraine.” However, at the moment there are relatively few private providers and reportedly barriers to entering the market are very high.
Experiences from the Region:

Many governments believe that enhancing the role of the private sector in the provision of publicly funded services will reduce their ongoing fiscal burden. While there are generically many benefits to involving the private sector more, premature introduction of the private sector into an unstructured system without clear role delineation, without a sophisticated purchasing function and lacking an explicitly defined ongoing strategic role for both public and private parties can prove to be problematic. For maximal incorporation of private providers into a publicly funded system (i.e. as directly contracted providers of the complete range of a hospital’s services) the government or its agent must know exactly what services - at what volumes and at what quality - the private sector is being asked to deliver and must also know what price represents a beneficial margin on the public sector. That is, in the absence of an extremely well developed purchasing function, private sector provision of publicly funded services at this level should be approached cautiously.

Having said that, however, a phased introduction of private sector participation (PSP) can be extremely advantageous. Many forms of PSP exist from the simplest and least ‘invasive’, that of managing a small non-clinical support area, through to perhaps the most internationally ‘high-profile’, that wherein the private sector builds, owns and operates a new hospital under contract with the government. In between such extremes are situations where the private sector may manage the entire public hospital with hospital employees remaining government employees or where the private sector might supply all non-clinical support services and also be the employer of all affected staff. In short the PSP options are extensive and a private sector option can almost always advantageously be designed to reflect government’s particular objectives and to be environmentally congruent.

Naturally different PSP options involve both differing degrees, and differing areas, of risk transfer and again it is critical that governments evaluate their ongoing exposures and their ability to manage these prior to determining the appropriate point for PSP. As in wider industry risk-reward trade-offs are an intrinsic feature of PSP in the provision of publicly funded services and therefore accuracy and comprehensiveness in preparatory cost-benefit appraisal is critical.

Some countries are now also contemplating involving the private sector in purchasing roles, more often in quasi supplementary or ‘opt-out’ insurance schemes. While an economy has to be extremely robust and a society notably egalitarian for opt-out insurance schemes (whereby an individual can opt to pay a lesser rate of general taxation and not be eligible to receive publicly funded health care services with the intention being that the individual would instead ‘cover’ themselves via private insurance) permitting private supplemental insurance is almost a necessity in circumstances where publicly funded services are less than optimally available. Where there is a likelihood of supplemental insurance schemes developing the public sector's capacity to appropriately regulate and monitor the private sector frequently needs development.

Implications for Ukraine:

Ukraine will need to do a substantial amount of work if it genuinely wants a viable and competitive private sector. One constraint will be Clause 49, which, strictly interpreted, renders the provision of ‘private’ private services redundant due to the constitutional requirement to provide free treatment within a non-diminishing infrastructure. Similarly the absence of a dedicated purchasing function for publicly funded services makes incorporation of privately
owned providers of publicly funded services problematic. Indications are also that the current regulatory environment is not particularly welcoming for private health care providers.

In the Bank’s experience, while an optimal health care system is a “dual” system (i.e. featuring both public and private providers), the unstructured introduction of the private sector can create dysfunctions and inappropriate prioritization and resource usage. Accordingly the Bank usually advocates the preparation of a strategic plan for the introduction and/or expansion of the private sector so that the local government does not lose control of the agenda. It is essential that such a document appropriately highlights the critical role that a well developed regulatory function can play in ensuring that the private sector does play a value-adding rather than resource-draining role.

C. RESTRUCTURING THE DELIVERY SYSTEM

The Proposal:

Despite the relatively low percentage of GDP expended upon health services in the country and the considerable reductions in both hospitals and hospital beds over the past decade the GoU recognizes that it may still retain a surplus of supply, in terms of both hospitals and hospital beds, and is seeking to address this issue constructively while at the same time recognizing the challenges inherent with remaining consistent with the spirit of Article 49 of the Constitution.

Experience from the Region:

Reductions in hospital bed numbers across Europe and Central Asia over the past decade have been extensive. Few countries have not experienced such restructuring, albeit that by international standards the number of hospital beds per thousand across the region remains relatively high, and across many of the CIS nations, extremely high. Complete hospital closures and the envisaged downsizing of staff from the bed reductions are however less evident and, as a consequence, even where significant bed reduction has been effected in many places, affordability remains challenging. It is also readily apparent that small rural institutions have been impacted more than urban facilities.

Belli (2000) points out that the most significant restructuring of the delivery system has taken place in Kazakhstan, where reductions in beds and facilities have been in the order of 40-50 percent. Georgia has also seen marked reductions in supply and in Estonia the government’s intention is to consolidate 78 hospitals into 13 and reduce 8200 beds to 3000. Some regions within the Russian Federation are also implementing hospital restructuring plans that foresee a profound reduction of the delivery system. Features of the Georgian rationalization exercise and of the Estonian plan emphasize affordability-driven strategic planning coupled with selective contracting and extensive communication programs.

Two of the most common causation factors in faltering health reform (particularly vis a vis hospital rationalization) are lack of appropriate sequencing and inappropriate governance. One of the greatest barriers to effective hospital and/or service rationalization is, for example, the existence of separate boards of directors (boards of governance) for individual hospitals. Such governing bodies tend to adopt an objective more closely aligned to the good of their individual
facility rather than to the betterment of the wider system and to increased overall efficiency, thereby making subsequent closure or significant service re-profiling of their hospital more problematic. While the introduction of expertise into the governance structures of hospitals is essential as systems progress into split purchaser-provider models, unless a government is convinced of both the ongoing clinical need for, and affordability of, a particular hospital, caution should be exercised in respect to the introduction of an independent board for it.

Where further facility and service rationalization is envisaged, an alternative is to group a number of hospitals, either by natural geographical position or by clinical coherence, under a single governing body. By so doing, ongoing rationalization is facilitated while at the same time increased operational efficiencies are possible due to the ability to consolidate support services and optimize upon the organization’s economies of scale. A further issue which impacts significantly upon the subsequent operations of the entities is the composition of the board, i.e. what skill sets are present on the board.

**Implications for Ukraine:**

A study of the hospital sector in Ukraine revealed that much has been achieved over the past decade. Hospitals have been reduced by 16.5% and beds by 33.5% and the GoU should be congratulated on these achievements, particularly in light of the constraints imposed by Article 49. However bed numbers remain high (at 9.6 / 1000); relative inefficiency is apparent (e.g. ALOS is 15.2) and sub-optimal integration and lack of overall affordability is evident. Notwithstanding Article 49 guaranteeing 'free access' 88% of people surveyed stated that the reason that they did not attend hospitals for care was due to the high cost of attendance. The challenges associated with the affordability of the current hospital system were further highlighted in the fact that 94% of people reported having to pay for their medication and 82% for food during their periods of hospitalization. Estimates by hospital personnel of the official level of budget sufficiency range from 40% through to 90% of expenses.

Inefficiency is also apparent in areas such as staffing where the numbers of medical staff and nursing staff (at 46 /10000 and 111 / 10000 respectively) are relatively high albeit that in the case of medical staffing the MOH's staffing norms indicate a staffing shortfall of 15%.

Further evidence that the GoU is aware of potential efficiency gains within the sector and the current arguable affordability of the system is apparent in the Minister of Finance's recent public advocacy for a restructuring commission.

Many of the potential initiatives previously outlined within this paper could constructively be utilized in an effort to improve the efficiency and longer-term viability of the hospital sector within the Ukraine so this section of the paper will not unnecessarily readdress them in any detail. Suffice it to say that strategic planning at a macro-level and the introduction of sophisticated and selective purchasing would be advantageous to reduction of surplus capacity and that the system's overall efficiency would similarly benefit from the introduction of more advanced purchasing. Improved governance would also be of added value vis a vis the current degrees of inefficiency and contemplation of increased and more targeted roles for the private sector may also prove to be advantageous.

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**Footnote:**

10 "The major bed reductions were in rayon hospitals (decreased by 57.7% from 1990 to 1999) and to a significant extent due to re-profiling (allowed under Clause 49) of the small village hospitals into rural ambulatory facilities (by 69.1%)"
In the event that further investigation demonstrates that Ukraine has equity of access challenges associated with geographical location (initial tangential evidence appears to indicate that rural hospitals have greater challenges associated with affordability and resourcing levels) redefinition and re-weighting of the variables within the current population-based funding formula, may prove to be beneficial.

In relation to overall affordability two areas already being explored within the Ukraine may also prove to be contributory - these being the determination of minimum guaranteed levels of service and the expansion of primary health care, the latter particularly if the consequential is a reduction in hospitalization. On a somewhat different note caution should be exercised in attempting to resolve or reduce the affordability challenge via additional funding mechanisms as this may merely serve to reinforce, and render fiscally viable, an inappropriate and inefficient service delivery system.

V. CONCLUSION

Ukraine faces a number of challenges in respect to its health care services. While the intention of the paper was to comment upon some of the matters and options being contemplated and in other instances simply to raise awareness it is apparent that, notwithstanding the imperative to address the issue of the constraining nature of Article 49, certain initiatives could be commenced now which would assist the longer term health reform requirement.

Many of the initiatives that the GoU is actively contemplating are eminently appropriate and have proven to be extremely beneficial when introduced in other countries facing similar problems of constrained affordability and relative inefficiency. However it is important that such initiatives be considered in a wider environmental context so that their ramifications, including the negative as well as the positive, and their optimal sequencing can be evaluated and implementation decisions made being cognisant of such issues. By so doing the GoU will avoid potentially disadvantageous ‘downstream’ impacts associated with premature and ad hoc decisions to implement some of the customary high profile features of health reform programs.

A strategic plan which enunciates the ongoing structure of the health system (for example, whether a purchaser/provider split is to be introduced; what role the private sector might play in service delivery etc), its operational context (i.e. how revenues will be generated, funding allocation mechanisms etc), and which outlines priority areas for development and/or rationalization is normally of immense benefit as an initial step to countries undergoing health reform. Such a strategic plan in Ukraine’s context could ensure ongoing consistency, the essential role-clarity, and an appropriate operational focus upon the espoused objectives, as decentralization is effected.

A resource-realistic strategic plan would also help shape consumer expectations and contextualise the affordability driven requisite service and facility rationalization. The framework for the interface between ‘publicly funded’ services and any supplementary insurance scheme could also be outlined within the plan. In addition, given the natural tendency for health service subdivision it would be advantageous were the strategic plan to encapsulate all aspects of the nation’s health services and to identify not only the critical interfaces between the service areas but also to reflect how such interfaces should most appropriately be managed to ensure service continuity and optimal overall quality.
Possibly the most urgent of these tasks is to undertake an in depth costing and efficiency study. The results of this should then drive GoU’s decisions in respect to ongoing service affordability and in respect to options such as the introduction of a guaranteed minimum level of service and the introduction of supplementary insurance.

Similarly work on determining the most appropriate operational structure can be initiated, i.e. where purchasing should occur, whether a purchaser-provider split would be advantageous, whether multi-hospital boards of governance would be advantageous etc, prior to determining ongoing affordability and/or revenue raising mechanisms.

The Bank believes that the GoU is well placed to successfully continue the pursuit of a range of health care reform initiatives. The Bank would welcome the opportunity to work with the GoU whether the Government decides to adopt a strategically and structurally congruent macro level reform program or whether the Government decides to pursue a number of independent reform initiatives possibly addressing some of the issues outlined in this paper.

Specifically, the Bank would assist GoU to define its overall expectations of its health care system, its long-term models for operational service delivery (including those relating to the purchasing function ), and to determine optimal financing methodologies. In short, the Bank would work with GoU and other impacted parties to establish a workable and mutually understood ‘blueprint’ or conceptual end-picture. The Bank would also assist in the definition of reform priorities and in the appropriate sequencing of such.

The Bank would use its ‘independent expert’ status to bring the parties together to focus on a common solution – which would greatly assist in implementation success – and would provide assistance in evaluation of options etc.

Extensive ‘awareness raising’ vis a vis international experiences with health care reform and re international performance benchmarks and international ‘resourcing norms’ would also be most advantageous especially in relation to increasing efficiency and ensuring ongoing financial sustainability (re both revenue raising and fiscally based service planning).

The Bank would also maintain a consistent dialogue with the international donor community to assist in ensuring that macro-level objectives do not become distorted and to ensure potential project congruence.

Institutional capacity requires extensive development and a key role for the Bank would therefore be capacity building and particularly ensuring appropriate training is facilitated consistent with the envisaged future model.
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UNDERLYING SOCIO-ECONOMIC AND HEALTH SITUATION

Key economic indicators

- Ukraine is a low income country with a nominal GDP per capita of US$840, and $2,250 per capita (PPPS).
- The gini coefficient is 29.0. The lowest quintile consumes 8.8 percent and the highest quintile consumes 37.8 percent.
- The unemployment rate is approximately 11\(^\text{12}\) percent - and is the same for both men and women.
- Budget deficit is 1.1% of GDP.
- Social budgetary payment arrears were 4.2 percent of GDP in 1998. 21.5 percent of these arrears were from the health sector.
- For the first time since the transition, real GDP grew 3-5% in 2000 and is expected to grow 1 percent in 2001.

Human development indicators

- The population is approximately 49.7 million, 68 percent of which is rural.
- The average annual population growth rate is –0.8 percent. The population has declined approximately 3% since 1995.
- 18 percent of the population is below the age of 15 and 14 percent is 65 and above
- 98 percent of the adult population (15 and above) is literate.
- 99 percent of children under 12 months are fully immunized against measles and DPT.

Health indicators

- Life expectancy at birth is 73 for women and 62 for men.
- The crude birth rate is 9 per 1,000 people.
- The crude death rate is 16 per 1,000 people.
- The infant mortality rate is 14 deaths per 1,000 live births.
- 0.43% of adults aged 15-49 in Ukraine are infected with HIV/AIDS.
- In 1998 the rate of TB infection reached 55 per 100,000, increasing more than 70% since 1990.
- Nutritional deficiencies are widespread as Ukrainians. Consumption of meat has fallen 50%, fruit 20%, eggs 40% and fish 75%.

Reproductive health indicators

- The total fertility rate is 1.3 births per woman of reproductive age.
- The maternal mortality rate is 27 deaths per 100,000 births.

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\(^{12}\) 11 percent is IMF statistic. GoU official unemployment rate is 4.2 percent.
INTERNATIONAL COMPARISONS

The tables in Annex 1 compare Ukraine’s health care system with other countries in ECA on several dimensions: demographic, health status, delivery system and health expenditure. The figures in the Annex compare the country’s characteristics to those of other countries worldwide and countries of similar income levels.
## ANNEX I Regional Tables

Table A.1: GDP and Health expenditure trends

<table>
<thead>
<tr>
<th>Country</th>
<th>Per capita GDP (PPP $)</th>
<th>% Change in real GDP 1990-97</th>
<th>Per Capita Health expenditures (PPP $)</th>
<th>Total health expenditures as % of GDP</th>
<th>Real health spending (public) as % of 1990 spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croatia</td>
<td>6,735</td>
<td>-18%</td>
<td>481.1</td>
<td>402.2</td>
<td>78.9</td>
</tr>
<tr>
<td>Czech Rep.</td>
<td>12,930</td>
<td>-9%</td>
<td>758.3</td>
<td>695.3</td>
<td>62.9</td>
</tr>
<tr>
<td>Estonia</td>
<td>7,504</td>
<td>-21%</td>
<td>241.2</td>
<td>209.1</td>
<td>32.1</td>
</tr>
<tr>
<td>Hungary</td>
<td>9,914</td>
<td>-6%</td>
<td>510.9</td>
<td>417.4</td>
<td>93.5</td>
</tr>
<tr>
<td>Slovakia</td>
<td>9,526</td>
<td>-2%</td>
<td>617.6</td>
<td>498.4</td>
<td>119.2</td>
</tr>
<tr>
<td>Slovenia</td>
<td>14,032</td>
<td>4%</td>
<td>897.0</td>
<td>802.8</td>
<td>94.2</td>
</tr>
<tr>
<td>Albania</td>
<td>2,683</td>
<td>-11%</td>
<td>58.0</td>
<td>44.5</td>
<td>13.5</td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>4,513</td>
<td>-40%</td>
<td>123.7</td>
<td>83.5</td>
<td>40.2</td>
</tr>
<tr>
<td>Latvia</td>
<td>5,609</td>
<td>-45%</td>
<td>195.4</td>
<td>151.2</td>
<td>44.2</td>
</tr>
<tr>
<td>Poland</td>
<td>7,438</td>
<td>27%</td>
<td>413.9</td>
<td>315.4</td>
<td>98.5</td>
</tr>
<tr>
<td>Romania</td>
<td>6,209</td>
<td>-13%</td>
<td>78.5</td>
<td>54.9</td>
<td>23.5</td>
</tr>
<tr>
<td>Russian Fed.</td>
<td>7,031</td>
<td>-40%</td>
<td>228.2</td>
<td>175.5</td>
<td>52.7</td>
</tr>
<tr>
<td>Azerbaijan</td>
<td>2,039</td>
<td>-57%</td>
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*Source: Jakab, Preker and Shneider, forthcoming*
Table A.2: GDP growth (annual %)

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Global Trends in Infant Mortality, 1997

[Graph showing trends in infant mortality rate versus per capita GDP, with a focus on Ukraine.]
Table A.3: Health expenditure, public (% of GDP)

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Source: World Development Indicators, 2000

Health Expenditures as Percent of GDP
Global Trends, mid 1990s

![Graph showing health expenditures as percent of GDP](image-url)
Table A.4: Hospital Beds per 1,000 People in selected Central and East European, Former Soviet Union, OECD and Newly Industrialised Nations (1996)

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*Source:* World Bank, World Development Indicators 1999

**Global Trends in Bed Capacity, mid 1990s**
### Table A.5: Physicians per 1,000 People in selected Central and East European, Former Soviet Union, OECD and Newly Industrialized Nations, 1996

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*Source: World Development Indicators 1999*

**Global Trends in Physician Number, mid 1990s**

![Graph showing global trends in physician number mid 1990s](chart.png)