Key strategies for further development of the health care sector in Ukraine

Joint report
Key Strategies for Further Development of the Health Care Sector in Ukraine

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translated from ukrainian

under joint editorship by
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This publication contains materials on the health care development strategy in Ukraine, prepared by national Ukrainian experts with additional expert support from the World Bank and European Commission. The document includes analytical data on the health status of the population, current problems with the present health care system in Ukraine; justification within the context of goals and principles, optimal organizational model, ways of transforming the health care system and specific measures necessary for purposeful, gradual and effective reform of the health care sector.

The document targets analysts, policy-makers, government officials responsible for solutions and decision making in the health care sector, and also other specialists concerned with health care reform.

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The elected government, which has won power by the will of the people, has to justify its people’s trust and live up to their expectations. For this reason, the government bears great responsibility for resolving the most difficult issues facing the nation, which have accumulated over the entire period of the state’s existence. This is particularly true for the socially relevant health-care sector, which has the highest expectations from the people. The government’s mission is to develop a health-care system which meets the public need for accessible and high quality medical services in the most effective manner.

The Cabinet of Ministers of Ukraine presented a plan to address urgent and long-range political, social and economic issues in the Government’s Program of Activity “Meeting People”. This document emphasizes that the “confidence of citizens in the future will increase as expectancy increases, fertility rises and mortality decreases. We must choose our path toward transforming the national health-care system, and follow it steadily, progressively, and without vacillations. We cannot allow mistakes to be made. Our decisions should be based on reliable scientific research, analyses of both positive and negative national and international experience, as well as our political, cultural and economic realities.

We are grateful for the work carried out within the framework of the Joint Project by the World Bank, the European Commission, and the Swedish International Development Cooperation Agency. A group of national and international experts explored the possibilities for improving the health-care system in Ukraine on the basis of extensive research analysis and balanced assessments.

It is hoped that this document will be used by policy-makers, analysts, and managers in taking responsible decisions on the reform of the Ukrainian health care system.

Minister of Health of Ukraine
Mykola Polischuk
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Armin Fidler, Health Sector Manager and Paul Bermingham, Director for Ukraine, Moldova, and Belarus, World Bank, supervised the preparation of the study, reviewed the report and provided useful comments.

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Authors’ Notes

Ukraine’s health care system has to solve serious problems in the health sector operation and the population’s health. Under current social and economic conditions, the Ukrainian health care system is not well prepared to adequately respond to public health care needs. Budget resources are limited and private expenditures grow, creating barriers to access to medical services.

Although Ukraine inherited a well-developed infrastructure of hospitals and system of personnel provision from the Soviet Union, the system of primary health care was underdeveloped. Most of these resources are expended on personnel costs and utility payments, and very little remains for medications, equipment and the modernization of the infrastructure. The lack of incentives (legal barriers, strict hierarchical control, and a system of financing oriented to cost reimbursement) continues to preserve the current, economically unsustainable system, which cannot provide effective, quality-assured medical and disease prevention services.

Given the growing demands of the Ukrainian healthcare system, the international community is increasingly involved in discussions with the Government on the development of the healthcare system. The dialogue is focused on topics such as ensuring equality, access, appropriate provision of medical services, effectiveness of sectoral funding, taking into account rising in healthcare costs according to the economic growth rate. After numerous discussions on how to improve the healthcare system, the Government of Ukraine committed to supporting a number of implementation strategies, including the health care restructuring, rationalization of the service network, improvement of primary healthcare and creation of a regulatory environment for more effective use of private sector resources.

This study aims to assist in the process of planning and coordination of a state policy, to provide specific guidelines to the Government of Ukraine for a systematic development of the healthcare sector over the next 10 years, as well as to help experts plan their further actions.

This work is an example of a joint effort and a strategic partnership in support of healthcare reform between the Government of Ukraine (Ministry of Economy, Ministry of Health, Verkhovna Rada of Ukraine (Parliament) and international organizations (World Bank, European Commission and the Sida).
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Abbreviations

GDP — Gross Domestic Product
WHO — World Health Organization
PHC — Public Health Care
HFA — “Health for All”
HCF — Health Care Facility
GP/FM — General Practice/Family Medicine
CG — Clinical Guidelines
TPF — Prevention and health care facility
MOH — Ministry of Health
PPP — Purchasing Power Parity
PMSC — Primary medico-sanitary care
SMI — Social Medical Insurance
VMI — Voluntary Medical Insurance
ALE — Average life expectancy
FOP — Feldsher-obstetric point
INTRODUCTION

Recently Ukraine has determined faster integration into the European community as its main priority.

In order to implement these ambitious plans, it is necessary to significantly improve the quality of human resources, in addition to meeting a range of political and economic requirements.

Health of the population is now viewed as an indicator of social and cultural progress and the overall quality of life. The 2002 report on the state of the European health care system by the WHO Regional Office for Europe says that investments in the health care system should be considered as a contribution to the development of the national economy and to the reduction of the poverty rate. In the World Bank’s World Development Report of 1993, health care is defined as an important area of investments in the promotion of the general economic and social growth of a nation. The World Bank states that financial investments in health care is vital for a nation’s economic growth.

The aim of this survey was to use scientific data, national and international experience to formulate a set of priorities for radical improvements in the health care system in the country and to develop relevant recommendations for the Government of Ukraine.

In order to meet the goals of the survey, the following tasks were carried out:

• Assessment of population health status in Ukraine.
• Description of rights with respect to equality and equity of public health.
• Analysis of the problems in the existing health care system.
• Identification of objectives and principles and of an optimum model for health care system organization based on the current status of public health in Ukraine.
• Assessment of methods of reform and specifying activities to reform the health care system.

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HEALTH STATUS OF THE POPULATION AND THE HEALTH CARE SYSTEM IN UKRAINE

Section 1
POPULATION HEALTH STATUS IN UKRAINE: EQUITY AND EQUALITY

Population health status

The health status of the population is an important internal indicator of a nation’s demographic and social welfare. Societal transformations, including the foundation of a fundamentally different model of Ukraine’s economy, were accompanied by a long and intense socio-economic crisis, ultimately affecting the health of the people. The majority of the population lives under adverse conditions which lead to increased morbidity, mortality, and disability rates.

The medico-demographic crisis peaked in 1995-1996. It was caused by an abrupt drop in living standards during the period of socio-economic changes, unfavorable environmental conditions, difficulties in adapting to new market conditions and socio-psychological stress, curtailed health care system financing and reduced health care accessibility. This had a serious effect on the labor-force, particularly men. According to an analysis by foreign experts, in 1995, during the transition to a market economy, the risk of death among men aged 16 to 60 reached 28%. This rate is surpassed only in Central Africa [14].

Although the situation has improved since then, however Ukraine falls behind economically developed nations in health and life expectancy indicators. The Ukrainian population entered the 21st century with a poor health status. This had an unfavorable impact on sustained development, and consequently on the economy. Disease prevention and health improvement are among the key priorities for the nation and the goal of socioeconomic reform. In order to evaluate the effectiveness of activities, health status should become the main criterion. All areas of the economy should be aimed at improving the conditions of living, particularly working conditions, lifestyle, reproductive activity within the framework of a strategy being implemented in many countries under the name “Health for All” [5].

The well-being of people relates directly to health. The health status of the individual determines the individual’s role in the life and development of society as well as the magnitude of his/her reward for such involvement.

Decreasing birth and increasing death rates cause a complicated population situation in Ukraine. Both experts and the public regard the nation’s health status as unsatisfactory.

Population size and its age-gender characteristics

For the last decade, the country’s population has gradually decreased by 4.1 million people. This decrease is due to increased death rates and low birth rates. According to Jan. 1, 2004 data, Ukraine’s population was 47.6 million (51.334 million in 1995; 49.7 million in 1999) [1]

The Economics Institute of the Academy of Sciences of Ukraine projected that Ukraine the population will decrease to 38.5 million by 2030 and to 31.0 million people by 2050 (i.e. over a third). At the same time, the proportion of people of retirement age will rise to 31.9% (fig. 1.1). It should be noted that this forecast is based on the assumption that the socio-economic situation in Ukraine will gradually improve.

The main features of the changing age structure include a decline in the proportion of children (to 17.3%) and an increase in the number
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of people aged over 60 (to 21.35) (Fig.1.2.) High concentration of people of retirement age mostly in the rural areas is a characteristic feature.

Ukraine ranks eleventh for the percentage of the population aged 60 and older, lagging behind such “demographically old” countries as Italy, Greece, Germany, Japan, Sweden, etc. (for comparison: Belarus ranks 26th, Russia 27th.) Considering the projected ageing pattern the growing number of old people will increase the burden on medico-social services as well as on geriatric care.

Birth rate

In recent years the birth rate in Ukraine has declined — from 12.7 per 1,000 in 1990 to 8.5 per 1,000 in 2003 (preliminary 2004 data: 9.1) (Fig.1.3.) This is due to the ageing of the population and self-regulation of the number of children by families (in Ukraine one woman gives birth to approximately 1.1 children in her lifetime, which is below the rate required for replacing the parental generation), This, in turn, is due to socioeconomic conditions.

While there was some increase in the birth rate in 2002-2004, this trend cannot be attributed to policy. Demographers ascribe this trend to the beginning of an active reproductive period for the relatively large group of women born in the 1980s.

According to the last national census, the gender disparity is decreasing: while there were 1,163 women of reproductive age per 1,000 men in 1989, the number at present is 1,031. The combination of these two favorable trends provides a good basis for implementing a policy to promote reproductive health and encouraging fertility immediately. This is important because the reproductive portion of the population will decrease. (16.0 per 1000 of population).

Crude death rate

The crude death rate in Ukraine remains high, mainly due to circulatory diseases, malignant tumors, accidents, poisonings and injuries (Table 1.1). At present the standardized death rate factor (14.1%) is twice as high as in EU countries (7%) [7].

There are significant regional differences in mortality (higher rates in the southeast and the

Fig. 1.1. Population Size for Ukraine from 1994 to 2010 (Source: State Statistics Committee and the Institute of Economics of ASU [1])

Fig.1.2. Percentage of the Total Population Aged 16 and ≥ 60 (Source: State Statistics Committee [8])

Fig. 1.3. Changes in Birth and Death Rates in Ukraine, 1975-2003 (Source: Annual demographic reports: “The Population of Ukraine” for each year cited [2])
south). Death rates in rural population are higher than in urban populations.

Mortality from circulatory diseases has increased almost 1.5 times compared with the early 1990s (1991: 671.7 per 100,000 of population.) The mortality rate in Ukraine due to cerebral-vascular pathology is the highest in Europe and is the leader among people under 65. In all developed countries, cardiovascular diseases are the main cause of death, but their prevalence in Ukraine is much higher, with relatively young people, primarily men suffering from such diseases.

Deaths from infectious diseases are also relatively frequent in Ukraine, mostly due to tuberculosis, which is not typical for developed countries. Mortality from TB has almost tripled since the beginning of the 1990s (tentative 2004 data: 22.5 per 100 000 of population).

Population growth rate

Between 1990 and 2003 the birth rate considerably declined (from 12.7 in 1990 to 8.5 per 100,000 in 2003.) (2004 tentative data — 9.1) (Fig 1.3) The rate of natural decline of population in Ukraine in recent years has been the highest in Europe (Fig.1.4.) The 2002 Report of the WHO Regional Office for Europe points out that in times of peace there is no precedent for changes of such scale [15].

Infant mortality

In recent years infant mortality in the first year of life has been gradually declining, which is evidence for the high priority given to maternity and child health care and the improvement of the quality of health care system (Fig.1.5.) According to the tentative data by the Ministry of Health, infant mortality rate in 2004 was reduced to 9.53 per 1000 live births. However, mortality rate for infants less than one year old is still high with respect to European standards, exceeding indicators for the European Union 2 to 2.5 times (Fig.1.5.) It should be noted that due to the changes made to the Civil Code of Ukraine on the time and procedure for medical interruption of pregnancy, and updates to infant mortality registration procedures according to WHO requirements and EU standards, the indicator of registered infant mortality is bound to rise starting in 2005.

Tab. 1.1. Death Rates in the Total Population by Cause (per 100,000 individuals)

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>Statistic of the years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1996</td>
</tr>
<tr>
<td>Total</td>
<td>1519,6</td>
</tr>
<tr>
<td>circulatory diseases</td>
<td>874,2</td>
</tr>
<tr>
<td>malignant tumors</td>
<td>194,0</td>
</tr>
<tr>
<td>external causes (accidents, poisonings and injuries)</td>
<td>157,2</td>
</tr>
<tr>
<td>respiratory diseases</td>
<td>86,1</td>
</tr>
</tbody>
</table>

Source: Indicators of population health status and national health care system resources 2002-2003 [8]; * tentative data
Maternal mortality rate

Maternal mortality rate is high compared to other European countries, although there is a stable trend toward decline (preliminary data for 2004: 13.5 per 100,000 of live births) (fig 1.7).

Working age mortality rates

The rate of mortality among the working-age population has been distressingly high for many years. In 2003 this indicator was 619.7 per 100,000 individuals, which is 2 to 4 times higher than values for other European countries. Most of the deaths are caused by "unnatural or external causes", which include accidents, poisoning or injuries, most frequently suicides and alcohol poisoning.

Alcohol abuse is one of the most important risk factors for all types of violence and accidents. In terms of direct expenses and decline in labor productivity, alcohol-related losses for society are estimated at 2% to 5% of gross national product (GNP). In 2003, mortality from alcohol poisoning among the working-age population was 27.0 per 100,000 individuals (for comparison, the rate was 28.2 for all respiratory diseases.)

Male over-mortality is a specific feature of mortality for a specific age group. In 2003, the mortality rate from all causes among able-bodied men was 3.6 times higher than that among women (926.9 and 264.2 per 100,000, respectively), which is a serious problem for both industrial productivity and the reproduction of the nation (Table 1.2.) The disproportionate loss of male lives at reproductive age — which is virtually identical to working age — distorts the gender ratio, resulting in a large number of single women, broken families and orphaned children.

Under current conditions, mortality in the working-age population is projected to increase due to changes in the gender and age structure, increase in risk factors, and deteriorating living conditions [12].

Preventable mortality refers to deaths that can be prevented within the framework of existing policies in the public health area and by the efficient supply of health care services (i.e. time-
ly medical assistance and appropriate medical intervention) It is important to note that the rate for such “preventable” mortality is high in Ukraine [8,11].

**Average life expectancy**

Average life expectancy (ALE) is an integral indicator of population health. ALE in Ukraine fell by almost 3 years from 1990 to 2003 (1990: 70.57; 2003: 67.6 years) and today it is lower by 6.45 years than the average European indicator, and by 10.39 years compared to EU countries. The gap between ALE indicators for men and women is upward of 10 years (2002: 10.55 years). The trend toward longer female life expectancy is observed all around the world, partially due to a number of biological factors. However, gender-specific ALE differences in industrialized countries are much smaller than in Ukraine: 6.45 years in EU countries; 8.3 and 8.45 years respectively in Ukraine’s closest neighbors — Poland and Hungary (Fig.1.8).

**Morbidity and disease prevalence**

The general indicator of disease prevalence (2003: 163,294.5 per 100,000; tentative 2004 data: 168,234.7) is mostly based on circulatory, respiratory diseases and diseases of digestive organs, osteo-muscular system and conjunctive tissue, etc. In recent years, the rate of endogenous pathology has progressively grown for diseases of the circulatory system, malignant tumors, and metabolism, which is to some extent related to the rise in risk factors such as non-rational nutrition, hypodynamia, smoking, alcohol and drug abuse [3]. The share of exogenous pathology also remains high, which is not typical for developed countries.

The situation with TB and HIV/AIDS epidemics remains difficult. Over 27,000 new TB patients are registered every year. Current rates are 2.5 times higher than that of 1990 at 77.7 per 100,000 individuals (preliminary 2004 data: 80.9.) The number of serious and neglected TB cases has increased and new health problems have appeared, including the appearance of multi-resistant TB, which is not treatable under standard medical treatment, and AIDS-related TB [13.]

Ukraine is at the epicenter of the AIDS epidemic in Eastern Europe. HIV incidence is nearly twice as high as that in Western Europe and 14
times as high as in Central Europe [MOH]. A major concern is not the total number of individuals with HIV infection, but the speed with which the epidemic has begun to spread in 2005. The epidemic spread beyond the risk group of injection-drug users and is now also spreading among the general population.

In 2004, 12,491 HIV-positive citizens were registered, including 2,293 children. Overall, there were 134,320 known HIV-positive cases in Ukraine as of January 1, 2005 (according to current data.)

The most infected oblasts (regions) are in eastern and southern Ukraine (Donetsk, Dnipropetrovsk, Odesa, Mykolayiv, Autonomous Republic of Crimea.) These regions also have the highest rates of injection-drug use and hepatitis B infection (which has the same route of transmission as AIDS).

Diabetes mellitus is also a serious problem, as nearly one million people suffer from it. The rate of general disability remains high.

The number of disabled people is almost 2.5 million (equal to the population of a large oblast).

**Equity and equality in health care**

Eliminating poverty is viewed by the international community as a major priority for socioeconomic policy in nations where poverty is still a major issue.

The social focus of the national health care policy, and protection of the interests of socially vulnerable groups of society is emphasized in various program documents, including the inter-sectoral comprehensive program “Health of the Nation” for 2002-2011, the national program “Children of Ukraine”, “Reproductive Health for 2001-2005”, the “TB Control Program for 2002-2005”, etc. The comprehensive program on implementation of the “Poverty Elimination Strategy” (Resolution of the Cabinet of Ministers of Ukraine #1712 of December 21, 2001) foresees social support for unemployed and disabled people, development and implementation of a compulsory social medical insurance system, and the adoption of a consolidated and targeted social assistance program within the health care system. Free provision of medicines to certain categories of citizens is ensured through the legislations entitled “On the Status of War Veterans and Guarantees for Social Protection” and “On the Basic Principles of Social Protection for War Veterans and other Elderly People of Ukraine”, etc. There is a functioning network of veterans’ drug stores that serve war and labor veterans and other elderly people.

Social stratification in the country is extensive. Research indicates that 27% of population is poor and 12-14% is destitute. Polarization of the population has intensified [4, 13.]

The decline in the standard of living affects the health of the population indirectly because of inadequate nutrition, inferior health care services, and a lack of access to affordable medications for large groups of the population. Abandoning physical activity, chronic psychological and emotional stress, and unfavorable working conditions, are also some other factors that contribute to this.

The energy value of food for almost one fifth of the population is below 2,100 kcal, which is the poverty threshold according to WHO [3]. According to the State Statistics Committee (2003), the population’s diet is unbalanced. The consumption of meat, vegetables, fruit, and eggs has dropped by 10% to 15% compared with the year 2000, with the actual consumption of these biologically valuable foods remaining below physiological standards.

Inadequate nutrition (primarily low consumption of food of animal origin food and vitamins, consumption of inferior foods containing pesticides, antibiotics, and other contaminants, genetically modified products) leads to health and developmental problems, including the growing number of newborns with birth defects.

The impact of poverty on the health of the population in Ukraine is the growing number of people suffering from TB (see above), a disease affecting mostly lower income groups, is indicative of the impact of poverty.

Both infectious and non-infectious diseases are more common in the low-income and otherwise vulnerable groups of society. The results
of a large-scale survey on equality within the health care system, conducted by the Ukrainian Public Health Institute [5, 6], showed that the incidence of diseases in the low-income range was 45% higher than in more affluent groups of society. Hospitalization rate for low-income people is three times as high as that of persons with incomes above the average. The incidence of chronic non-infectious diseases in low-income groups (Table 1.3.), that limit opportunities for earning a living, is also higher. Adverse living conditions and malnutrition aggravate the situation, and medical costs drain already meager savings. Smoking and alcohol abuse and other bad habits are also more frequent in low-income groups leading to diseases and, as a result, a growing need for medical help.

The overwhelming majority (75.5%) of low-income people in Ukraine are families with children aged under 18. Because of low salaries, families cannot provide decent living conditions for their under-aged children, even with both parents working. For this reason many chose to limit the number of children or decide not to have children at all. Of the households with children (but no retired or other adult dependents), with both parents employed, 26.1% are poor. This is due in part to low wages but also to extremely insufficient social assistance provided for families with children [3].

Typically, poverty also affects medical workers, and this has an overall impact on the health of the nation. Thus, physicians, just as teachers, scientists and engineers, who at the start of the transformation period had medium-level incomes by the national standards, now have become the “new poor.” The fact that this highly educated workforce, often employed in socially relevant occupations, has fallen into the low-income group, also has very negative consequences for society.

In 2004, the average salary for health workers increased by 28% compared with the start of the year (by 10.8% as of March 1, 2004 and by 15.61% as of September 1, 2004; workers of the TB control service received a 15-30% raise as of September 1, 2004). Even with these increases salaries in the health care system are lower than those in the industry and remain insufficient and inappropriate for the complexity and the

Tab. 1.3. Noninfectious Disease Incidence in Various Socioeconomic Groups

<table>
<thead>
<tr>
<th>Diseases</th>
<th>Number of infected (per 10,000 of people)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low-income</td>
</tr>
<tr>
<td>General incidence:</td>
<td>2149,5</td>
</tr>
<tr>
<td>hypertensive</td>
<td>124,5</td>
</tr>
<tr>
<td>diseases</td>
<td></td>
</tr>
<tr>
<td>chronic bronchitis</td>
<td>38,2</td>
</tr>
<tr>
<td>chronic gastritis</td>
<td>45,2</td>
</tr>
</tbody>
</table>
amount of work involved and for the level of responsibility assumed by health care workers in society.

An average salary in the health sector during 2003 and 2004 was Hr339.81 and Hr385*, respectively whereas in the industrial sector for the same period, it was Hr680.12 and Hr800.90*. This means that the two-fold difference was not eliminated over the two years. Compared to the general salaries in economy, the pay of health workers accounted for 61.7% and 57.8%* respectively whereas wages in the industrial sector, 123.4% and 124.3%* (* — State Statistics Committee data.). The ratio between wages in the health sector and an average living standard minimum in 2003 was 0.99, with the same nationwide indicator being 1.51, in 2004 (November data) — 1.06 and 1.78, the ratio of salaries in health care sector to the living standard minimum for person capable to work in 2003-2004 was 0.93 and 0.99 respectively (nationwide: 1.61 and 1.67).

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly average living standard minimum (LSM) per person (Hr)</td>
<td>270,10 311,30 342,00 342 362,23</td>
</tr>
<tr>
<td>Living standard minimum for persons able to work (Hr)</td>
<td>287,63 331,05 365,00 365 386,73</td>
</tr>
<tr>
<td>Average salary in economic sector (Hr)</td>
<td>230,13 311,08 376,33 550,95 644,27</td>
</tr>
<tr>
<td>Average salary rate in health care sector (Hr)</td>
<td>155,00 199,64 250,63 339,81 385</td>
</tr>
<tr>
<td>Ratio of national average salary to average LSM/person (%)</td>
<td>85,2 99,9 103,0 151,0 177,86</td>
</tr>
</tbody>
</table>

* Based on indicators of the social development from the Ministry of Labor and Social Security for 2000–2004.
Source: MOH data, including operation data * of November 2004.

**Conclusions for Section 1**

1. The health status of the Ukrainian population deteriorated dramatically in the 1990s and it continues to be unsatisfactory. This is shown by:

• high rates of general mortality, as well as mortality due to specific causes, are both two times as high as in EU countries;
• extremely high mortality rates in the working-age population, which are 2 to 4 times high the rates in industrialized countries;
• the phenomenon of male “over-mortality” when the death rate of men aged 25-44 is almost four times the death rate of women of the same age;
• decreasing life expectancy (nearly 3 years from 1990 to 2003); the difference between the national and average European indicators is > 6 years, and the difference between the national and EU indicators is > 10 years;
• the natural population reduction rate is the highest in Europe, leading to fast depopulation;
• low reproduction leading to the ageing of the population; the proportion of the population in retirement-age is much larger than the 0-15 years age-group;
• minor improvements in birth rates, infant mortality and maternal mortality were seen but these cannot compensate for the severe demographic situation;
• high rates of general morbidity with increases in disease risk behaviors, such as tobacco, alcohol and drug abuse, especially among young groups;
• TB and HIV/AIDS epidemics.
2. Large differences in disease rates between poor and wealthy groups reflect inequity within the health care system (there are over 3-fold differences in incidence for some noninfectious diseases).

3. Deterioration of population health status leads to an increased demand for health services, which cannot be provided by the current health care system based on old Soviet concepts.

**Literature for Section 1**


Section 2
HEALTH CARE SYSTEM IN UKRAINE

2.1. Organizational Structure and Management

Organizational structure

The Constitution of Ukraine, adopted in 1996, declares that provision of health care services to the population is one of the most important functions of the State.

Therefore, the health care system is fully controlled by the State. This system is managed and coordinated by the Ministry of Health of Ukraine through the Ministry of Health of the Crimean Autonomous Republic, which is part of the Government of the Crimean AR, as well as through 24 health care departments of the Oblast state administrations, and the health care departments of Kiev and Sevastopol city state administrations. The latter two are structural units of the city administrations, and are at the same time functionally subordinate to the Ministry of Health of Ukraine.

As is seen from fig. 2.1, the main participants in the health care system are as follows:

On the National Level — the Ministry of Health of Ukraine (MOH), which is the leading body within the executive power branch, responsible for implementation of state health policies, and administering state-owned health facilities that belong to the scope of its control;

On the Regional Level — the Ministry of Health of the Crimean Autonomous Republic, the health care departments of Oblast state administrations, Kiev and Sevastopol city state administrations, which are responsible for implementation of state health policies in the relevant jurisdictions, and health facilities under state ownership and health facilities jointly owned by territorial communities (Crimean AR and Oblast hospitals, diagnostic centers and so on) placed under their control by the decisions of governmental authorities and rayon or oblast councils (i.e. self-governing bodies.)

On sub-regional (rayon) and city (community) levels — rayon state administrations, rayon, city district, town and village self-governing bodies (councils) and the rural rayons, town, city rayons, village health facilities established to provide medico-sanitary care directly to the population.

An important role is also played by:

The Ministry of Finance (MOF), which is accountable to the Cabinet of Ministers for the preparation of a draft State Budget, which is then submitted to the Parliament for approval. The MOF also establishes requirements for the formulation and implementation of budgets for budget institutions, which include state and communal health care facilities;

The Ministry of Defense, Ministry of Internal Affairs, Security Service, Ministry of Transport, which have their own health care facilities that provide health care services for employees and their family members, as well as the State Penal Jurisdiction Department, which is responsible for organization of health and preventive services within the penitentiary system;


4. Under the Constitution of Ukraine, the country’s administrative and territorial system is comprised of the Crimean AR, 24 oblasts, rayons, cities, city districts, towns and villages. The cities of Kiev and Sevastopol have special status, defined by separate laws, practically equivalent to the status of Oblast.
Fig. 2.1. Organizational Chart of the Health Care System

2. HEALTH CARE SYSTEM IN UKRAINE
The Ministry of Labor and Social Policy, which is responsible for providing specialized health care for elderly and disabled persons in nursing homes under their jurisdiction. In addition, it is also responsible for exercising government control over the compulsory state social insurance funds (in particular, the Social Insurance Fund for Temporary Disability and the Fund for Social Insurance for Industrial Accidents and Occupational Diseases);

The Fund for Social Insurance for Temporary Inability to Work is used to provide, among other things, financial coverage for temporary disability, including taking care of a sick child, pregnancy and childbirth. Payment for trips to sanatoriums and health resorts are provided to insured persons and their family members.

The Fund for Social Insurance for Industrial Accidents and Occupational Diseases covers health care costs for insured persons in case of an accident;

The Fund for the Social Protection of the Disabled is used to provide the disabled with medicine, artificial limbs, auxiliary devices, and health rehabilitation services;

The Red Cross Society of Ukraine: its local branches run their own home-nursing service employing about 3,200 nurses, annually, providing health care services for almost 250,000 single older citizens and disabled people. Furthermore, health care assistance is provided in more than 450 health care and social centers and Red Cross stations. The activities of Red Cross Organizations are financed from the state budget and from voluntary contributions by legal entities and individuals, including foreigners.

The majority of health and preventive services are provided by health facilities that are under state ownership or owned by local communities (communal property) (see Section 2.4, Organization of Health Care Services.)

The Ukrainian health care system continues to be financed through state and local government budget.

The role of insurance companies that offer voluntary medical insurance is insignificant. High cost of commercial insurance services, operating on the voluntary medical insurance market are not affordable for most citizens (see subsection Voluntary Medical Insurance, in section 2.3 Health Care System Financing).

Although the public can participate in resolving health care issues by law, and many professional medical associations and NGOs of patients are planned or operating, there are few relationships established. There is no self-governing of the medical profession in Ukraine (participation in formulating state policies on health and health care system management, to ensure transparency and quality is very important in countries with a developed civil society.)

In this regard, no major changes have taken place in Ukraine's health care system over the past few years.

Future prospects for the compulsory medical insurance system remain uncertain, and the role of important players, such as the National Social Medical Insurance Fund is still unclear. A few attempts have been made in recent years to introduce legislation, but all have failed in Parliament. The main reasons for this will be discussed in more detail in Section 6.3, Funding for the Health Care System and Institutions.

In February 2000, the law “On Procurement of Goods, Works and Services with Public Funds” was passed regulating the purchase of health care services with public funds on a contract basis from providers of different forms of property (including private). In practice, this law has not been implemented as yet.

The time-frame for establishing health care supervisory bodies at the rayon state administration level is still under discussion.

Planning, regulation and management

This legislation, other laws, and related clauses regulate issues surrounding the development and implementation of health policy. The Verkhovna Rada (Parliament) of Ukraine plays a role through building the constitutional and legislative foundations for health care, by setting its goals, major objectives, areas of action and priorities, establishing budget guidelines, creating a system of financial, tax, customs and other regulatory bodies and approving a list of comprehensive and targeted national health programs.

The health care policies of the Crimean AR, local and regional comprehensive and targeted programs formulated by the Verkhovna Rada of the Crimean AR, and self-governing bodies reflect the specific health care needs of people living within their jurisdictions, are integral parts of the state health care policy in Ukraine.

The implementation of state health care policy is the responsibility of state executive bodies.

The President of Ukraine acts as guarantor of the rights of citizens to health care: through the system of executive bodies, he ensures that health care legislation is applied and the state’s health care policy is implemented, and as well he carries out other functions assigned to him by the Constitution.

The Cabinet of Ministers of Ukraine organizes the development and implementation of comprehensive and targeted national programs, creates economic, legal and managerial mechanisms to promote the efficient operation of the health care system, oversees the development of the network of health institutions, forms international agreements, coordinates international relations in the health care field and performs other health-related functions assigned to the executive power branch.

Ministries, agencies and other central executive power bodies develop programs and make projections in the health care field, establish common scientifically-based state standards, criteria and requirements to promote public health issues, prepare and place state orders for providing material and technical support to the health care system, exercise government control and supervision and carry out other related functions in the health field.

The Council of Ministers of the Crimean AR, city state administrations, and bodies subordinate to them and local governing bodies implement state health policies according to their authorities.

The Ministry of Health is the authorized central executive body in the health care field. In order to coordinate the operations of health facilities that are under the control of ministries and other central and local executive bodies, it allocates material and technical resources and improves public health care standards. The Interdepartmental Board for coordination of health institutions, with the Minister of Health as head, has been established under the MOH by resolution of the Cabinet of Ministers.

The executive functions in Ukraine’s administrative and territorial units are assigned to the MOH of the Crimean AR and the health departments of local state administrations.

As emphasized above, the overwhelming majority of health care and preventive services are provided by government-owned state and city health facilities. The state and communities act as agents that ensure the maintenance of health facilities within the limits of strict line-item budgets. Health facilities continue to have little authority in making independent management and financial decisions on efficient use of resources. Public procurement of health care services on the basis of contractual relations between payers and service providers is not being carried out in spite of the relevant legal framework in place.

In contrast to developed European countries, where a contractual public procurement model is applied for purchasing health care services, financed by general taxes, Ukraine still uses the integration model of health care organization (the Semashko model).

Unlike most other branches of the economy, the financing of the health care system continues to be almost fully dependent on the state and local budgets. This process is secured in the Budget Code, which was adopted by the Parliament on June 12, 2001, and which has divided expenditures on health care system needs among budgets at different levels (see insert 1).
Given all known benefits of the decentralization principle, this organization of health care financing is inefficient, and this is, in fact, found to be the case in practice. Financing of the majority of health care services still has not been shifted to community pools at the village, town, city and rayon level, where financial resources and risks could be utilized to efficiently manage local health services.

A series of state programs addressing the most urgent health problems are underway in Ukraine. Approved by the Presidential Decree and Resolution of the Cabinet of Ministers, they are financed from the state budget. The Council of Ministers of the Crimean AR, oblast state administrations, Kiev and Sevastopol city state administrations are required to develop and approve relevant regional programs, which are financed from local budgets.

Until recently, Ukraine however, did not have a unified state plan in the health care field. Approval of the Inter-sectoral Comprehensive Program “Health of the Nation” for 2002-2011 by the Cabinet of Ministers on Jan. 14, 2002 was a step towards the creation of the document which would be comprehensively present the health care policy. The Program addresses a wide range of problems and introduces measures for:

- the development and improvement of state health care policies;
- ensuring equality and equity in health care;
- improving means of subsistence and the quality of life;
- improving the health of women, children and youth, working people and elderly citizens;
- creating better opportunities for disabled people;
- reducing morbidity rates and controlling the spread of communicable diseases, minimizing accidents, injuries and poisonings;
- promoting a healthy lifestyle;
- resolving environmental health problems;
- improving the financing and management of health care system resources;

Expenditures From the State Budget Include:

(a) Primary medico-sanitary, out-patient and in-patient care (multi-field hospitals and polyclinics that carry out specific nationwide functions according to the list approved by the COM of Ukraine);

(b) Specialized out-patient and in-patient care (clinics of scientific-research centers, specialized hospitals, health centers, hospitals for lepers, hospital for WWII veterans, specialized medical-sanitary units, specialized polyclinics, specialized dental clinics according to the list approved by the COM of Ukraine);

(c) Sanitary-rehabilitation care (state hospitals for TB patients, state specialized sanatoriums for children and teenagers, specialized sanatoriums for WWII veterans);

(d) Sanitary-epidemiological surveillance and monitoring (sanitary-epidemiological centers, disinfection centers, anti-epidemic activities);

(e) Other health care programs that promote the performance of nationwide functions according to the list approved by the COM of Ukraine).

Expenditures out of the budgets of villages, towns, towns of rayon jurisdiction and their associations include expenditures for primary medico-sanitary aid, out-patient and in-patient care (district hospitals, out-patient departments, medical and obstetric stations).

From the rayon budgets and city budgets of the republican jurisdiction of the Crimean AR, and cities of oblast jurisdictions, expenditures are made for primary sanitary — medical aid, out-patient and in-patient care (general hospitals, maternity hospitals, first aid and emergency stations, polyclinics and out-patient departments, general dental clinics) and expenditures for health care educational programs (city and rayon health centers and health education activities).

From the budget of the Crimean AR and oblast budgets, expenditures are made for primary sanitary medical aid, out-patient and in-patient care (hospitals of republican jurisdiction of Crimean AR and of oblast jurisdiction); specialized out-patient and in-patient care (specialized hospitals, clinics, including dental, health centers, hospitals for disabled WWII veterans, children’s homes, blood transfusion centers) for sanatorium and resort facilities (TB sanatoriums, sanatoriums for children and disabled people, medical rehabilitation centers); other state health programs (medical-social expert boards, forensic investigation centers, medical statistics centers, medical supplies depots, sanitary education activities, other programs and arrangements).

5. Starting on Jan.1, 2006, these expenditures will be made from rayon budgets or the budgets of cities of the Oblast jurisdiction, in accordance with the changes to the Budget Code of Ukraine introduced by the Parliament on Jan.13, 2005.
• improving the delivery of health care services to the population;
• improving health employee training;
• developing health information systems;
• developing scientific research in health care;
• developing medical ethics and deontology;
• improving the socio-economic security of health workers;
• promoting international cooperation and partnership of Ukraine in the health care field.

Plans are to finance nationwide activities of the Program from the state budget. The Council of Ministers of the Crimean AR, oblast state administrations and Kiev and Sevastopol city state administrations are to develop regional programs in consultation with the Program and set annual goals for implementation using local funds.

In planning the total number of in-patient beds, health authorities should be guided by standards established for each of the 27 regions in 1997 by the Resolution of the Cabinet of Ministers. These standards are based on in-patient health care requirements estimated per 10,000 individuals of the population in a given area. For Ukraine, the average standard is 80 beds per 10,000 residents. At the same time, there are no standard limitations on the number of hospital beds at specialized institutions and departments.

The number of nursing staff providing out-patient medical aid is planned on the basis of standards for a given number of doctors in a specific profession. Standards also exist for the number of nurses at medical and obstetric stations to provide out-patient services in rural areas. These standards are based on population size, specified by the MOH.

The number of medical staff for in-patient hospitals is planned based on the staff standards established by the MOH, for the standard number of beds in different departments of hospitals of different levels of jurisdiction (oblast, rayon, city hospitals, etc.)

This method of hospital bed and medical staff planning lacks rationale. On the one hand, it is economically inefficient and makes it difficult to control costs. On the other hand, it does not reflect the actual health care needs of the population.

The functions of state regulation in the health care sector are concentrated mostly on the national level. Only some regulatory activities in this area are within the authority of local executive bodies.

The Ministry of Health is responsible for the organization and implementation of mandatory state accreditation of health facilities of different property, issuing licenses to economic agents (legal entities and individuals) that are engaged in the delivery of medical services or the production and sale of medicines. It takes part in the development of state social standards in the health care area and approves related standards. The MOH is also responsible for state registration and control of production, proper storage and sale as well as quality control of medicines, immune-biological preparations, medical equipment and medical products. The MOH establishes requirements for professional staff training, retraining and professional development of health and pharmaceutical workers, uniform qualification standards for persons pursuing medical or pharmaceutical activities and the list of medical and pharmaceutical specializations.
In addition, the MOH, in agreement with the Ministry of Economy, approves the list of national and imported drugs; regulates prices for these, and ensures that this list is revised and amended on a periodic basis.

The MOH, in agreement with the Ministry of Finance, is also empowered to make changes to the list of national and foreign drugs (approved by Resolution of the Cabinet of Ministers), which may be procured by health facilities and which are financed, fully or partially, from the state or local budgets.

At the same time, the right to set trade margins on drugs and medical products that are included in the list above, and are sold through drugstores, or are procured by state and communal health institutions, was granted by the Cabinet of Ministers to the Council of Ministers of the Crimean AR, oblast, Kiev and Sevastopol city state administrations. The jurisdictions can regulate trade margins within certain limits set by the Cabinet of Ministers. The Council of Ministers of the Crimean AR and the local state administrations also regulate tariffs on the small list of paid services that are provided by state and communal health facilities financed from personal savings.

The procedure of developing, reviewing, approving expenditure and income budgets of public and communal health facilities as well as key requirements to their utilization (just like budgets of other budgetary institutions and organizations) is regulated by the Cabinet of Ministers’ directive, while the forms of relevant documents are approved by the Ministry of Finance of Ukraine.

Salary scales of medical and other staff of state and communal health facilities as well as salary scales of employees of other budget institutions are also regulated by a special Resolution of the Cabinet of Ministers. The specific terms of remuneration take into account the type of work. In addition to the Cabinet of Ministers, the MOH in consultation with the Ministry of Labor and Social Policy and the Ministry of Finance are also involved in the establishment of salary scales for health care workers. The heads of state and community health facilities are authorized to establish, within the limits of budgeted payroll fund, specific salary rates and benefits for employees. They can provide financial assistance, including assistance for health improvement, but excluding funerals, in the amount of not more than one year’s salary. They can also endorse the procedure for granting bonuses and the size of these based on employees’ performance.

Special laws regulate the size of contributions to the mandatory state social insurance fund for temporary disability and expenses related to the birth of a child or death, as well as the size of contributions to the fund for mandatory state social insurance for industrial accidents and occupational diseases causing disability. These laws are periodically (as a rule, annually) revised by the Parliament. Activities of the funds for mandatory state social insurance are supervised by the Ministry of Labor and Social Policy of Ukraine.

Laws are currently in place to allow citizens to participate in health care management. They can participate in organizing the functioning of community advisory and supervisory boards, establishing professional associations for health workers and other associations with interests in health care promotion. Still no legislative basis exists to allow self-governance in the medical profession, although the important role of this in health care management in developed countries was described above.

The main responsibility for planning, management and regulation of the health care system on the national level is assumed by the Ministry of Health (MOH). The Ministry of Health of the Crimean AR and the health care departments of oblast, Kiev and Sevastopol city state administrations are responsible for planning, management and regulation on the regional level. Rayon state administrations and rayon chief medical officers, who are also head physicians of central rayon hospitals, are responsible for these functions on the sub-regional level (in rayons), where there is no special health care authority. On the community level (village, town, city), these functions are performed by elected local councils supervised by rayon state administrations.
The scope of authority of the MOH, Oblast health care departments, Kiev and Sevastopol city state administrations and the Ministry of Health of the Crimean AR is described below. The authority of village, town and city councils is discussed in the sub-section Decentralization of the Health Care System.

The Ministry of Health of Ukraine

The scope of authority of the MOH is detailed in the Statute of the MOH approved by Presidential Decree. Certain powers of the MOH are set forth in a number of laws adopted by the Parliament.

The principal objectives of the MOH include:

- implementation of state policies, sanitary-epidemiological safety of the population, development, production, quality control and sale of medical drugs;
- coordination of national health care development programs, particularly those concerning disease prevention, provision of medical services, development of the pharmaceutical industry;
- organization of free medical services by state and community health facilities;
- development of activities for disease prevention, reduction of morbidity, disability and mortality rates;
- organization, together with the Academy of Sciences of Ukraine and the Academy of Medical Sciences of Ukraine, of research programs in the key medical science development areas.

The MOH is also responsible for:

- management of state-owned assets under MOH control, including a small number of institutions financed from the central budget;
- organizing and carrying out state accreditation of health facilities;
- promoting entrepreneurial activities, licensing economic agents (legal entities and individuals) that provide health services, produce and sell medicines, etc;
- coordination of institutional activities and scientific-research centers (irrespective of their property) on issues of diagnostics, disease treatment and prevention, promotion of health;
- monitoring the compliance with sanitary legislation, state standards, criteria and requirements;
- participation in the development of national social standards in the health care field, approval of relevant regulatory acts;
- approval of state sanitary standards, rules, hygienic standards, quality standards for medicines, immune-biological medications, drinking water, medical equipment and other medical products;
- participation in developing and adopting of environmental standards and radiation safety norms;
- participation in state regulation of radiation safety;
- ensuring state registration of medicines, immune-biological medications, medical equipment and medical products, as well as control over their production, proper storage, sale, and quality;
- establishment of common qualification standards for health care workers, pharmaceutical businesses and professions.

Decisions made by the MOH within its scope of legislated authority are binding upon individuals, central and local executive bodies, self-governing bodies, enterprises, institutions and organizations of all ownership structures.
**Management of the health care system by the local State Administrations, the Ministry of Health of the Crimean Autonomous Republic**

The scope of authority of the health care departments of Oblast, Kiev and Sevastopol city state administrations is set forth in the relevant standard statutes approved by a special Resolution of the Cabinet of Ministers of Ukraine.

The main tasks include:

- ensuring local implementation of state health care policies;
- forecast development of the health facility network to provide health care services in compliance with established standards;
- carrying out activities for prevention and elimination of infectious diseases and epidemics;
- organization of provision of health care services, the operation of medical-social boards of experts, forensic institutions;
- ensuring compliance with legislation and that state standards, criteria and requirements aimed at protecting the environment and enhancing the sanitary-epidemiological well-being of the population;
- ensuring compliance with professional standards, requirements of the State Pharmacopeias, standards of medical services.

In order to fulfill those tasks health care departments of local state administrations:

- prepare proposals for programs and draft budgets on economic and social development of regions, submit them to relevant state administrations for consideration and ensure their implementation;
- assist local self-governing bodies in addressing issues of local socio-economic development;
- study the health of the local population, take action to prevent and reduce morbidity and disability, as well as promote longevity;
- exercise, based on sector-specific health standards, control over the quality and amount of health care services provided by health facilities of different property;
- identify demand for medical equipment, medicines, construction materials, fuel, vehicles;
- submit proposals and approve draft plans for privatization of health facilities;
- finance health facilities that are maintained with funds of oblast budgets, budgets of the cities of Kiev and Sevastopol, control the efficiency of utilization of financial, material and labor resources;
- exercise control over the maintenance of proper sanitary and epidemiological conditions, organize health education and awareness-building activities for the public;
- carry out state accreditation of community health facilities in accordance with established procedures;
- assist citizens to exercise their right to participate in health care management through executing relevant civic examination, initiating the operation of community advisory and supervisory boards, civic organizations of health workers and other associations of citizens;
- organize the legal training of health workers, including explanation of health care laws;
- identify demand for different professionals in the health care sector, prepare requests and organize the training, retraining and employee rating of health workers;
- establish interaction with other state administrations, local self-governing bodies as well as enterprises, agencies, organizations and citizens’ associations.

The MOH of the Crimean AR performs the same functions as the oblast health departments.

However, there are no authorized agencies to control health care at the level of rayon state administrations. The rationale for establishing such agencies on rayon level in the form of health care departments of rayon state administrations is currently under discussion.
Decentralization of the health care system

In managing the health care system of Ukraine, the following methods of decentralization are used: functional de-concentration within the health care system, de-concentration of general administrative authority on the regional and sub-regional levels, and delegation of authority.

Functional de-concentration means that the Ministry of Health of Ukraine manages the system through the MOH of the Crimean AR and the health departments of oblast, Kiev and Sevastopol city state administrations. The latter are under the administrative control of the Council of Ministers of the Crimean AR and the heads of local state administrations, respectively. They are also under the functional control of the MOH of Ukraine. At the same time, the State Sanitary and Epidemiological Service, which exercises state control over compliance with the sanitary and anti-epidemic rules and standards (the Service has offices on national, regional (oblast, rayon) and local (large cities) levels) and the State Inspectorate of the Quality of Medicines, which has offices on national and regional (obl Mist) levels, are fully centralized and under the vertical control of the MOH of Ukraine.

De-concentration of general administrative authority on the regional and sub-regional levels implies that executive authority in the Crimean AR, oblasts and rayons is exercised by the Council of Ministers of the Crimean AR, oblast, Kiev and Sevastopol city state administrations and rayon state administrations, respectively, whose heads are appointed by the President of Ukraine (the head of government of the Crimean AR is appointed by its parliament). The Council of Ministers of the Crimean AR and local state administrations ensure that all decisions (including those related to public health) of local authorities comply with legislation. They coordinate the operation of functionally de-concentrated public services too. The heads of oblast, Kiev and Sevastopol city state administrations, in agreement with the MOH of Ukraine, appoint or dismiss the heads and deputies of local health care departments, which are structural units of these administrations. The minister of health of the Crimean AR is appointed and dismissed by the Crimean Parliament upon request by the government of the Crimean AR. The minister of health of the Crimean AR and the heads of oblast, Kiev and Sevastopol city state administrations approve the appointment and dismissal of heads of health facilities that are under the control of rayon, district Kiev and Sevastopol city state administrations (signing and termination of contracts with heads of these institutions is the responsibility of the heads of state administrations). The heads of local administrations may, within the scope of their authority, issue instructions on the provision of health care services, and the Council of Ministers of the Crimean AR may issue resolutions and orders. The minister of health of the Crimean AR and the heads of health care departments of oblast, Kiev and Sevastopol city state administrations issue orders regulated by legislation.

Delegation of authority is used in managing health care on the regional, sub-regional and local levels in collaboration with executive authorities and local self-governing bodies. In the process, the principle of reverse delegation of authority is applied: on the one hand, administrative authority may be delegated by executive authorities to local self-governing bodies and, on the other, by local self-governing bodies to local executive authorities.

Under Ukrainian Law on Self-Governing, passed by the Parliament in 1997, only plenary sessions of oblast and rayon councils (i.e. elected local representative bodies) may approve development programs and budgets of oblasts and rayons, which, among other things, address health care issues. Health care system development (in fact, its management) is delegated according to the same legislation, by oblast and rayon councils to oblast and rayon state administrations (i.e. local executive authorities.) The latter perform this function on the basis of local development programs and budgets adopted by the councils mentioned above, using financial, material and other resources placed under their control by decisions of the mentioned local self-governing bodies. The reason is that, according
to the law, oblast and rayon councils have no authority to establish executive bodies of their own. However, in terms of authority delegation local state administrations report to and are under the control of councils.

The Council of Ministers of the Crimean AR and the MOH of the Crimean AR have almost the same relationships with the representative bodies.

At the level of local communities (village, town, city) the situation is just the opposite. The relevant local councils here also have an exclusive right to approve local development programs and budgets. However, since there are no executive authorities (local state administrations) at this level, the self-governing powers of village, town and city councils and their executive bodies have legislated control over health facilities that belong to territorial communities or are transferred to them by the state. Also, the law delegates to the executive bodies of village, town and city councils executive powers for the provisions of accessible and free medical services, development of these services and the management of the network of health facilities of all types of property. They also have authority to identify demand for and prepare requests for staffing these institutions, organize staff training and ensure supply of medicines and medical products for eligible individuals, as specified by the law. Furthermore, registration of charters of health facilities and submission of proposals for licensing of entrepreneurial activities are also involved. Chief executive officers of municipalities appoint and dismiss heads of the health institutions that are in community ownership. In some cities, the executive committees of city councils have city health divisions (departments), but, in fact, they are structural units of self-governing bodies, rather than of local executive bodies.

Furthermore, in exercising the powers delegated by the state, the local self-governing bodies operate under the control of local state administrations. According to the legislation “On Local State Administrations”, these administrations:

- implement state policy in the health care sector within their jurisdiction;
- formulate and submit to local self-governing bodies (councils) drafts of local budgets (which also contain proposals on health care financing) for approval and reporting;
- finance health facilities that are of state or community ownership, but are placed under the control of local state administrations by central government authorities or local self-governing bodies;
- supervise health facilities, provide logistical and financial support to them, organize their work on the provision of medical services to the population;
- in the common interests of territorial communities, combine funds from the budget with funds from businesses, institutions, organizations and the public, on a contractual basis, for the construction, extension, renovation, modernization or maintenance of health facilities;
- take measures to prevent infectious diseases, epidemics and epizootics, and eradicate them.

These tasks are currently carried out, within the defined authorities, by local health departments, which are structural units of oblast, Kiev and Sevastopol city state administrations. They perform activities primarily connected with the financing of territorial health care systems, in close cooperation with the financial departments of local state administrations and the regional offices of the State Treasury of Ukraine.

The use privatization as a means de-centralization, which envisions transfer of public health institutions to individuals and legal entities, is limited by the Constitution of Ukraine. Under the Constitution, the existing network of state and community health facilities cannot be reduced. As a result, the private sector in the health care system is developing mostly through privately funded institutions and practices. Due to the lack of a system for public contract procurement of medical services from providers, with alternate ownership structures, the process of so-called functional privatization fails to make progress. This kind of privatization envisions transfer of the delivery of some public medical services to the private sector (e.g. primary medico-sanitary aid provided by private family doctors, etc.).
Conclusions for Section 2.1

In summary, during the years of Ukraine's existence as an independent state, no substantial changes have taken place in the structure and organization of the health care system. Just as before, the integrated command-driven system continues to be used in health care management, and because of this:

• there is no distinct division between the payer and the provider of medical services, nor are there contractual relations between them;

• there is no strategic planning and the institutional and personnel capacities are highly inadequate for efficient management of resources at macro and micro levels;

• the state and community health institutions continue to have the status of financial managers of the budget, with severely limited rights and incentives for making management and financial decisions that would allow more efficient use of resources;

• the policy of decentralization (both administrative and financial) is being applied inconsistently and inefficiently;

• the public (the medical community, in particular, and the population in general) has no impact on the development and adoption of political and management decisions.
2.2. Public Health Care System

With advancements in medical science, mostly since the middle of the 20th century, the preventive and clinical branches of medicine have been developing in independent directions. They have been funded from different sources and overseen by different administrative structures. The WHO policy “Health for All — 21” offers a new vision of this problem with a focus on health improvement. Prevention of diseases, treatment, and rehabilitation are not independent elements but integral parts of one system, which operate in concert to improve health status [1].

During the period of social reforms and a dramatic deterioration in the health status of Ukrainian people, ideas for improving public health received special attention. New approaches have emerged, based on new concepts that define the “New Public Health”. The New Public Health is a synthesis of scientific research and practical experience accumulated during hundreds of years of provision and use of medical services, to define actions for the prevention of diseases and for the improvement of health.

Public Health as a Resource — medico-social resource and potential for the society to help enhance national security. Public health is determined by the complex interaction of social, behavioral and biological factors; its improvement promotes an increase in lifespan and quality of life, well-being of people, harmonious development of personality and society. It is assessed by various indicators of population health.

Public Health as a System — system of preventive actions supported by medical and non-medical structures; activities are aimed at the protection and improvement of people’s health, preventing diseases and injuries, increasing the duration of active life and capacity for work and encouraging individual participation in community efforts. Public health is part of the health care system and it has the important mandate to support the life of the community [3, 4].

In Ukraine the principal body officially responsible for public health is the state sanitary-epidemiological service. The state sanitary-epidemiological service focuses on two main public health objectives: infection control and environmental protection (ensuring quality and safety of water, air, soil, food).

The state sanitary-epidemiological service has a hierarchically organized branching infrastructure. Facilities of the service have a laboratory base supporting physical, chemical testing, as well as bacteriological and viral testing to identify sources of infectious diseases.

Sanitary-epidemiological specialists conduct preventive and routine sanitary-epidemiological surveillance of the sanitary and epidemic status of all businesses, establishments and organizations regardless of their type of property, covering utility and water supply facilities, housing and public spaces, children and adolescent institutions, health care facilities and others. Control of epidemics is carried out by the epidemiological subdivisions of sanitary-epidemiological, stations together with treatment and prevention facilities.

An abrupt cutback in health care spending impacted negatively the ongoing preventive activities of the health care facilities (HCF), particularly those aimed at the adult population.

According to current legislation, health protection and promotion of health is the responsibility of health care authorities and facilities. Physicians in all specialties and primary health care doctors, in particular, are responsible for hygiene and health education. Furthermore, the staffing list for HCFs includes positions for physicians or nurses responsible for various aspects of sanitary-education activities, including organization, practical assistance and monitoring. Coordination of programs on health promotion involving non-medical stakeholders is the responsibility of health centers. However, physicians and nurses working there do not have specific training in this area.
Health improvement was not a priority for the Soviet health care system despite numerous declarations to this effect, and following the disintegration of the Soviet Union, it was abandoned. The economic devastation experienced by the health care system, had a particularly harsh impact on hygiene education services. Specialists were laid off, budgetary and other support was drastically cut, the capacity of the service decreased significantly, and for certain population groups, the hygiene education system was destroyed. Production of educational films, and preventive printed materials was halted [5].

As a result, currently Ukraine faces a great many of serious public health problems [2]:
- high infant mortality rate during the first year of life, low life expectancy, especially among men;
- negative birth rate;
- disparity of health status in main social groups;
- low level of health status among rural population;
- earlier onset of chronic illness, faster progression of illness, multiple pathology in one patient;
- changes within the structure of morbidity (increase in mental illness) and mortality (increasing number of murders, suicides);
- increase in infectious diseases (AIDS, diphtheria, TB, measles, Hepatitis A, B, C, lice, STIs);
- increased frequencies of rare diseases (endocrine disorders, allergies, congenital defects, immunodeficiency).

According to the National Health Self-Assessment Survey (State Committee of Statistics, 2000), only 23.9% of the interviewed population assess their health as “good” (for Scandinavian countries, the rate found in a similar survey was 80%).

Compared with the 60s the number of chronically ill children increased by 72% and during school years the increase is 2.5 times (insert 2).

Inadequate working conditions also lead to the deterioration of the health status. According to the State Statistics Committee, by the end of 2003, the number of employees working in conditions that do not meet sanitary-hygiene standards reached 1.6 million, which is 26.1% of the total number of permanent employees.

---

**Insert 2**

The European School Survey Project on Alcohol and Other Drugs

In 2003, the European School Survey Project (involving 30 European Countries) on Alcohol and Other Drugs in Ukraine was conducted. 5749 students (high school, vocational schools, technical (secondary) schools students or first-year students of higher educational establishments) aged 13-17, were assessed.

The Survey showed:
- 82% of boys and 72% of girls had tried smoking before reaching the age of majority;
- 49% of boys and 28% of girls aged 15-16 smoked a cigarette 40 times or more;
- 35% of boys and 19% of girls aged 16-17 are active smokers (more than 5 cigarettes a day);
- in the 15-16 years age group, every fifth girl and every fourth boy tried alcohol 40 times or more;
- 29% of boys and 12% of girls tried drugs at least once in their life. Although the majority understand the harmful effects on health, there is a tendency to be tolerant toward the so-called “soft drugs”.

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**Conclusions for Section 2.2**

Public health care priorities include:

- lack of efficient mechanisms for implementing public health care policy in the country;
- lack of professional knowledge in the area of public health and on the organization and management of the public health care system on all levels (including top management);
- lack of adequately trained public health professionals;
- inadequate attention and poor professionalism in conducting scientific research in the area of public health;
- poor coordination of efforts of government authorities, public organizations, international and national funds, technical assistance programs in implementing programs aimed at improving public health and public health care system;
- underestimation of the necessity to involve the population in addressing public health problems and of the public's to influence processes in the area of public health.

The problems mentioned above, as well as socio-economic and political reforms taking place in Ukraine over the last years, highlight the need for a radical review of the approaches to problems of public health and of the public health care system.

**Literature for Section 2.2**

2.3. Financing for the Health Care System

Basic system of financing

The general approach to the financing of the health care system in Ukraine practically has not changed since the Soviet times when it was mandatory, based on joint taxation and provided virtually free medical care to the public. The Constitution of Ukraine, adopted in 1996, declares that “state and community health institutions provide medical services free of charge; the existent network of such institutions may not be reduced.” The citizens' right to health insurance is also guaranteed in the same Article of the Constitution. Since most health facilities in Ukraine are state and community run, despite the existence of the private health care sector, the state budget and the budgets of local and regional self-governing bodies remain the major official source of health care financing. Within a consolidated health budget structure, local budget funds account for 70-80%, with the remaining 20-30% provided by the national budget.

According to official statistics, the serious economic crisis of 1991-99 adversely affected the macroeconomic indicators: GDP fell by 61.7% since 1991; industrial output declined by 48.9%, agricultural output dropped by 51.5%. Even taking into account the “shadow” (informal) component of the economy, which, according to some estimates, accounts for a third of the economic potential, the actual decline of GNP was at least 40% in the past ten years [7].

In 2000, for the first time in ten years, the GDP increased (the growth rate in 2000 was 106% compared to 1999). Economic growth continued in 2001-2003 (the growth rates, compared to the previous year, were 111.1%, 106.3%, 110.3%, respectively.) However, the nation's economic situation remains difficult. The economic crisis resulted in a reduction in national income and, accordingly, reduced health care state financing. On-budget expenditures for health care purposes increased in parallel to economic stabilization (Fig.2.2.): from 2000 to 2003, health spending rose 1.7 times; the rate of its growth is expected to reach 111.7% in 2004 with respect to 2003.

It is important to note that one reason for the increase in on-budget expenditures for health care was the adoption of regulatory documents on pay raise in the health care sector. Health care spending increased, in recent years, per capita spending is still far less than it was during the Soviet period (in terms of US dollars: about $33 in 2003, about $80 in the late 1980s.)

Appropriation of funds for the health care system in Ukraine is fraught with difficulties, primarily due to conflicting statistics and the problems with accounting for unofficial health care costs. In debates on the adequacy of health care financing in Ukraine, comparative data on the health spending portion of the GDP in Ukraine and other countries are normally cited. According to the European database of the WHO “Health for All” [1], the proportion of total health care spending in the past 13 years varied from 3.3 to 3.5% of the GNP and neared the average indicator of NISs, but was still much below the indicators of Ukraine’s western neighbors — Poland, Hungary, Lithuania, Latvia, the Czech Republic and Estonia where this indicator is now very close to the European average and varies between 5.5 and 7.0% (Table 2.1.)

The situation appears different if one looks at data from the State Statistics Committee of Ukraine (Table 2.2). Public spending on health care, expressed in % of GNP, somewhat increased in 1995–1997 after the country had curbed runaway inflation and the microeconomic growth indicators had become somewhat stabilized. The 1998 crisis, which affected virtually all NISs, was accompanied by cutting of health spending and the tendency persisted: in 2000, public spending accounted for 2.8% of GNP. In 2001–2003, it gradually rose to 3.7%, (according to the State Statistics Committee). Thus, it is rather hard to establish the actual dynamics of health spending in terms of % of GNP. It can be assumed with some certainty that public expenditure on health care in % of GNP was nearly 3.5%. The proportion of health spending with respect to total public expenditures was rather stable and varied between 10 and 11%. It was
not until 2001 that this began to rise and gradually, and, according to the MOH, reached 14.4% in 2003.

Actual levels of health care spending in different countries is better assessed through the comparison of per capita health spending in US dollars based on purchasing power parity (PPP). Table 2.3. shows that the spending level in Ukraine, which is US$147.9 per capita, is 1/9th of the average for Europe (US$1,335.3), and 1/14th of the EU (US$2,128.1), 1/4th-1/7th as high as in Central and Eastern European countries (US$ 645/1,118). Among the NISs, Ukraine falls behind Belarus (US$359.52), Russia (US$242.9) and is practically level with Georgia (US$135.86) and Kazakhstan (US$106.6) on PPP-based total health spending.

The proportion of the budget allocated for health care in Ukraine cannot meet the needs of the public. The shortage of public funds results in the implicit replacement of free medical care with chargeable care.

While health care was fully financed from the budget when Ukraine was part of the USSR and in the first years of its independence, this fell to a little over 80% in 1996, 66.4% in 2000 and to 61.5% in 2003 (Table 2.3.4.) Estimates based on

### Tabl. 2.1. Changes in the Share of Total Health Spending Dynamics in Percentage of GNP in Ukraine, NISs, EU and European Countries

<table>
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<td>3.3</td>
<td>3.8</td>
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<td>n/i</td>
<td>n/i</td>
<td>2.8</td>
<td>2.9</td>
<td>n/i</td>
<td>n/i</td>
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<td>3.0</td>
<td>2.9</td>
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<td>2.1</td>
<td>3.5</td>
<td>4.5</td>
<td>4.3</td>
<td>5.1</td>
<td>n/i</td>
<td>n/i</td>
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<td>2.1</td>
<td>1.9</td>
<td>1.6</td>
<td>1.9</td>
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<td>Kyrgyzstan</td>
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<td>7.1</td>
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<td>7.4</td>
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<tr>
<td>Lithuania</td>
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<td>6.0</td>
<td>6.2</td>
<td>6.1</td>
<td>6.1</td>
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<td>5.75</td>
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<td>5.2</td>
<td>4.8</td>
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<td>5.9</td>
<td>6.5</td>
<td>5.9</td>
<td>5.5</td>
<td>5.5</td>
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<tr>
<td>EU</td>
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<td>8.5</td>
<td>8.5</td>
<td>8.6</td>
<td>8.6</td>
<td>8.65</td>
<td>9.0</td>
</tr>
</tbody>
</table>

Source: European base "Health for All", 2004 [1].
NIS – New Independent States, UE – European Union, n/i – no information
unofficial data on the size of “shadow” spending by the public in exchange for medical services, the proportion of joint taxation funds is reduced to 48%.

Personal spending on health care is rapidly becoming more common. According to official statistics, in eight years (1996–2003) the proportion of private payments rose from 18.8% to 38.5% and, including informal payments, the estimate becomes 52%. This extent of the public participation in health care spending is typical of developing countries with low incomes (53%) and Russia (55–60%) [9].

A network of private health care providers and private health facilities has emerged in Ukraine since it won its independence [5]. It is impossible to estimate precisely public spending on the services delivered by private health facilities due to a lack of relevant statistics.

Paying out of pocket

Out-of-pocket payments for health care services by the individual can take one of different forms. When receiving medical services in state and community health facilities: (i) patients are charged a formal fee for the medical services that are on the list approved by the government; (ii) patients may officially make contributions and donations (which, more often than not, is a covert way of paying for services); (iii) inpatients have to pay for medicines (with the exception of special groups of patients with privileges for provision of medicines); (iv) patients are charged, semi-officially, for supplies (medicines during hospital treatment, reagents, medical products); (v) health workers receive informal payments from patients as compensation for services delivered. In private health institutions, patients pay for the medical services and medical supplies. In addition, patients can

<table>
<thead>
<tr>
<th>Public health care expenditure</th>
<th></th>
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<tbody>
<tr>
<td>Years</td>
<td>% of consolidated budget</td>
<td>% of GDP</td>
</tr>
<tr>
<td>1990</td>
<td>10,1</td>
<td>2,6</td>
</tr>
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<td>1995</td>
<td>10,3</td>
<td>4,7</td>
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<tr>
<td>1996</td>
<td>9,2</td>
<td>3,9</td>
</tr>
<tr>
<td>1997</td>
<td>11,5</td>
<td>4,2</td>
</tr>
<tr>
<td>1998</td>
<td>11,6</td>
<td>3,5</td>
</tr>
<tr>
<td>1999</td>
<td>10,9</td>
<td>2,9</td>
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<tr>
<td>2000</td>
<td>10,3</td>
<td>2,8</td>
</tr>
<tr>
<td>2001</td>
<td>13,1*</td>
<td>3,1</td>
</tr>
<tr>
<td>2002</td>
<td>13,9*</td>
<td>3,3</td>
</tr>
<tr>
<td>2003</td>
<td>14,4*</td>
<td>3,7</td>
</tr>
</tbody>
</table>


*Working materials of the Economy and Finance Departments and the MOH of Ukraine

| Total Per Capita Health Spending In Terms of US$ Based on Purchasing Power Parity (PPP) in Countries of the WHO European Region, 2002 (or the last year for which data is available) |
|---|---|
| Country | PPP (in US$) |
| Ukraine | 147,90 |
| Poland | 645.00 |
| Hungary | 1079.00 |
| Czech Republic | 1118.00 |
| Estonia | 559.40 |
| Lithuania | 491.30 |
| Latvia | 386.50 |
| Belarus | 359.52 |
| Russian Federation | 242.90 |
| Georgia | 135.86 |
| Kazakhstan | 106.60 |
| Uzbekistan | 64.00 |
| Moldova | 62.30 |
| Kyrgyzstan | 63.25 |
| Azerbaijan | 24.72 |
| Tajikistan (1998*) | 12.50 |
| Europe | 1355.30 |
| EU | 2128.10 |

Source: European database Health for All, 2004 [1]

| Sources of Health Care Financing in Ukraine, 1996–2003 |
|---|---|---|---|---|---|---|---|
| Total financing (UAH m) | 4033.4 | 5346.1 | 5218.0 | 5812.5 | 7544.9 | 11061.4 | 13749.9 |
| Consolidated budget, % | 81,2 | 77,1 | 69,6 | 65,5 | 64,8 | 58,4 | 61,5 |
| Total from other sources, % | 18,8 | 22,9 | 30,4 | 34,5 | 35,2 | 41,6 | 38,5 |

made their own decisions (without physicians’ prescription) to buy drugs and medical supplies at pharmacies.

The size of out-of-pocket payments is hard to measure as data are lacking, particularly on the extent of “shadow” payments in the health care sector. There is some evidence, however, that a large portion of the health care costs press on the patient. Official payments made by the public, including expenses on medicines, constitute 62.5% of the consolidated budget, and show a growing trend (Table 2.5.).

Most money is spent by citizens on the purchase of medicines and bandaging material. From 1996 to 2003, spending on medicine and other medical products grew more than six-fold and have tendency to grow, and the public’s share in the general structure of official health care costs in 2002 and 2003 was 30.5% and 28.9% respectively.

Payments for medical services and contributions constitute a relatively small part of personal expenses, but this is gradually growing.

 Provision of medical services for a fee remains the main official source of off-budget receipts, which are used for health care purposes. The volume of payments for medical services increases each year (from UAH 74 millions in 1996 to UAH 234.1 millions in 2003.) However, they account for about 2% of total health spending and about 3% of budgetary expenditure.

In 2003, 167.1 million UAH were received from voluntary contributions and donations by legal entities and individuals. The amounts from this source are constantly increasing: UAH 7.1 million in 1998, nearly 19 million UAH in 1999, 254.4 million UAH in 2002. Nonetheless, this accounts for only 1.5-2.0% of total health spending and not more than 3% of budgetary expenditures on health care.

According to unofficial estimates, the total “shadow” turnover of funds in the health care system in 2001 reached 3 billion UAH [7]. This constituted more than half of the funds of the national consolidated budget appropriated for the health sector for the period. There is currently no evidence of any change in the size of the shadow turnover. It is, therefore, assumed that the public incurred the same or higher level of informal health expenses in the years that followed.

Tabl. 2.5. Spending on Health Care in 1996–2005 (UAH million)

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</thead>
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<tr>
<td>Consolidated budget</td>
<td>3273.8*</td>
<td>4123.3*</td>
<td>3632.0*</td>
<td>3808.7*</td>
<td>4888.2*</td>
<td>5432.1**</td>
<td>6460.2**</td>
<td>8459.0**</td>
<td>9447.4**</td>
<td>11408.3**</td>
</tr>
<tr>
<td>Expenses of population, including the use of their own money</td>
<td>108.6**</td>
<td>174.3**</td>
<td>314.0**</td>
<td>452.8**</td>
<td>728.7**</td>
<td>941.3**</td>
<td>1227.3**</td>
<td>1317.4**</td>
<td>1077.5**</td>
<td>—</td>
</tr>
<tr>
<td>Payment for medical services</td>
<td>77.0</td>
<td>104.0</td>
<td>131.6</td>
<td>118.3</td>
<td>152.4</td>
<td>200.0</td>
<td>199.0</td>
<td>234.1</td>
<td>194.4</td>
<td>—</td>
</tr>
<tr>
<td>Payment for non-medical services</td>
<td>6.4</td>
<td>9.4</td>
<td>83.4</td>
<td>63.3</td>
<td>249.4</td>
<td>214.2</td>
<td>300.1</td>
<td>421.7</td>
<td>376.6</td>
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<td>Educational services</td>
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<td>50.1</td>
<td>91.9</td>
<td>128.9</td>
<td>153.5</td>
<td>275.9</td>
<td>278.2</td>
<td>290.2</td>
<td>265.1</td>
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<td>Humanitarian aid</td>
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<td>—</td>
<td>—</td>
<td>123.6</td>
<td>99.4</td>
<td>125.5</td>
<td>195.6</td>
<td>204.3</td>
<td>103.6</td>
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<td>Donations</td>
<td>7.1</td>
<td>18.7</td>
<td>74.0</td>
<td>125.7</td>
<td>254.4</td>
<td>167.1</td>
<td>137.8</td>
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<tr>
<td>Expenses of the public on medicines and bandaging material</td>
<td>651.0*</td>
<td>1049.0*</td>
<td>1272.0*</td>
<td>1552.0*</td>
<td>1928,*</td>
<td>—</td>
<td>3373.9*</td>
<td>3973.5*</td>
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<td>—</td>
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<tr>
<td><strong>Total</strong></td>
<td>4033.4</td>
<td>5346.6</td>
<td>5218.0</td>
<td>5812.5</td>
<td>7544.9</td>
<td>—</td>
<td>11061.4</td>
<td>13749.9</td>
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</tbody>
</table>

More detailed data were obtained through two regional household surveys conducted in 1998-2001. The total official and non-official expenses incurred by the population in paying for medicines, materials and medical services now exceed the size of the health care budget (about UAH 230, or $40 per capita) [3]. More than half of the citizens (51.6%) describe health expenses as exorbitant. Expenses for medicines (62.5%) account for the bulk of payments. Expenses for medical services and supplies (except medicines) in state health institutions accounted for 10.1%, informal payments for nearly 14%, and payment for medical services in private health institutions accounted for over 13%. Of the households that spent money on medicines and medical services, 35.9% said that the money spent accounted for half of their monthly income and 4.2% said it accounted for more than that. The poorest groups of the population are very badly affected: the health care expenses of 44.8% of low-income households accounted for over half of their monthly income and the expenses of 6.6% of households accounted for more than their monthly income. For most of the wealthy households (78.2%), these expenses constituted less than 30% of their monthly income. Half of the surveyed households with chronic invalids or disabled persons reported that they had cut the number of visits to doctors. The main reasons for this are as follows: individuals cannot afford medicines (22.6%); they cannot afford paying for medical services (20.3%); and shortage of time (17.3%). Most of the population (94.1%) is in favor of financing health care with public funds and using limited funds by citizens. The respondents feel that level of required payments by patients should be determined primarily by income.

Data from another regional survey conducted with the assistance from the Budapest-based Open Society Institute [8], showed that only 2% of in-patients and 5% out-patients had received medical treatment free of charge. From 1998 through 2000, the payments made by in-patients for treatment increased more than 1.5 times. There is an alarming trend toward an increase, both in absolute and relative terms, in total expenses on health care with decreasing household incomes, which is due mainly to the poor health of low-income people and postponing visits to hospitals for lack of money. In analyzing the structure of expenses on the medical treatment of one in-patient in the hospital and the delivery of medical services to one out-patient in the polyclinic, it was found that the bulk of expenses can be attributed to the purchase of medicines. Fees to staff constitute 24-27% of funds, while 6-12% goes to payments for tests and treatment procedures (Table 2.6). Shadow payments accounted for nearly 40% (most medicines are also purchased in the informal sector of the economy).

Unregulated payment has caused a sharp decline in accessibility to health care. A national survey of 48.2 thousand people, conducted by the State Statistics Committee between October 2000 and October 2001, shows that 28.7% of households were not in the position to receive the medical services necessary for some of their family members. The level of accessibility somewhat improved compared to 1999-2000 (35.3%) but continues to be low. The main reason for this, according to most of the respondents, was the high cost of medicines, medical products and services. Mostly due to financial problems, sick persons of 10% of households had to refuse to see a doctor and of 6% of households failed to receive the necessary treatment in the hospital. The survey also showed that in-patients had to acquire on their own: medicines (92.7%), food (81.1%), and bedding (63.9%), i.e. services the national health system should provide [6].

Voluntary Medical Insurance (VMI)

The Insurance Law, adopted in 1996, paved the way for the introduction and development of voluntary medical insurance (VMI) in Ukraine. However, VMI has not become prevalent. The share of VMI in the general structure of health spending is insignificant. Most of the health facilities are not involved in VMI programs. According to the MOH, there are currently nearly 80 insurers on the VMI market, offering a variety of insurance programs with different coverage. In 2003, about 3.4 million people (0.7% of the population) were insured this way. According to the MOH, health facilities received approximately 16.6 million UAH for servicing VMI policyholders in 2003, which accounts for nearly 0.25% of funds appropriated for health care, by the state and local budgets.
Tabl. 2.6. Structure of Patient’s Expenses for One Case of Medical Treatment in Hospital and at a Polyclinic (in %)

<table>
<thead>
<tr>
<th>Type of Payment</th>
<th>Hospital</th>
<th>Polyclinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchase of Medicines</td>
<td>43</td>
<td>51</td>
</tr>
<tr>
<td>Doctor’s Fee</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>Payment for Services of Nurses</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Payment for Tests, Procedures</td>
<td>6</td>
<td>—</td>
</tr>
<tr>
<td>Payment to Managerial Staff</td>
<td>12</td>
<td>—</td>
</tr>
<tr>
<td>Payment to the Health Institution (donation)</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Results of the Project “Shadow Economy and the Future of Medicine in Ukraine” implemented by the Odessa-based regional organization of the Ukrainian Doctors’ Association, with the assistance of the Budapest-based Open Society Institute, Odessa, 2001 [8].

The causes for the underdevelopment of VMI in Ukraine are:

- Lack of positive experience by the public in interacting with insurance companies;
- Social indetermination of medical insurance status and prospects in society, preference for payment for medical services upon delivery rather than payment of insurance premiums;
- Lack of interest from employers in medical insurance for his/her employees and their families. By law, insurance contributions are paid from profits, and profit-making companies want to direct the funds towards production development and the payment of dividends on corporate capital;
- Opportunities for medical insurance development using citizen’s funds are limited due to low incomes and the growing number of the unemployed (unemployment, ageing of the population.)

Only private commercial insurers are engaged in VMI. The medical insurers are small companies lacking the financial means and the infrastructure to run their own health care facilities. They fulfill their insurance obligations by relying on state health institutions. Through collaboration with state institutions for providing services to policy holders, insurance companies have to accept the standard of medical care offered by these institutions or select the best of them by criteria of equipment, staff qualifications, and compliance with sanitary and hygienic standards. The quality of insured health care and additional services provided this way is not always adequate.

The main type of private medical insurance is corporate (group) insurance, which is provided by companies to their employees. Individual insurance constitutes a small part of VMI.

Many companies engaged in VMI prefer surrogate insurance without actuarial payments, replacing fee services with alternate financial schemes. Insured employees of companies, are reimbursed for their own expenses in case of an insured event (illness), including primarily the purchase of medicines or medical products, but together, and about 0.1% of total official expenditures for health protection, including out-of-pocket payments by the public (fig. 2.3.)
not above a pre-determined cap. Thus, the insurers bear no financial risks, i.e. are not liable for efficient use of health care resources, and act as passive transmitters of funds.

The scope of VMI operations is not defined. VMI is intruding into the public health sphere, often duplicating state obligations because the boundary between free and fee care is blurred. A VMI policyholder pays for what he/she is entitled to by law and pays additionally for the right to receive medical treatment in the best institutions.

The prospects for the future development of the private VMI sector in Ukraine depend on a number of conditions, including the distinguishing between state obligations and other medical services and drugs that are outside of state guarantees, enhancing tax incentives for individuals and legal entities that enter into VMI contracts, and educating the public on the meaning and benefits of voluntary medical insurance.

Even with these changes, VMI programs are unlikely to be accessible to the public at large in the near future because it is not affordable for most people.

**Sick-funds**

In order to raise additional funds for the health care system, NGOs (sick-funds, credit unions), various charities and funds are being set up in Ukraine. A well-developed network of such organizations is in place today. According to the State Statistics Committee, 4,805 charities and funds were registered in Ukraine as of January 1, 2001.

Special hopes are pinned on sick funds. Sick funds are civic associations of legal entities and individuals that are founded on a voluntary basis to improve the standards of medical services for their members. The first sick-funds appeared in Ukraine in the mid-1990s. Their organization is based on article 36 of the Constitution of Ukraine, which allows citizens to establish civic organizations to protect and exercise their rights, freedoms, and interests. Originally, the creation of sick-funds relied on the Ukrainian law, Associations of Citizens, and since 1998, establishment, development and
operation of these organizations has been regulated by the Law on Charity and Charitable Institutions.

Membership in sick-funds is voluntary and is open to individuals and enterprises, companies and institutions that pay contributions for their employees. The document that proves a person’s membership is his/her written application and membership card.

The principal function of sick-funds in Ukraine is the provision of medicines to members in case the funds allocated to this purpose are insufficient. Some sick-funds also have other objectives, such as assistance in supplying modern equipment to health facilities, formulating targeted programs, training and retraining of health workers, promoting a healthy lifestyle, and mother and child protection.

The resources for forming sick-funds include contributions by founders and members, donations and charitable contributions of individuals and legal entities, businesses, receipts from charitable events. The major source, however, is member contributions. These are established by the governing bodies of sick-funds and constitute a set percentage of wages (normally within 5%) or a fixed contribution (UAH 3-7 per month). The efficiency of a sick-fund depends directly on the number and composition of its members. Therefore, sick-funds give preference to collective memberships, with hired staff, businesses, or institutions paying contributions for their employees.

According to the MOH, in five years (1999–2003), the number of sick-funds increased by almost 17 times and was over 652 thousand in 2003. The amount of funds raised increased by the same degree (UAH 28.7 in 2003). Overall, sick-funds have a minor impact on the financial status of the health sector, with a financial share in the structure of total official spending constituting only about 0.2%, and within the structure of total budgetary expenditures, only 0.3%. It should be noted, nonetheless, that in smaller cities, where sick-funds are established with the active support of local governments and the community, they are considered favorably by health facilities, for contributions to accessibility to and quality of medical care (fig. 2.4.)

**External sources of financing**

External sources also play a role in the financing of the health care system in Ukraine. The donors are both international organizations (UN agencies, EU, WB) and governments of a number of countries (USA, Sweden, UK, Japan, etc) *(Insert 3).* It is impossible to measure the total financial contribution to the financing of Ukrainian health care system by these sources. The funds go mostly to technical assistance. Particular attention is being paid to controlling dangerous social infectious diseases (TB, AIDS); mother and child welfare. This assistance, however, does not have a great influence on the state of the health care system overall. According to experts, external sources accounts for less than 1% of total spending on health care in Ukraine.

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**Insert 3**

Major International Projects implemented in Ukraine in 2004

1. Financing and Management of Ukraine’s Health Care System. Donor: European Commission
2. Preventive and Primary Activities of the Health Care System. Donor: European Commission
4. Agreement between the Government of Ukraine and the Swiss Confederation on Granting Non-repayable Financial Assistance under the Ukrainian Perinatal Services Improvement Project 2003-2006 in Donetsk, Ivano-Frankivsk, Volyn, Rivne oblasts, the Pediatrics, Gynecology and Obstetrics Center of the ASU
5. Agreement with the UN Population Fund “Development of Integrated Network of Reproductive and Sexual Health Care Services”
7. Cooperation with UNICEF under the programs Health Care and Development of Minors and Health of Young People, Mother-Child AIDS Transmission Prevention, Support of Breast Feeding
8. Cooperation with the Republic of Cuba on issues of medical assistance to children affected by the Chornobyl nuclear disaster
9. Cooperation with USAID under the POLICY Project (MOH, Ukrainian Network of Reproductive Health)
Conclusions for Section 2.3

• The state budget and the budgets of local and regional self-governing bodies remain the main official source of health care financing in Ukraine.

• Health care in Ukraine is not currently among state priorities. Public expenditures for the health care system account for around 3.5% of the GNP. This is much below the 7 to 10% recommended by the WHO ERB as the acceptable rate for meeting needs for efficient and skilled medical services [2]. Indicators for Ukraine’s western neighbors that have been recently admitted to the EU (Poland, Hungary, Lithuania, Czech Republic, and Estonia) are closer to the recommended levels with % of GNP between 5.5 and 7.0%.

• Lack of public funds results in the replacement of free medical services with a fee-for-service system. Public spending on medical expenses is falling, while out-of-pocket payments by the public are on the rise (in 2003, the ratio between official public expenditures and private expenses was 61.5 to 38.5).

• Informal (shadow) payments by individuals constitute a substantial portion (over 50%) of total health care expenditures.

• Official payments for medical services and charitable contributions account for a small portion of the general spending structure (3.5–4%, and 6% relative to budgetary expenditure.) Voluntary medical insurance or sick-funds, as alternate methods for raising funds for health care, have little influence on the financial status of the health care sector. Their total contribution does not exceed 0.5% of total budgetary expenditures or 0.3% of total official (cumulative budgetary and personal) payments.

• The boundary between free and paid services is blurred. The scope of operations of VMI and sick-funds is not defined and they frequently duplicate state obligations.

• The current financial structure in place violates the fundamental principles for modern health care systems: solidarity and equity. With decreasing family incomes, total expenses on medical services tend to increase both in absolute and relative terms. More than half of citizens (51.6) describe health expenses as exorbitant.

Literature for Section 2.3

8. Shadow economy and the future of medicine in Ukraine, A. Litvak, V. Pogorelyi, M. Tymoschuk, research was conducted by the Odessa regional organization of All-Ukrainian Doctors Association supported by the Opened Public Institute of Budapest, Odessa, 2001.
2.4. Organization of Health Care Service Provision

The Ukrainian health care system has great potential. A branched network of state, and community, health care facilities are available for the provision of medical care. In late 2003 there were 7,574 out-patient facilities (around 13% of them are departmental), over 16,000 FOPs (feldsher-obstetrical points), 2,993 operating in-patient facilities (over 10% of them are departmental). Of all HCFs 3.4% are at the national level and funded from the state budget. Remaining facilities are operated at the regional or local levels.

After Ukraine has gained independence, a private health care sector began to develop in the country. At present, the private health care sector is represented by nearly 3,500 independent health care facilities and about 30,000 private practitioners 6. The majority of private health care facilities are low-capacity structures and they do not play a significant role in providing health care services to the public. This is due to a traditional view by the people, which places trust in the public health care sector, as well as the high cost of private health sector services.

Current status of primary medico-sanitary care

In Ukraine the primary health care system (PHC) originates from the Soviet times. It bears an imprint of the historical conditions of its formation. The foundations of the system were established in the 1920’s and 1930s during a period of severe economic crisis in the country. Under these unstable conditions, structures were established to address key health care issues relevant at that time. These included medical care for children, women, and the economically active portion of the population (workers in industry and the agricultural sector), and the control of social diseases. These structures have been “anchored in” since then and are still operating notwithstanding major changes in the health sector. As a result PHC is provided by a branched structure including territorial adult and children polyclinics (or polyclinic departments of hospital amalgamations), polyclinic departments of departmental multidisciplinary health care structures, women’s consultations, rural out-patient facilities, and out-patient departments at rural district hospitals.

By the end of 2003, the primary medico-sanitary care was provided by 2750 independent polyclinics, 668 city hospital-based polyclinics and 467 rayon hospital-based polyclinics to urban populations and 734 out-patient departments of district hospitals, 2892 rural out-patient facilities, 1451 out-patient family and general practices, and 15655 FOPs to the rural population.

In the recent years on the initiative of MOH of Ukraine, some rural district hospitals were reorganized into out-patient facilities on the basis of large FOPs serving 1,000 people and more. As a result, the number of separate nonaffiliated out-patient facilities increased by 50%. However, there is a disturbing tendency toward an increasing number of HCFs where none of the positions are occupied by professional health workers. In 2003 those were 143 rural out-patient facilities and 242 FOPs (fig.2.5).

Covering population needs for out-patient health care

Usually population needs for out-patient health care are assessed using the number of out-patient contacts per person per year. In Ukraine the number of out-patient contacts (or visits per capita) in 2002 were 10.3 per person. This indicator remains stable over the last 12 years and is significantly higher than the average indicator for Europe (7.42) and the indicator for European Union countries (6.4) (Table 2.7). MOH specialists tend to interpret this as maintaining accessibility to out-patient health care. However, analysis of the data in Table 2.7 shows that the number of out-patient contacts in a country does not necessarily reflect accessibility of out-patient care but the methods of funding of the out-patient services. Thus, in the countries with systems of honorary payment for

health care services (Check Republic, Hungary) and in countries with funding of out-patient facilities according to the capacity indicators (Ukraine, Russia, Belarus) the number of out-patient contacts per capita is significant, and in the countries with per-capita funding (Poland, Estonia, Lithuania), it is significantly lower.

More than half of the visits (56.2 %) were made late in disease progression. The most important factor influencing this aspect of visits is the cost of medical care (46.1 % of patients mentioned have to pay extra money for health care services and it was the main reason for postponing their visits). As a result, there is an increase in the ratio of severe and advanced conditions that require expensive in-patient care (50-70% of patients are hospitalized on an emergency basis) [3].

In Ukraine, the numbers of out-patient contacts per capita in urban and rural areas differ substantially: for urban population, 14 to 15, for rural, 7 to 8. Despite the fact that after establishing ambulatories on the basis of former large FOPs there is a tendency towards replacing felder positions by physician positions (Table 2.8.). Nursing visits still predominate in rural areas.

**Territory-and district-based principle of service provision**

Primary care provision in Ukraine is organized according to the territory- and district-based principle, which means that the catchment territory (area) of a polyclinic is divided into districts. The key providers of PHC are a district internist and a district pediatrician. These specialists constitute 25% of all practicing physicians. The standard number of individuals for one district is 1,700 adults for one district internist, and 800 children for one district pediatrician. In practice, one city district internist serves around 2,100 people, but the workload of one district pediatrician in cities is close to the standard. The average size of the population for one rural district is 6,000 to 7,000.

The territory- and district-based principle was intended to bring medical care closer to the home or place of work, to ensure continuity of care, to increase the capacity to provide comprehensive care (prevention, treatment, rehabilitation, disease-specific regular follow-up).
However, linking the population to PHC physicians shifted the focus from the patient to the physician. From the legal and ethical point of view, this can be regarded as a violation of consumer’s right to choose. The territory and district-based principle did not achieve its main goal of consistent health care. Survey results showed that of all patients seeking help from district internists, less than a half (47.6%) actually received care from the assigned physician. Many patients tend to visit physicians with convenient hours. The current system of geographically assigning individuals to health care service districts has a number of drawbacks. It hinders the development of a competitive market environment within the PHC system and deprives the physician of a powerful incentive to provide satisfactory care. Lack of free choice, and lack of competition among health care workers, leads to a mutual (physician and patient) loss of interest, and the abandonment of the primary health care system [2, 4, 7]. Replacing a district physician is possible only when there is an insistent demand from a patient. However, physicians resist this as it enlarges their catchment areas and home visits become more difficult.

Involvement of specialists in providing primary health care

In Ukraine there is no strict division between services of primary and secondary (specialized) health care. Patients can go to specialists without being referred by a district physician, and they use this opportunity. This approach is approved by the Ukrainian Legislation on Health Care which recognizes the patient’s right to free choice of physician and health care facility. District physicians are paid fixed salaries regardless of the quality of performance, they are not generally interested in patients, and are reluctant to introduce change. Moreover, with qualifications in internal medicine, physicians are not trained to address all areas of primary health care.

As a result, obtaining medical services (services delivered when a patient arrives at a health care facility) is characteristically chaotic and uncoordinated, and often does not correspond to the severity and nature of the patient’s illness (Insert 4, fig. 2.6.).

**Insert 4**

Description of the Routes Used by Patients to Receive Medical Services

According to the results of a survey conducted by the specialists of Dnipropetrovsk Medical Academy in 2001-2003, on entering a system of professional health care, patients often determine their own routes. 41.2% of patients go directly to PHC physicians, 29.5% visit specialists directly, and about 1/3 erroneously choose inappropriate specialists; 1/6 (16.9%) seek in-patient care on their own, and on average 26.5% receive medical care without being referred to a specialist or another health care facility (see fig. 2.4.2.).

Free, uncoordinated migration of patients through the levels of care leads to frequent (65.9%) cases where the services rendered are inappropriate for the patient’s condition. The most typical example is providing care at a much higher level than required (43, 2%).

Quality of care is low — integral quality of care rate is 56, 4%. The lowest care quality rates are registered on the primary health care level (10.2%). Experts think that increasing adequacy of care on the outpatient level would prevent using specialized and/or in-patient levels of care in 58, 1% of cases.

Despite a lack of resources in health care system, available resources are used irrationally -19.6 % of treatment and diagnostic interventions were over-prescribed.
Physician of primary Level of Care → Subspecialists → Hospital-substituting Types of Care → General Hospitals

Emergency Care

Population (per 100 people)

Intensive Care Hospitals

Fig. 2.6. Generalized Medical Route for Patients (refer to Kryachkova L.V, 2003[3])
At the same time, the possibility to visit specialists directly is viewed positively by the public as it is regarded as an exercise of the right to free choice, a form of participation in decision-making regarding their own health, and it creates an illusion of accessibility of specialized health care.

However, objective analysis of the practice of primary level contacts between specialists and patients revealed an array of negative consequences. For example, HCWs lose the sense of responsibility for the results of care, there is duplication of care due to an absence of clear differentiation between objectives and functions of primary and secondary levels of care, loss of some primary care functions to specialists, and a decreasing level of professional competence among specialists due to the addition of primary care services to the workload [4].

In general direct access of patients to specialists results in decreased quality of medical care and leads to the abuse of the services of outpatient facilities. A primary care physician responsible for health of his catchment area population is transformed into a sub-specialist providing care to a portion of patients requiring internist services.

In addition, international experience and scientific medico-economical analysis show that giving a patient full freedom in choosing a physician of any specialization increases the cost of medical care because: (1) a patient is not able to make a rational choice because he/she is not adequately informed regarding the kinds of medical services needed; (2) a patient is encouraged to receive the most expensive care which is not the same as (and sometimes it is opposite to) getting quality care. Arising from the fact that a patient is not an adequately informed consumer of health care services, the structure and extent of medical care is defined by his/her physician. Applying economic methods to health care organization and management, forces physicians and providers of health care services (primarily those delivering specialized out-patient and in-patient care) to offer unnecessary, expensive hi-tech services which are perceived by a patient as attention given by the physician and a sign of competence.
Development of primary health care based on principles of family medicine

Following a long period of uncertainty, a number of steps were taken to change orientation toward a family/general practice-based system of primary health care. The year 2000 became a turning point when two very important documents were adopted: “The Concept of Health Care System Development in Ukraine” and “Decree of the Government on Comprehensive Measures for Integrating Family Medicine into the Health Care System”. In the former, family-based primary health care is determined as a priority activity for health care reform. During 2000-2001 a legislative framework was developed for the development of family medicine in Ukraine. The Ministry of Health developed a plan of gradual transition to PHC based on family medicine principles and approved a number of documents regulating different aspects of organization of primary health care work (see Sub-section 2.9 for more detail). The document outlines regulation for general practitioners/family physicians, qualification profiles for family physician and family nurses, regulation of general practice/family medicine departments, regulation of general practice/family medicine ambulatory, equipment required for a general practice/family medicine out-patient facility (department). The standard workload per one family physician is specified as 1,500 adults and children in urban areas and 1,200 in rural areas. Some regions of Ukraine (Kharkiv Oblast, Lviv and Lviv Oblast, Zhitomir Oblast, Komsomolsk of Poltava Oblast etc.) already have experience in transition to family-based primary health care.

On adoption of these documents, the number of staff positions in health care facilities and the number of trained family physicians began to grow rapidly. By the end of the first half of the 2004, 4057 GP/family physician positions were created and 3354 were filled by family physician. Furthermore, 2018 GP/family medicine facilities are in operation, with 85% of them located in rural areas (fig.2.7.).

Care provided to adults and children in small rural out-patient facilities has practically always had general practice nature, rather than a therapeutic focus. Transforming rural out-patient facilities into family practice facilities will further legitimize existing practices.

Preliminary calculations show that with the specified workload of 1,500 patients, 33,000 family physicians are needed to provide care for the entire population. This means that currently only 12% of the demand is met. Furthermore, some family medicine facilities are established simply by a name change, while their material and technical resources do not comply with requirements. A massive effort is needed to complete the transition to facilities based on family medicine principles for all PHCs.

Secondary and tertiary health care

Out-patient care

Out-patient services at the secondary level are provided by specialized departments of territorial polyclinics and polyclinic departments of city hospitals, pediatric hospitals, central rayon hospitals, dentists’ clinics, polyclinic departments within disease-specific facilities.

As mentioned above, because there is no strict demarcation between primary and secondary levels of care at city polyclinics, specialists provide care both to patients referred to them by district physicians and to those who come to visit them directly.

Out-patient obstetric and gynecological care is provided by women’s consultations which are parts of either Maternity Hospitals or polyclinics.

Key facilities providing tertiary out-patient care are health care facilities at the Oblast level. In large cities, within the structure of multi-field hospitals specialized centers of various types can be created, which are designed to provide tertiary care to the city population. Consultations can be provided either by physicians of outpatient, or in-patient departments of health care facilities.

In-patient care

In-patient care is the most expensive form of medical care. For this reason, increasing the efficiency of resource utilization in the in-patient sector is an issue of the utmost importance.

In 2003 there were 592 city hospitals, 104 city pediatric hospitals, 486 rayon hospitals, 125 specialized hospitals, 734 district hospitals, and 25 Oblast hospitals in Ukraine. The total number of...
Key strategies for further development of the health care sector in Ukraine

The number of hospitals per 100,000 people is significantly higher (5.94) in Ukraine than in neighboring European countries that are intensively reforming their health care systems (Poland: 2.15; Hungary: 1.79). It is also considerably higher than the average figure for Europe (4.39) (Table 2.9). The large numbers of inpatient facilities lead to the dissipation of the limited health care resources, limiting possibilities for the introduction of modern medical technologies.

At the same time, some hospitals were subjected to cut-backs because of the reorganization of low-capacity, rural district hospitals into ambulatories. Obviously this was an economically reasonable decision, but it made it more difficult for rural populations to receive medical care, especially for those living in areas without ambulatories. The constrained economic situation in villages, poor transportation, and communication between villages, and the absence of inpatient beds creates many barriers for sick people to receive adequate care.

Despite the fact that in 1996-1997 the number of beds in Ukraine was reduced by one third, the number of beds per 10,000 individuals remains high (according to the State Committee of Statistics: 97,3) and is close to the numbers for Russia (107.1) and Belarus (119.4). This figure is 1.8 times the value for Poland and Estonia, and 1.3 times the average European value (fig.2.8.).

In Ukraine the general period of hospital stay is high at 14.4 days per patient. To some extent, this is related to the severity of disease and the poor technological support for hospitals (fig.2.9.). However, the main reason for this high value is the lack of impetus for short-term, intensive care.

One of the most informative measures for characterizing utilization of in-patient care is the number of bed/day for one person per year. This value combines the level of hospitalization with average hospital stay. In Ukraine, the level of in-patient service use (2.87 days per one person per year), is somewhat less than that of Russia and Belarus, but it exceeds the value for Estonia (1.60 days) by 79%, the value for Poland (1.38 days) by 107%, and the average European

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**Table 2.9. Comparison of the Number of Hospitals in Ukraine and Other European Countries (per 100,000 of people)**

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ukraine</td>
<td>5.94</td>
</tr>
<tr>
<td>Poland</td>
<td>2.15</td>
</tr>
<tr>
<td>Hungary</td>
<td>1.79</td>
</tr>
<tr>
<td>Check Republic</td>
<td>3.63</td>
</tr>
<tr>
<td>Estonia</td>
<td>3.68</td>
</tr>
<tr>
<td>Lithuania</td>
<td>5.65</td>
</tr>
<tr>
<td>Latvia</td>
<td>5.52</td>
</tr>
<tr>
<td>Belarus</td>
<td>7.87</td>
</tr>
<tr>
<td>Russian Federation</td>
<td>6.76</td>
</tr>
<tr>
<td>Europe</td>
<td>4.39</td>
</tr>
<tr>
<td>EU</td>
<td>3.2</td>
</tr>
</tbody>
</table>

Source: European data base «Health for All», 2004 [1]

**Fig. 2.8. Number of Beds per 10,000 Individuals in Ukraine and Other European Countries**

(Source: European database "Health for All", 2004, * State Committee of Statistics, Ukraine)
value (2.14 days) by 34% (Table 2.10). In other words, an average Ukrainians stays in a hospital bed much longer than citizens of countries that have effectively managed health care systems.

The system of in-patient care in Ukraine was traditionally formed according to a hierarchical principle. In other words, in-patient care in principal specialties was supposed to be delivered on a secondary level by central rayon and city hospitals. Tertiary care centers were designed to treat complicated and severe cases (Oblast hospitals, Regional and Republican centers). However, recently, the border between secondary and tertiary levels of care began to diminish. Currently in Ukraine there is practically no difference between performance indicators for hospitals at different levels of care. If a patient stays at a rayon or city hospital, this is an indirect indication of poor organization and poor quality of care. Conversely, a short stay at Oblast hospitals may be an indication that the patient is receiving tertiary level care unnecessarily. Research conducted by N.P. Yarosh [8] shows that in 35.7% of cases, patients admitted to Oblast hospitals actually require treatment at secondary level facilities. Such problems of organization drive up costs for in-patient care and limit access to tertiary care.

Analysis of a group of patients currently under in-patient care shows that the majority do not need the 24-hour supervision and care the hospitals provide. Unnecessary treatment for a large number of patients in hospitals results because hospitalization profiles are inconsistent with the severity of the patients’ condition. Since there is no differentiation of beds with respect to the patient needs, patients from all categories end up in specialized departments of hospitals. Therefore, those who need intensive care, those who recover quickly, patients who need nursing care and patients with terminal illness, may be found in the same facility.

According to Russian researchers who conducted an in-depth study of in-patients in the beginning of the 1990s, only a third of patients of large city hospitals, and 15 to 20% of patients at central rayon hospitals (CRH) actually needed in-patient care and monitoring of vital functions. Instead, they were subjected to medical procedures that cannot be provided in the home. In addition, about half of the patients

<table>
<thead>
<tr>
<th>Country</th>
<th>Days of Hospital Stay</th>
</tr>
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<tbody>
<tr>
<td>Ukraine</td>
<td>2,87</td>
</tr>
<tr>
<td>Poland</td>
<td>1,38</td>
</tr>
<tr>
<td>Hungary</td>
<td>2,08</td>
</tr>
<tr>
<td>Check Republic</td>
<td>2,38</td>
</tr>
<tr>
<td>Estonia</td>
<td>1,60</td>
</tr>
<tr>
<td>Lithuania</td>
<td>2,52</td>
</tr>
<tr>
<td>Latvia</td>
<td>2,18</td>
</tr>
<tr>
<td>Belarus</td>
<td>3,72</td>
</tr>
<tr>
<td>Russian Federation</td>
<td>3,34</td>
</tr>
<tr>
<td>Europa</td>
<td>2,14</td>
</tr>
<tr>
<td>EU</td>
<td>1,80</td>
</tr>
</tbody>
</table>

Source: European database «Health for All», 2004 [1]
were provided with care according to approved treatment protocols. The rest (about a third) stay in hospitals without specific indications and receive treatment at the primary level, along with lodging (hotel services). The time patients spend in hospitals for routine check-up is unjustifiably long [7].

Recently, efforts to reform the area of in-patient care were concentrated on reducing (mostly by cutting administration) the excess number of beds. However, the overall effectiveness of the in-patient sector did not change substantially. Some savings on salary were achieved, but major expenditures (facility maintenance, utilities cost, etc.) decreased little. As before, about 90% of resources are spent on costly and inefficient forms of medical care. There was no positive effect on the health of the population because the number of beds was changed without complimentary changes in the operation of the primary health care system. No steps were made toward increasing the accessibility of social support.

Health services to replace hospital care

In parallel to reducing the number of beds, alternatives to hospital care are emerging rapidly (day health care service, home-based clinics, day-surgery departments). Over the last 12 years, the number of home-based and day in-patient health care clinics grew almost 5 times. However, increasing these form of care, does not reduce the rate of admissions because hospitals strive to keep beds filled and the associated funding flowing. Furthermore, regulations restrict the use of these facilities exclusively to out-patient care, limiting the development of efficient alternatives to hospital care. Home experts believe, that it is unreasonable to exclude hospitals from offering alternatives to hospital care as this creates additional organizational and financial problems related to the allocation of space, equipment, training of personnel etc. Use of home-based in-patient care is hampered by poorly developed care providing services.

Conclusions for Section 2.4

In Ukraine, the health care system was inherited from the Soviet times. Current use of resources is grossly inefficient. Under conditions of limited funding, there is a shift within the health care structure toward relatively expensive types of in-patient care and specialized out-patient care. This aggravates existing problems of accessibility and duration of care. Unregulated payment for health care services, and the public’s inability to afford services, especially in rural population, adds further to the difficulties.

Weaknesses in the existing primary health care system

• PHC is provided within a branched structure (adult and children’s polyclinics, departmental multi-field health care structures, women’s consultations, rural ambulatories)

• Differences between services at the primary and secondary levels of care are unclear.

• As long as district physicians specialize in internal medicine, they are not in the position to deal with all primary health care problems.

• Patients can often visit specialists without a referral from a district physician.

• District physicians with fixed salaries regardless of the volume and quality of services they provide are not motivated to see more patients.
**Weaknesses in the in-patient service**

- Too many hospitals
- Excessive specialization of beds and hospitals
- Little functional differentiation between hospitals of different levels of care
- Parallel systems of in-patient care (departmental, governmental)
- High admission rate at specialized hospitals
- Long period of hospital stay
- Development of alternatives to hospital care does not complement changes in the in-patient sector.

**Literature for Section 2.4**

3. Kryachkova L.V. Analysis of medical routes of cardiology field patients, Newsletter of social hygiene and organization of health care in Ukraine, 2003, #3, pp. 61-64
Availability of human resources is a key factor in the functioning of the health care sector. The quality of health care, and accessibility to it, depend on the network adequately staffed and qualified health facilities. Moreover, costs related to personnel constitute the largest component of health care spending, making human resources an important economic factor to be considered in implementing reforms. Finally, performance in the health care sector ultimately depends on the skills and motivation of health care staff [4].

An analysis of the availability of specialists reveals a growing trend. The indicator was 45.1 in 1995, and 47.1 in 2003 (Fig. 2.10) [3]. However it would be wrong to assume that there is a substantial surplus of staff in Ukraine. When the number of clinicians directly involved in patient treatment (excluding qualified specialists working within administrative bodies, in the sanitary and epidemiological surveillance, or in the auxiliary diagnostic and treatment divisions, as well as dentists) is compared for different countries in Europe, the staffing indicator for Ukraine turns out to be close to the European average (fig. 2.11).

From 1996 to 2003, the staffing indicator for clinicians directly involved in treating patients, has undergone almost no changes. It remained stable around 30.0 per 10,000 persons (fig. 2.12).

Staffing indicators for nursing staff has been decreasing over the same period, with 116.5 in the year 1995, and 110.3 in 2003 per 10,000 persons (fig.2.13). Nurses leave the health care sector for other sectors of the economy, primarily because of low wages and a lack of opportunities for career advancement.

Numbers of health care personnel in the system depend on the approaches to planning adopted in Ukraine and based on the stringent staffing norms (for details see section 2.1), which over the past years have been set on the grounds of “situational expedience”, and not on the results of special research.

The bulk of human resource capacity is centered in the Ministry of Health of Ukraine. According to MOH data, by the end of 2003, there were 240,216 registered positions for physicians at health facilities, and 81.3 % of the positions were filled. Moreover, 29,000 positions...
were filled by doctors holding two jobs. The human resource deficit, expressed as a ratio of the number of doctors to the number of positions, is 15,800, of these 4,600 in rural areas.

Low staffing is also a problem for primary health care. According to the MOH data, staffing levels at rural out-patient facilities was 73.6%, and 76.4% for catchment area internists and pediatricians in the cities. Even in the Kiev city only 80% of positions are filled, and the average for Ukraine is 77.8%. Ukraine has a chronic deficit in primary health care practitioners, due to a surplus of specialists [1]. Under current conditions, primary health care remains the least attractive alternative for health care professionals both in rural and urban areas. At the same time, there is unemployment among subspecialists. Some carry only 50% workload for a half-time or quarter-time position. Still, the most urgent problem is the staffing of rural health care facilities. Here, the number of primary health care facilities without a single position for a physician or nursing staff worker at a FOP increases from year to year (see also section 2.4).

There are state-regulated mechanisms for the placement of medical graduates who were supported by state scholarships for their studies. In recent years, this mechanism has not worked well. This is partly because the medical profession and primary health care in particular, are losing their image of prestige and the program is not administered efficiently.

Each year the sector receives about 3,500, for 2005, the number is 3,708. About 3% (over 5,000) doctors leave the sector for different reasons. The state does not have any influence on the graduates trained on the contractual basis.

The number of nursing positions in 2003 was 476,564 and 461,771 of these were filled. The number of individuals filling these positions was 467,576. The difference between the number of positions and the number of individual 8988, which translates to 98.11% of positions filled by one person. Over the past ten years the staffing level for nursing personnel has decreased by almost 7%.

According to the MOH of Ukraine data, the ratio between the number of doctors and nursing personnel in 2003 was 2.4 (in 1994, it was 2.6) [9].
Various factors influence the number of doctors and nurses, in rural areas, including the availability of higher educational establishments of the III–IV accreditation levels, the number of educational establishments of the I–II accreditation levels, specific features of the socio-economic development of the region, availability of an extensive network of research facilities, the number of health resorts/recuperation facilities, the level of radiation contamination due to the Chernobyl disaster, human resource policy of the local health care bodies [11].

The population of health care workers, particularly at the primary health care level, is showing an aging trend. In 2003 there were 39,284 doctors of retirement age or 20.1% of all practicing doctors (in 1994, this rate was 16.1%, in 2002, it was 19.5%). Of all nursing personnel, 55,289, or 11.8% are of retirement age which has remained nearly stable over the past years (11.8% for 1994 and 11.4% for 2002) [5].

Imbalance in the development of the primary and specialized health care is the most likely cause for the imbalance seen in the health care workforce.

Ukraine provides training for doctors in as many as 123 specialties, which significantly exceeds the number of medical specialties in developed European countries (insert 5). The medical specialties nomenclature has been revised several times over the past years and each time more specialties were added. As a result, the number of sub-specialists is constantly increasing, especially in the cities.

In 2005 the MOH Order #81 dated February 23, 2005 reduced the list of basic clinical and pharmaceutical specialties from 54 to 16. However, the decrease in the total number of specialties has not yet occurred.

The key consideration in the distribution of practitioners is the optimum ratio between the number of general practice family medicine practitioners (GPFM) and sub-specialists, which is determined by each state according to specific needs. In Ukraine the proportion of general practitioners/family doctors as a percentage of all physicians is 1.9% (in some European countries this proportion is as high as 50%).

Gender aspect analysis in the health care sector of Ukraine reveals that women constitute the vast majority of the health care workforce (61.1% among doctors and 94% among nursing personnel).

Management personnel
Changes in the health care system lead to an increase in demand for higher levels of management and administrative knowledge [7, 8]. There is practically no training in health care management in Ukraine. Traditionally, certified doctors, with sufficient experience and high qualifications in their professional area were appointed to top administrative positions. However they did not have any professional training in management. They received service training as health care managers through the advanced training courses in the “Organization and Management of Health Care System” specialty. In 2000, a short 2-month specialization in health care system organization and management was introduced [1,10], which is evidently insufficient for providing professional management skills. Nomenclature of professions in the health care system of Ukraine still does not have a “health care manager” specialty. Nonetheless training of personnel in this qualification has already started at a number of educational institutions. Qualification as a “health care manager” or “state health care administration” is not a mandatory criterion for obtaining administrative positions with health care administrative bodies, or health facilities. This leads to many problems, such as lack of initiative and a negative attitude toward making managerial decisions [6] and is a serious obstacle to health care system reform.
Conclusions for Section 2.5

The workforce situation in the health care sector of Ukraine is unfavorable due to:

• deficiencies of the state regulatory mechanisms and utilization of an archaic system of human resource needs planning, based on the strict staffing standards;

• imbalance in the human resources structure, resulting in the overspecialization of doctors (in Ukraine there are 123 clinical specialties, in European countries 16 to 28; secondary and tertiary health care doctors make up 74 % of the total (26% primary care); in other European countries the ratio is almost 50:50);

• Deficit of primary health care human resources in the rural areas;

• Ageing of the sector’s workers (20.1 % retirement-age doctors, predominantly in primary health care);

• Negative human resources balance
  • not enough students studying medicine (annual enrollment rate to medical universities is about 7,000 with only 3,500 students admitted by government order);
  • only about 450 medical university graduates enter the general practice/family medicine specialty each year;
  • loss of human resources (over 5,000 or 3% leave the sector annually)

• No basic training for managers and administrators.

Literature for Section 2.5

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2.6. Pharmaceutical and Material-technical Resources

Pharmaceutical provision

Pharmaceutical provision is an important part of a high-quality medical care system. Therefore, optimal selection and use of medicines is a major problem both for Ukraine and other countries having a shortage of funds for health protection activity.

Finding solutions to this problem is essential, not only for the authorities (central and regional) but, first and foremost, for the consumers of medicines. Experience in many countries proves that the most efficient way of spending budget funds, is to optimally select medicines and target their use.

Efficient provision of citizens with medicines involves medical, economic, and social consideration.

After the disintegration of the Soviet Union, the pharmaceutical sector in Ukraine was in a desperate situation. Only few domestic enterprises produced medical goods and the quality was inferior to foreign products. As a result, there was an acute shortage of medicines. In 1991, the local pharmaceutical industry accounted just for 20% of domestic drug supply. The vacuum was quickly filled by imported medicines, sometimes of doubtful quality. Relevant state institutions, manufacturers, scientific research institutes, inspection and certification bodies were not able to cope with this.

Transition to a market-based system of drug supply was the response to those challenges. Pharmaceutical enterprises were privatized and the private pharmaceutical sector was established. Today, there are 180 domestic enterprises manufacturing medicines in Ukraine, 90% of them owned privately. The pharmaceutical enterprises, classified as strategic for the country’s economy and security, still belong to the state. Production of more than 800 types of medication is in place. Some pharmaceutical companies produce medicines that meet GMP standards (Darnitsya, Borschchagivka, Styrolfarm, etc.). The number of domestically made products exceeds 1,500, making it possible to treat most types of diseases while the average cost is by 20%-60% lower than their foreign counterparts. In 2001, domestically made medicines accounted for over 50% of the country’s supply, the rest were imported. Nearly 560 companies supply medicines to Ukraine, about 100 of these are large enterprises [1].

Most pharmacies were privatized as well. Numbers keep growing quickly. Within the last decade, the number of pharmacies has grown almost threefold. There are presently 39 pharmacies per 10,000 individuals. In 2001, this network included 19,000 pharmacies and drug kiosks, 18% were privately owned, 52% were jointly owned, less that one third belonged to the state and municipal authorities. Municipal ownership of pharmacies is typical of rural areas. Drugstores have mainly switched to the sale of ready-made pharmaceutical products and function close to the location of consumers. At the same time, the prices of these products have sharply grown [6].

Due to market transformations, there is no longer a shortage of medicines on the market. However, the shortage problem has transformed into a problem of economic accessibility to high-quality, efficient and safe medicines and medical products. Almost one third of the population is not able to buy the necessary medicines due to high cost [2].

Several measures were taken on state regulation of the pharmaceutical sector in Ukraine. The legislation “On Pharmaceutical Products” was passed in 1996, setting forth the fundamentals of the state policy in the spheres of development, testing, registration, manufacture and quality control of pharmaceutical products. Implementation of certain provisions of this law helped improve conditions, now approaching those in developed countries. However, many provisions of the law have become obsolete and require changes.

The State department for quality control, safety and manufacture of pharmaceutical and medical products has been established with the following chief tasks: management and control of the quality, safety and manufacture of pharmaceutical and medical products, biomaterials and medical equipment; state control over export, import, retail and wholesale; participation in the development and implementation of the state policy in the manufacture of pharma-
caceutical products and their supplies to population and health facilities. In addition, the structure of the Ministry of Health of Ukraine includes the Pharmacopoeia expert center, Pharmacopoeia committee, Committee for immunobiologic preparations, Committee for control over the traffic of narcotic and psychotropic drugs.

The National Pharmacopoeia of Ukraine was introduced (MOH order as of March 12, 2001, #95), and a system of certification of medicines by domestic manufacturers was set up. Special institutions in charge of quality control have been set up: control at the stage of manufacturing is imposed by the Inspectorate of adequate production practice while control at the stage of realization is done by the State inspectorate for control over the quality of pharmaceutical products.

Government regulation defined the National list of basic (vital) pharmaceutical and medical products (2001). The National list, compiled in terms of ATC (anatomical-therapeutical-chemical), in accordance with the international nonproprietary names, includes 741 medicines to treat the most common infectious, chronic, and surgical diseases [4].

The above list is the basic reference for the provision of pharmaceuticals within state programs and with essential state guarantees. In accordance with the order of the Ministry of Health, this list shall be used for tender purchases, state procurement for implementation of targeted programs, for adoption of the programs of state support for domestic manufacturers of pharmaceutical products.

In addition to the National list, the following special lists of pharmaceutical and medical products have been introduced:

1) A list of domestic and imported pharmaceutical and medical products with prices subject to state regulation (600 medicines from 9 pharmacologic groups);
2) A list of domestic and imported medicines that may be purchased by the state and municipal health facilities using budget funds (1500 domestic and 800 imported medicines);
3) A list of mandatory medicines for pharmacies (418 names, including 300 domestic and 118 foreign medicines).

Licensing is a basic component of the system of state regulation and control over manufacture, retail and wholesale of medicines. Licensing is done by the State department for quality control, safety and manufacture of pharmaceutical and medical products. Enactment of the law “On licensing certain kinds of economic activity” considerably simplified the licensing procedure. At the same time, the law removes control by local self-governments which runs counter to the provisions of the law “On local self-government”. In addition, beginning in 1998, mandatory state accreditation of pharmacies is done pursuant to the Government’s regulation.

The existing pharmaceutical support system, the level of social security and the capacities of budgets at all levels do not make it possible to realize the basic provisions of Article 49, of the Constitution of Ukraine concerning the guaranteed provision of medicines, medical products and equipment. Taking into account the fact that the population assumes over 80% of all expenditures for the purchase of medicines, it is believed that the dynamics of this indicator reflects the changes in the level of consumption of pharmaceutical products [1]. The data, collected by the State Statistics Committee, show that the population’s expenses for the purchase of medicines grew more than 6 times in the 1995-2003 period. Despite the fact that these data are not fully reliable since they do not include the expenses for acquisition of medicines through unofficial channels, they still testify to a rapid growth of consumption.

The existing market regulators, being separate from the government’s influence on the sectoral development, limit the accessibility of medicines for many segments of the population. Thus, citizens pay for drugs much more often than the state does. The demand for medicines remains fixed, as the population remains the most stable consumer of pharmaceutical products. Expenses for medicines exceed other expenses.

One of the problems related to providing the population with medicines is the high cost of essential drugs. This is due to the absence of a standard mechanism for setting prices for domestically made medicines and to the inadequate and expensive system for the distribution
of drugs. Transportation is slow and there are no quality guarantees for pharmaceutical products. The situation is also aggravated by the absence of price regulation by the state for the most essential drugs. The economic crisis in 1998 made the acquisition of drugs very difficult for all segments of the population, increasing the demand for cheaper, domestically made medicines. The main reason for this was, unfortunately, not the quality of local products, but the difference in the price of local and foreign products, which increased after the economic crisis. The demand by individuals using state subsidized medicines has also increased.

Certain tax incentives have been introduced to reduce the price of medicines. In 1997, the pharmaceutical and medical products, registered in Ukraine, became exempt from VAT. Within the last 4 years (2001-2004) the Ukrainian Parliament and Government advanced several initiatives to enhance the policy of state price regulation of pharmaceutical and medical products.

Since 2000, after the law “On procurement of goods, works and services at the state’s expense”, came into effect, the purchase of medicines by health facilities has been done mainly on an open bidding basis. The Ministry of Health makes centralized procurement of medicines, primarily, for patients with socially dangerous diseases (tuberculosis, diabetes, malignant tumors). For instance, in 2001, this produced a 12.3% savings of funds [5].

The primary mechanism of state regulation of the price of medicines in Ukraine is the establishment of marginal levels of mercantile additions to pharmaceutical and medical products subject to state regulation. According to the Government’s regulation (1996), the right to establish such additions was delegated to the regional management bodies. Large differences in mercantile additions to the price of medicines in different regions (10% to 50%), was the result of regulation decentralization.

This problem forced the Ministry of Health, jointly with the Ministry of Finance and the Ministry of Economy, to start developing a system-based approach to formulating the state’s policy on setting prices for medicines. It was a difficult and painful process. In 2001, marginal mercantile additions to the prices of pharmaceutical and medical products were fixed for the first time at the state level:

- 35% of manufacturer’s wholesale price (customs cost) when medicines are sold through the network of drugstores;
- 10% — when acquiring such medicines at budget expense by the state and municipal health facilities.

At present, the state regulation covers 16% of the medicines registered in Ukraine. The government of the Autonomous Republic of Crimea, regional, Kyiv and Sevastopol city state administrations still retain the right to fix the amount of additions within prescribed limits.

The results of increased centralization of regulation were quickly felt:

- price fluctuation for the medicines fixed in the List decreased;
- average level of mercantile additions to the prices for the most commonly used medicines dropped from 40% to 23%;
- price for domestically manufactured medicines dropped by 0.2%-0.6%.

Introduction of marginal mercantile additions had a negative effect on municipal pharmacies that render services to budget-sustained health facilities and the citizens receiving social benefits. Profits dropped by almost one third and they faced the threat of bankruptcy.

An order, by the Ministry of Health of Ukraine, has also compiled a list of drugs that can be obtained only by doctor’s prescription. However, most of these drugs can still be bought in pharmacies without any prescription.

However, the largest group of drugs sold without a prescription, distributed through the network of pharmacies, are drugs intended to treat the disorders of the digestive tract, metabolic system, central nervous system, respiratory system, cardiovascular system, as well as antibiotics. These amounted to over 80% of total sales in 1998-1999. Uncontrolled use of antibiotics is particularly harmful in producing strains of micro-organisms resistant to antimicrobe therapy. Inadequate regulation of pre-
scription drugs by the Ministry of Health is the main reason for the over-consumption of such drugs in Ukraine. This, in turn is the result of inadequate primary health care. Aggressive, uncontrolled growth of the market segment of drugs without prescription has a negative impact on the cost of medications and the quality of medical care.

Regardless of the complexity and drawbacks of the existing pharmaceutical support system in Ukraine, patients subject to preferential or free provision of drugs enjoy special consideration by doctors and pharmacists, with proper observance of rules. When prescribing treatment for these patients, doctors write prescriptions for generic drugs on the National List of Medicines. In other words, under partial or full coverage for medicines it is possible to exercise control over drug consumption. However, such practice has little impact as coverage of this type is provided only to 9% of the urban population and to 5% of the rural population.

In general, the country does not have an adequate pharmaceutical support system despite the low level of social security. The existing pharmaceutical management is at the embryonic stage of development. The shortage of medicines is accompanied by excessive consumption leading to inadequate control over the prescription and use of drugs at health facilities.

Today, the State program for funding the health system declares but does not cover the expenses for prescription drugs. It is important to note that the most economically vulnerable segment of the public, including the elderly, children, persons with social diseases and other low-income groups account for more than 50% of the Ukrainian population.

Despite the serious problems in this sector, Ukraine still does not have a standard List groups that should be provided with subsidized or free prescription drugs.

Absence of a mechanism for using personal funds of citizens for in-patient treatment, results in direct losses to patients because they buy the necessary drugs at retail prices, which exceed wholesale prices by 25%-30%. Small lots of medicines are not eligible for “discounts”, and patients are not usually informed about the availability of generic drugs that cost several times less than brand-name medicines.

Such state of affairs not only enhances the hang-the-expense trends in health protection but also negatively affects the living standards of the population.

We did not elaborate on the mechanism of public procurement relating to the manufacture and supply of essential drugs and medical preparations for the treatment of socially significant diseases. The system of tender [bidding] purchases also needs further improvement.

The system of information support for the pharmaceutical sector is inadequate either. The range of medicines is defined the business entities at their own discretion without market analysis and without taking into account the population’s needs. Due to a shortage in working capital, drugstores are not able to keep in stock all necessary drugs. Both in the regions and at the state level, databases with the information on the needs of the public and health facilities, on manufacturers and suppliers of pharmaceutical products, and on the cost of drugs [6] are very much needed.

In order to harmonize legislative and regulatory aspects, relating to pharmaceutical activity, with relevant EU standards, the Government concluded the Agreement on Partnership and Cooperation with the European Union that became effective in March 1998. The direction toward integration into the EU, outlined in the Agreement, was supported by enactments of the President of Ukraine and regulations of the Government. The main aim of adopting EU regulatory standards is reflected in the changes made to the Ukrainian regulatory framework. In addition to structural transformation, like the establishment of the State department for control over the quality, safety, and manufacture of pharmaceutical and medical products, which was transformed in 2003 into the State service of pharmaceutical and medical products, there have also been positive changes in the fiscal and tax policy [1]. These include elimination of discriminatory differences in registration fees for local and foreign companies, reorientation towards EU standards, deregulation of the pharmaceutical market, rejection of non-tariff import limitations, and simplification of the registration procedure for domestically and foreign made medicines.
Given the economic reform and financial constraints suffered by both the State and employers, it is necessary to determine the level, structure and scope of guarantees from the State taking into account priorities and consistency in the reorganization of the drug supply system.

Medical products

At present, the health protection system faces serious difficulties in the area of technological support and maintenance of available equipment. The analysis of provision of health facilities with medical equipment showed that most sophisticated equipment had been purchased by 1992. Some institutions still use devices manufactured in the 1970s. Equipment is over 50% obsolete.

In recent years, the government has been implementing a policy for technological support of health protection, to raise the quality and efficiency of medical aid through proper provision of this sector with medical equipment and to decrease dependence on import supplies.

Despite economic problems in the country, in 1996 the government approved a comprehensive program of industrial development of this sector for 1997-2003. One of the chief tasks was to develop and manufacture sophisticated medical equipment. High-tech enterprises of the military-industrial complex were engaged in the implementation of the program which helped start the process of revival for the domestic medical industry. Domestic enterprises developed and began to manufacture badly needed equipment in the health protection system. These include fluorography, anesthesia respiratory apparatuses, mammography, digital electrocardiographs, ultrasonic scanners, and the like. Ukrainian specialists have completed the development of the equipment for blood donations, blood plasma fractioning, colposcopy, ultrasonic complexes, neureondoscopes and hysteroscopes.

The Ministry of Health has outlined the basic directions of the comprehensive retooling of health facilities. These were adapted by regional health care authorities into local plans for re-equipment of health facilities during the five-year period (2001-2005). The priority is to provide district hospitals with mainly domestically made equipment. Sophisticated and expensive medical equipment for regional and national health facilities is procured in a centralized manner by the Ministry of Health.

However, the rate of technological modernization of health facilities still does not meet actual requirements.

Registration of manufacturers of medical equipment and issue of permits for import of such equipment are carried out by the State committee for control over the quality, safety and manufacture of pharmaceutical and medical products.

Regardless of these efforts the material and technical resources for most health facilities, especially those located in rural areas, need further renovation and development. Most premises are in need of major repair. Most equipment is outdated and obsolete. In most health facilities, the annual rate for the replacement of obsolete medical equipment does not exceed 2%.
Conclusions for Section 2.6

The main problems of the provision of medications and medical products are:

- Gaps in the existing normative and legislative framework and its incomplete compliance with international requirements in the area of supplies of pharmaceutical and medical products.
- Absence of rational pharmaceutical policy at macro and micro-levels.
- Inefficient use of medicines and the available range of medical products.
- Risk of drug interactions, violation of the sequence of rational pharmaceutical therapy.
- Limited influence of doctors on the use of drugs. The real influence on prescriptions is exerted by pharmaceutical companies that conduct aggressive marketing campaigns.

Literature for Section 2.6

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4. The Decree of the Cabinet of Ministers of Ukraine dated July 25, 2003 #1162 “On adoption of the national program on population provision with medications for years 2004-2005”.
5. The Decree of the Cabinet of Ministers of Ukraine dated November 16, 2004. # 1482 “On approval of the national list of essential (vital) medications and products of medical application”.
Key strategies for further development of the health care sector in Ukraine

2.7. Problems of Providing High-quality Medical Services

According to the sociological surveys concerning the quality of social and municipal services in Ukraine, conducted by the Center “Social monitoring” and supported by the UNDP (2002), 50% of the respondents assessed the quality of health care as low; over one third, as extremely low; which proves that most Ukrainian citizens are not satisfied with the quality of medical services [4,10].

The quality and efficiency of operation of health facilities are among the most pressing problems of health protection management directly connected with productivity and the use of limited resources in this sector [3].

The modern approach to high-quality medical services is the achievement of the maximum possible decrease in morbidity and mortality rates using the available resources.

The quality of medical services is a complex multi-component notion combining two aspects: objective (technical quality) and subjective (the way a patient understands the notion of quality).

The components of technical quality include the structure of a health facility, namely, all available resources of this institution like technological and technical facilities (premises, installations, and equipment), medical and managerial staff, and the process of medical services provision [4].

The quality of premises and installations covers the safety of design and structures, functional planning, availability of sanitary and technical facilities (water supply and sewerage) and the like. The quality of medical equipment and devices refers to compliance with the aims of medical interventions in a health facility, serviceability, proper calibration and safety operation of equipment and its regular maintenance. The quality of structure also means the level of standardization of methods being applied in a health facility. An important role is played by the quality of medicines and expendable materials, availability of permits for their use in medical practice, observance of storage conditions and.

Sufficient numbers of qualified medical personnel is an extremely important factor, essential for high-quality medical aid. The training level of doctors and medical workers, who regularly upgrade their skills, exerts a decisive influence on the overall capacity to render adequate medical services.

Much evidence has accumulated recently to show that efficiency of health facilities depends on the quality of management, namely, on the professional skills of managers. Therefore, the quality of structure also includes qualification of administration unit [1].

The actions, being taken by medical personnel through the use of available resources, are classified as the processes of medical attendance and provision of medical aid. Process quality refers to the mechanism for the use of available resources ensuring adequate application and proper intervention in accordance with the patient’s needs. This category involves observance of diagnostics technology, treatment, disease prevention, and also, the relations between doctors and patients, interaction between different divisions of a health facility etc.

However, high quality of both resources and the processes of their use lose significance if required treatment and care results are not achieved. The quality of results is a key component in the appraisal of the quality of medical services as a whole, and the quality of operation of all divisions of a health facility. Success of medical interventions also depends on a psychological component, namely, positive perception of the treatment process by patients, and their satisfaction with medical services rendered to them. In other words, successful results are achieved by a combination of technical quality and the quality estimated by patients [6].

The quality assessment is done through joint departmental (internal) and non-departmental (external) control.

Internal control of quality is the assessment of the work of medical personnel by the persons
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Internal control of medical service quality is usually exercised through comparison with commonly accepted standards of medical practice [2].

External (non-departmental) control refers to the control over observance of fixed requirements by the authority that is not part of a health care establishment.

In the last decade, the government, regional health authorities and administrations of health facilities have taken specific measures to ensure the quality of medical aid which can be theoretically classified as preventive and current measures.

Preventive measures include licensing of medical practice, accreditation of health facilities, certification of medical personnel, and standardization of medical aid. Current measures involve the current control over observance of licensing requirements by licensees and also the current control over the quality of medical aid both on the level of health facilities and the level of regional health authorities (health boards of regional and city administrations).

Licensing of medical practice

During 2000-2001, several enactments were passed in Ukraine that helped increase the role of medical practice licensing in order to create the preconditions essential for the provision of high-quality medical care. Among those enactments are the law “On licensing of specific types of economic activities” # 1775-14 and joint order of the State Committee of Ukraine for regulatory policy and entrepreneurship and the Ministry of Health of Ukraine as of February 16, 2001, # 38/63 (registered by the Ministry of Justice on March 2, 2001, # 189/5380) “Licensing conditions for economic activity relating to medical practice”.

Accreditation of health facilities

State accreditation of health facilities, introduced in Ukraine in 1997 (Regulation of the Cabinet of Ministers of Ukraine # 765 as of July 15, 1997 “On approval of the Procedure of state accreditation of a health facility” with amendments introduced as per Regulation of the Cabinet of Ministers of Ukraine # 678 as of June 21, 2001), makes provision for assessment of the operation of health facilities by expert consultation on compliance with set standards (conditions) of accreditation. At present, there are 27 accreditation commissions in Ukraine, functioning at health boards of regional, Kiev and Sevastopol state administrations in charge of accreditation of municipal health facilities. The main accreditation commission at the Ministry of Health of Ukraine approves the decisions of the above accreditation commissions and accredits the privately and state owned health facilities, and the institutions controlled by regional state administrations. In 1998, Ukrainian specialists, assisted by their US and Canadian colleagues, elaborated the state accreditation standards that, practically without any changes, were approved as the criteria (conditions) of state accreditation of health care and disease prevention institutions (order of the Ministry of Health as of January 20, 2001, # 20).

The first stage of state accreditation in Ukraine helped to analyze the activity of health facilities, to strengthen their material and technological resources and to improve the skills of medical workers. Accreditation initiated the creation of the preconditions for the realization of patients’ rights to medical care of adequate quality.

Certification of medical personnel

Doctors with medical education should undergo advance training and improve their skills.

All practicing doctors are subject to certification at least once in 5 years. Certification is done by the relevant certification commissions of the Ministry of Health, Academy of Medical Sciences, and regional health authorities. Qualification level is divided into three categories. The main criterion is the record of work, but not its scope and quality. A medical worker who has failed to meet the criterion is deprived of a raise in wages but does not lose the right to independent work.
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**Current measures to ensure the quality of medical care**

At the state level, the current external control of medical care quality is exercised by the Licensing commission of the Ministry of Health of Ukraine and regional health protection boards of regional state administrations, through routine checks of observance of licensing requirements by licensees.

The current internal control of medical care quality is exercised by health facilities and health authorities. The most broadly used method is a multilevel quality control system where, on the level of a health facility (HF), assessment of medical care control is done by head of a subdivision (level 1), deputy head of HF in charge of clinical-expert, treatment, out-patient-clinical care (level 2), clinical-expert commissions of HF (level 3), commissions of a health authority (level 4). This system was introduced within the framework of the “new economic mechanism” (end of the 1980s-beginning of 1990s) and is still used with some minor changes.

**Standardization of medical practice**

The traditional practice of standards is the approach involving the list of standard diagnostic and treatment measures with different diagnoses. At present, there are sectoral standards for the assessment of medical aid quality approved by the order of the Ministry of Health as of July 27, 1998, # 226 “On approval of interim sectoral standards of medical technologies of the diagnostic and treatment processes of in-patient care to the adult population at health facilities of Ukraine and interim standards of the scopes of diagnostic examinations, treatment measures and criteria of quality of medical treatment of children”.

Great progress was made in 2003-2004 when clinical guidelines were defined intended for different fields (family medicine, therapy, surgery, obstetrics and gynecology, nephrology, neurosurgery etc.). Some protocols have been officially approved by the Ministry of Health and others are at the stage of approval and coordination.

**Conclusions for Section 2.7**

At the beginning of 2005, the following problems existed in the system of ensuring the quality of medical aid:

*Problems of licensing in medical practice:*

- The law on licensing is not applied to the state and municipal health facilities (probably because the government does not classify them as full-fledged business entities or because there is no adequate control over observance of this law)7.
- The term “health facility” is not defined which enables the privately practicing medical workers, engaged in out-patient treatment, to avoid control over the quality of their service and not to submit statistical reports to regional health protection authorities. (this submission is a mandatory licensing requirement for health facilities).
- Licensing of a medical practice is a not a transparent process. Public organizations, including trade unions, do not take part in this process.
- There is discrimination concerning privately owned health facilities (issue of disability documents, application of narcotic and psychotropic drugs).
- There are also unjustified limitations on the operation of privately owned health facilities (concerning provision of specific types of medical aid).

7. In accordance with the Law “On licensing of certain kinds of economic activity” “a business entity [economic agent] shall be understood as an officially registered legal entity irrespective of its organizational and legal status and the form of ownership that carries out economic activity, excluding the state and local self-government authorities, also a natural person — a subject of entrepreneurship”.
Problems in accreditation of health facilities:

- During the first stage, the results of accreditation were not used in full (not a single institution that failed to receive accreditation was reorganized while not a single institution with the best accreditation grades was encouraged).

- Examination mainly has a subjective character as a result of a lack of training of experts of accreditation commissions.

- Regardless of the fact that the first national standards of state accreditation were highly appreciated by specialists, they have become outdated and need changes and amendments, in particular, introduction of mandatory and additional criteria (conditions) of accreditation, further development of standards for the institutions rendering specialized medical aid, also introduction of quality criteria (indicators) for different services etc.

Problems with certification of medical personnel:

- Absence of clear criteria of assessment of professional activity, connected with the quality of work of doctors and medical nurses, which makes it possible to take subjective decisions during certification.

- The existing system of certification of medical personnel includes a small raise in wages, but it is not enough to serve as a stimulus for improving skills.

- Certification is not controlled by medical self-management authorities (because the latter are not available in Ukraine).

Problems with the standardization of medical practice:

- Hierarchical multilevel approach to appraisal of medical care quality is inefficient and involves considerable expenses. Large portions of the limited resources are spent on the performance of control functions, since the control of everything, including each entry in a medical card requires much time investment by medical workers and distracts them from their professional work. Taking into account the fact that when applying such control system measures, the attention is concentrated on the actions of personnel, but not on the results of medical care, the efficient use of available resources for successful treatment of patients, achieved by the means differing from common practice, is considered as deviation from such practice in terms of the quality ensuring system.

- Absence of standardized approaches to the process of standardization of medical practice in Ukraine. When developing standards, it is necessary to take into account the fact that they should be easily understood and used by doctors. At the same time, it is necessary to use technologies of scientifically proven efficiency, scientifically grounded medical practice or “evidence-based medicine”. The use of randomized control studies to test new or existing methods of diagnostics and treatment helps to reach agreement on the issues involving different, often opposite opinions of experts due to an absence of adequate proofs of their correctness.

- Drawing an analogy between the state and medical standards is erroneous. Inasmuch as the medical standard is a standard of professional activity, it has different structures and objectives than the state standards. Therefore, medical standards shall be approved by professional associations in coordination with the Ministry of Health, but not with the State Committee for Standardization.

- Absence of sectoral standard “clinical pathways” which leads to misunderstandings among medical experts. The notions of “clinical management”, “clinical pathway”, “medical standard” are often combined, though these are different forms of standardization of the medical care process, that mutually supplement but not mutually replace each other.
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• Medical workers have limited access to information on “evidence-based medicine” and standardization, since there is no resource center of evidence-based medicine in Ukraine.

• The resource support for the medical care process is inadequate, and medical workers have no experience in the area of application of medical standards.

Thus, it is possible to conclude that the problem of ensuring the quality of medical care in Ukraine is not a major component of health policy. Ukraine has no integral strategy of control over the quality of medical care. Attention to the solution of this problem is diminishing. Regardless of the fact that in analyzing the activity of Ministry of Health in 1999 in terms of preparation for administrative reform, the quality of medical care was classified as a major function of the Ministry, the accreditation and licensing department was liquidated during reorganization of the Ministry in 2000. Since that time, control over medical aid quality is unsystematic and is often exercised by the officials without adequate training and experience in this area. At present, analysis of the results of the operation of health facilities in Ukraine is based exclusively on the reporting and accounting documents approved by the state authorities (statistical data and annual reports) and on the results of individual studies, thus, making it impossible to objectively appraise the quality of medical care.

In order to produce the proper effect on the quality and efficiency of medical care, it is necessary to develop methods to objectively assess the results of medical activity.

Literature for Section 2.7

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2.8. Allocation of Financial Resources

Allocation of finances in health care system

The main official sources of health care system financing are national and local budgets. The Budget Code of Ukraine (2001) regulates relations that arise in the process of drafting, consideration, approval, implementation and control over budgets.

The system of finance allocation is complicated. The MOH, as a main manager of finances that are allocated from the budget for health care, drafts the national health care budget and submits it to the Ministry of Finance. The national health care budget if formed in line with the main activities of the MOH, and covers the following: financing of the MOH management personnel, health care settings and health research institutions, sanitary and epidemiological services, national health programs and comprehensive programming activities in health care, and maintenance of health and preventive health care settings that report directly to the MOH.

In drafting the budget, the following considerations are taken into account: previous year’s work that has been completed, level of coverage of health care expenditures from the budget, epidemiology data that indicate changing needs for health care services, and organizational and financial restrictions set by financial organs for the next budget period. Priorities of health care development formulated by the government and MOH are taken into account.

Based on the main directions of budget policy of the country defined by the Parliament, and guided by the budget requests of main budget managers, the Ministry of Finances drafts the national budget for the upcoming year. The budget is approved by the Parliament, which passes the Law on National Budget.

The procedure for drafting local health care budgets is the same. Local health administrations are the main health care budget managers; they, jointly with executive agencies, organize drafting of cost estimates and budget requests for the MOH health care settings financing and submit them to the financial bodies.

Based on the socio-economic condition of the respective territory, projected volumes of inter-budget transfers, the Parliament of the Autonomous Republic of Crimea, local state administrations and executive bodies of city, village, town self-governments draft approvals on respective local budgets and, if needed, adjust funds request submitted to them.

The local budgets are approved by representative authorities not later than 2 weeks after the Law on the National Budget is published.

Expenditures from the budget are planned and done in line with budget classification codes (by lines).

The funds from the national and local budgets are spent strictly in accordance with the authority given by the main financial manager. In order to provide rational use of national funds, all procurement made by health care settings and institutions (medical and office equipment, medications, supplies, etc.) should be done through procedure of bidding.

Operations on budget funds spending for maintenance of health care settings are done through National Treasury organs. Main budget funds managers (MOH, local health administrations, and local administrations) make summary calculations of receipts and expenditure profiles for health care settings subordinated to them and submit them to the Head Treasury and its territorial offices, respectively. The health care settings receive information on the limits, which act as a basis for drafting their own calculations of receipts and expenditures (fig. 2.14).

Investments are financed both at the national and at the local levels. However, the current financial condition of the health care system does not permit spending enough funds on investment. According to MOH data, depreciation of capital assets in health care is more than 50%. Depreciated and obsolete capital assets is replenished very slowly. During 1991-2000, the replenishment ratio of depreciated and obsolete capital assets was 1.9%. In the majority of health care settings, the replenishment volume for obsolete medical equipment is less than 2%. At the same time, according to the Ukrainian Clearing House, there is inefficient use of funds...
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Fig. 2.14. Financial Flow in the Health Care System Scheme
in buying medical equipment. In a number of cases, expensive equipment was procured at inflated prices without previous market research or without taking into account priority needs of the health care settings. In order to optimize expenditures allocated to capital investment, as of 2000, the MOH switched to a practice of centralized procurement of complex medical equipment.

In recent years, a number of general profile activities had been carried out in Ukraine (Budget Code approval, introduction of the system of the budget treasury service and tendering for purchase of goods and services for the budget money); they are aimed at exercising stricter control over budget use. The most important issue for health care is that the Budget Code had set a strict procedure of equity of budget opportunities for different territories, done though budget transfers and subsidies. It allowed to even out slightly the large existing differences in health care financing between different regions, and between rural and urban areas. However, implementation of these mechanisms, especially in rural areas, faces considerable difficulties and it is not widely used.

Overall, there have not been substantial changes in the system of resource redistribution in health care. The law, which allowed purchasing of health care services from different health service providers based on competition and actually laid the legal basis for contractual relations in health care, does not work.

Financing of health facilities (in-patient and out-patient facilities)

In recent years, territorial health care systems in Ukraine have been financed based on the number of population that lives there, i.e. based on the per capita principle.

However, the health care establishments, which mostly remain directly subordinate to health administrations, continue to receive funds by the allocation principle, which is based on capacity (number of beds and visits). In the past, this principle helped create the health care infrastructure in a form of a developed network of health care settings. However, the positive potential of such an approach to financing was exhausted in this country a long time ago. Formally, health care settings (public and community) are financed on the basis of completed cost estimates line by line (or by codes of functional and economic classification).

The cost estimate of an in-patient facility usually includes such indicators as: wage bill with respective extra fees/charges on salaries, purchase of medications, catering, medical equipment, paying for utility bills, and maintenance of the facilities. Wage bill is calculated as a sum of products (products come from multiplication of a respective salary for position by the number of health professionals who are employed in such a position). The staff list is set in line with staffing norms for beds of the specific profile. Medication and catering expenditures are set as products of respective normative expenditures calculated by bed/day and planned number of bed/days. The profile of out-patient clinic-cost estimates is similar to that of the in-patient facility and include wage bills with fees/charges on salaries, funds for supplies for out-patient care, purchase of medical equipment, and maintenance of the facilities. The staff list of out-patient clinics for the calculation of wage bills is set in line with staffing norms and depends on the number of populations to whom services are rendered. Expenditures on the materials are calculated as a product of an expenditure norm for one visit and the planned number of bed days.

It should also be remembered that under conditions of inadequate health care financing, funds are primarily allocated to cover “protected” lines. Usually these are salaries with fees/charges, medications, catering, utility payments. Since recently, expenditures on financing maternity and childhood protection activities have also been added to this list. In local budgets for 2003, the partial weight of wage bills was 63.8%, medications —

8. On the state of financing and use of the national budget funds by facilities of the MOH of Ukraine/ Materials of Clearing House Board of 05/17/2000.
8.4%, catering — 4.3%, utility payments — 9.7%. One should remember that the scope of financing on some budget lines does not reflect real expenditures. Expenditures on medications, various medical supplies (syringes, needles, gloves, etc.) are covered primarily by the patients.

Thus, in Ukraine, the old Soviet approach to fund allocation between health care settings, depending on capacity, (financing of in-patient facilities is determined by the number of beds, and financing of clinics is determined by the number of visits) remains intact. In fact, the way resources are allocated within a territory is directed not by improvement of population health status, but by maintenance of health care settings. It should be mentioned that extensive development was possible only when the market did not exist, with the main share of resources in circulation being available at a relatively low price. Under market economy conditions, the capacity to maintain an excessively large network of health care settings has diminished considerably.

The fact that in-patient facilities are interested in keeping existing capacity indicators of the bed pool, when health care demand is actually declining, results in the increase of the number of unsubstantiated hospitalizations. Limited funds are allocated to keep “inflated” bed pools, instead of adequate resource allocation to each case when health care is needed. Financing of out-patient facilities by the number of visits does not create economic incentives for intensive and effective work, leads to a waste of health care resources and money of the public.

**Health professionals compensation**

Since Soviet times, fixed salaries of were used in Ukraine to compensate the work of health professionals. Efforts to make this compensation more flexible were without success.

Economic decline resulted not only in the downsizing of the total health care budget, but also the substantial erosion of health professional salaries. Low salaries encouraged the spread of informal payments for specific health care services, which is viewed by health professionals as a kind of compensation for inadequate appreciation of their work. Informal payments in turn, adversely affect accessibility of health care because patients with low income can not afford to pay doctors.

Salaries in public and community health care facilities are not only low, but they are also independent of the scope and quality of work.
Conclusions for Section 2.8

• Health care budget fund allocation between territories is done on a per capita setting. However, financial norms of budget allocation and, health care budget allocation are formed without any relevance to national obligations regarding free health care.

• Strict separation of health care expenditures of budgets at different level, along with certain streamlining of resource use, results in the disintegration of the territorial health care system, preserves conditions for the parallel existence of health care facilities on the same territory, and creates obstacles to optimizing health care setting network.

• Funds between health care settings are allocated following the Soviet approach. This means that allocation depends on capacity indicators (number of beds, number of positions, capacity of outpatient facilities, etc.). This creates incentives for health care facilities to develop excessively.

• Financing of public or communal health care settings envisages, according to the Budget Code, the allocation of funds for their maintenance — it does not provide coverage for expenditures according to the scope of work done.

• Cost estimate financing of health care settings (line by line or by budget classification codes) results in the restriction of the authority and responsibility of health care managers and does not create incentives to improve resource use effectiveness.

• Coverage of current expenditures, which is related to the generally inadequate financing of health care, does not allow timely replacement of depreciated and obsolete equipment; the allocated funds do not depend on the results of health professionals’ activities.

• Large portions of the population direct payments (both official and informal) for health care donot allow to effectively manage resources at the health care setting level.

• Salaries of health professionals continue to be small and they do not depend on the scope and quality of the work.

• The system of financial and statistical accounting and reporting in health care does not provide the necessary information for financial planning of the territorial health care system and facility activities; it does not provide information for correct assessment of budget funds use.

Thus, existing systems of financing of health care settings is the main cause of remaining deficiencies in the health care service profile; it encourages unsubstantiated increase of hospitalizations and out-patient counseling; it encourages ineffective spending of budget funds and funds of population; it preserves an unreasonable ratio between primary, secondary, and tertiary care. The ruling principle of “keeping” a network of health care settings, budget financing based on volume of resources engaged, allocation of the majority of resources without any relevance to activity results, ignoring the modern methods of financial planning and management — these are the characteristics of Ukrainian health care financing system; they slow down, and, in a number of cases, obstruct health care reforms and improvement in overall effectiveness of the system. Chronic lack of funds reflects not only inadequate financing, but also acute structural imbalances. Experts state that the health care pyramid is turned upside down in our country: the volume of specialized care is larger than the volume of primary care [2]. The health care financing system supports this upturned pyramid and encourages the impractical use of resources. Inadequate financing does not prevent the inappropriate use of resources. Keeping the current approaches to financial resource allocation in health care renders the problem of fund deficit unsolvable, even if the overall economic situation would improve.

Literature for Section 2.8

2.9. Health Care Sector Information Provision

It is well known, that managers in the health care sphere at all levels should have access to information both at local and national levels in order to have an opportunity to manage medical structures in the framework of their competence and to develop plans to effect changes in the health care system. In recent years, the medical community has come to consider the access to information on modern and reliable health care and patients’ health status as the main prerequisite for adequate treatment for people [2].

Unfortunately, in Ukraine, that current information system is made not for real need, but for the fulfillment of administrative tasks.

The system of managerial reporting and information flow

The structure of the managerial reporting system, which exists at health care facilities, is divided into two subsystems: medical and economic. These two subsystems are almost independent.

Economic data are gathered and processed exclusively in accordance with economic activity and are kept in subdivisions that are responsible for the financial activity of the health care facility.

Information about health care services and patients is gathered and processed by statistic subdivisions. Such weak collaboration of the sub-systems leads to the loss of very important data, especially as for costs, despite the availability of such information.

Both subsystems have peculiar features, meaning that they are directed towards the activity of external counterparts (management of tax administration bodies, financial structures of territorial administration of higher health care structures).

Medical information flow is reversed:

1. The collection of information and reporting of medical, statistical and economic data at every management level are conducted separately by way of comparison and comparison of data with those that were assessed at each administrative level. In increasing order with integration at each level of management (from bottom to top) including:
   - collection of medical, statistical, and financial information;
   - analysis by means of statistical methods;
   - preparation of reports and information analysis for decision-making.

Gathering of information and medical, statistical and economic data reports at every management level are executed separately by way of comparison and match of data with those that were evaluated at each administrative level.

2. After analytical processing the results are returned in a reverse manner to compare with activity figures between different management level, and they serve as guiding lines for lower managerial layer for the next period of work.

Primary source of medical statistics represent the information that is accumulated from reporting documents, the forms of which are approved by the Ministry of Health of Ukraine. However, nowadays the number of important characteristics is not registered at all, for example, the number of served cases of out-patient treatment in total and by nosologies, number of visits per one case, scope of health interventions in cases of different diseases, etc.. Later such forms are submitted to higher administration of health care system and to the department of State Statistics Committee at the territory, where a facility is located. The information provided in electronic form should be accompanied by a hard copy.

The information provided to the governmental bodies is strictly regulated by the whole range of regulatory acts. The most important among them are: annual order of the Ministry of Health of Ukraine “Regulation on submitting of medical statistic reports by health care system bodies” providing population health care system bodies of oblast administrations with transparent instructions on the information, which is submitted to the governmental bodies that are responsible for the statistics of health care system. According to the enactment all medical
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Statistics is gathered oblasts in oblasts and quoted in the reports that are listed in the enactment, which ensures that each region submits special reports to certain bodies according to the schedule.

Besides that, the order of the Ministry of Health of Ukraine #197 “Evaluation of population health care system status and material technical supply of health care facilities” dated May 31, 2002 lists the indicators, which should be submitted to the Ministry of Health of Ukraine by the regional health care administrations. According to the order of the Ministry of Health of Ukraine, “On improvement of the primary medico-sanitary care monitoring on the basis of family medicine and unification of the corresponding reporting medical documentation” dated January 8, 2004 the collection and analysis of current information on the development of the system, personnel, and resource provision and some other performance indicators of general practice — family medicine facilities are conducted [1].

It is significant as for the creation of economic information flows and in accordance with the decisions of local councils the budget resources for population health care are allocated among the facilities of health care system on specific territories with monthly schedules of their transfer. These budgets are formed by financial departments of local administrations in coordination with the administrations of population health care system institutions. To see for budget costs certain structures of the territorial unit provide the record keeping of expenses of the particular budget period.

The financial information, which is collected by the financial subdivision, serves as a basis for decision-making at the level of a territorial unit. Territorial administration compares and evaluates all financial data and medical statistical information in order to evaluate the results of the territorial policy operations in the health care sphere.

The flow of financial information is guided from bottom to top, namely: financial structures of all territorial units submit their financial outcomes to Oblast administrations, where the information is generalized and analyzed accordingly. After creating the joint financial document of oblast financial information it is submitted to such governmental bodies as the Ministry of Finance, the Ministry of Economy, and the State Statistics Committee.

Therefore, Ukraine does not have the system of managerial accounting, which could meet the modern needs of health care sector development. Furthermore, there are no profiles (sets of indicators, characteristics, criteria) for corresponding types of medical structures.

It is significant that recently medical statistic gathering and its processing which is needed for making decisions has become practically impossible without the use of modern information technologies. The majority of health care system facilities have computers, mostly in cities, where the level of PC skills is much higher then in rural areas.

Current status of informational technologies

Informational technologies in the health facilities are used both for accounting and producing medical statistics reports. As a rule accounting is executed with the specialists assistance on software products, which were developed especially for budget institutions, and software products of general accounting and book-keeping adapted to the needs of such institutions. Software products for medical statistics are mainly based on general programs such as Access and Excel, and data input is conducted manually on the basis of information on patients in statistic departments. In some health care institutions there are experimental computer databases of patients, which contain broad medical profile of them and it provides automatic summaries of patient information [5].

It is needed to mention that there are software products already available in Ukraine (for example automatized working place of a family doctor) which integrate medical and economic information in their modern approaches and can serve as the main component for forming the medical information flows.

It is needed to add that Ukraine the prerequisites were created for supporting the computerization of the health care system in Ukraine. It is the constituent part of the national policy of state computerization in general and it focuses on the efficient implementation of the urgent

It is essential to add that the dynamics of increase of nearly all informational and telecommunication technology segments in Ukraine. It constituted 20-30% at the beginning of 2004. In general, the domestic market of information and telecommunication technologies in the health care sector is now in the phase of active development [4].

It is essential to notice that an important problem of this process is the lack of or imperfection of resource provision of computer equipment in the health facilities (Insert 7).

In the sphere of software production and system integration of software products, the state policy focuses on creating competitive software systems, in compliance with national and international standards, and on the establishment of highly intellectual informational technologies. It should be emphasized that there is no more significant technological gap in software development between Ukrainian and leading Western centers [2].

Many medical informational systems (MIS) have been created in Ukraine. However, most of them cannot ensure comprehensive information which is necessary for successful reform of the health care sector. As a rule, they are designed for some branch of medical servicing or separate managerial function (statistical reporting, resource accounting, staff work planning, etc.).
The development of the national segment of the Internet is one of the priorities in the state policy. Internet starts to play a visible role in the life of the population, whose interest grows from day to day. In 1998 the number of Internet users constituted 0.2 % of Ukrainian population, and nowadays it is about 8%. The service provision on access to the Internet is ensured in all regions and most of regional centers. In total, the Internet services were used by approximately 4.5 million Ukrainian citizens with various frequencies. In 2004 health care institutions of Ukraine significantly expanded the use of the Internet [3].

It should be emphasized, that the preparation of the society for the computerization of health care is an important direction of the health care computerization development because its peculiarity is connected with the attitude to the information about individual level of health.

Conclusions for Section 2.9

- The existing information system is not well differentiated on the management levels and it is oriented basically toward the fulfillment of administrative tasks, but not toward the needs of health care management.
- The interconnection between informational, medical and economic subsystems is very poor — information is being gathered and processed separately, but is not analyzed as a whole.
- There is no management accounting system satisfying modern needs and prospects of development of the health care sector.
- There are no indicators (list of indicators, characteristics, and criteria) for different health care services.
- There are various medical information systems (MIS) created in Ukraine, although most of them are not able to provide comprehensive information which is necessary to reform the health care sector. As a rule, they are intended for specific branches of the health care sector or for separate management functions (statistical reporting, resource accounting, staff work plans, etc.)
- Insufficient provision of health care institutions with computer techniques having modern software and access to the Internet.

Literature for Section 2.9

2.10. Regulatory Support of the Health Care System

Determinative factors and goals of the health care reform and development of legislative framework in Ukraine in this sphere

The necessity for changes, that emerged right after Ukraine became independent, was a result of the set of factors, mostly economic.

Another reason was disparity of the Soviet health care model with new conditions of this sector. In late 1980s, it became clear that the positive potential of the health care system, based on the Semashko’s model, had been already depleted. Excessive development led to serious imbalances between the out-patient and in-patient components of the medical care system, distribution of limited resources in this sector and, as a result, to the worsening of the quality of medical care.

Political, social, and economic transformations fostered the processes of democratization and Ukraine’s integration into the world community and stimulated changes in the health care system.

One year after Ukraine became independent, the Parliament approved the “Fundamentals of Ukrainian legislation on health protection” (1992) which took into account new political and economic realities, defined the basic principles of the national policy in this domain that fully corresponded to international standards and recommendations related to human rights and the development of the health care system. This document is still the prime legislative act which regulates the relations in the sphere of health protection and medical services.

However, despite this, by the end of 2000, activity of the Cabinet of Ministers and other state executive bodies to implement legislatively fixed principles and determination of the most expedient and efficient political methods had been implemented without clear goals and priorities which as a result proved the low rates of reforms, inconsistency of processes which were executed inside it (often in contradictions of such activity).

Nevertheless, we can mark several main tasks of health care development during that period.

The main goal of changes within the conditions of grave economic crisis that hit the country at the beginning of the 1990s was to prevent the collapse of the existing health care system and to preserve the minimum level of social guarantees relating to provision of medical aid.

In order to achieve this aim, the work was executed in several directions, namely:

• search for additional resources for funding the health protection system, first and foremost, by attracting public funds;
• attempts at regulatory and legislative limitation of the scope of state guarantees relating to free medical care and at bringing them in line with the actual financial and economic potentials of the country;
• reduction of state expenditures for health protection through unreasonable decrease of the existing, huge number of beds and those which are not in use, health facilities, doctors and other medical and auxiliary personnel.

Important goals of the reforms at that time were to raise the structural efficiency of health protection and upgrade the quality of medical care. Efforts were made to prioritize the development of primary medical and sanitary aid, to intensify the process of creating alternatives to in-patient medical care, to standardize medical technologies and to introduce the accreditation system.

After the USSR’s collapse in connection with retirement of the completely centralized management system, one of the goals of national policy was the decentralization of management, including that in the health care system. That

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10 This section was prepared on the basis of materials presented in: Lekhan V., Rudiy V., Nolte E. Health care systems in transition: Ukraine. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2004, pp. 103–119 (part “Health care reforms”) with some changes and amendments taking into account the development of legal regulation in health care sector in 2003-the beginning of 2005.
process involved transformation of series of functions on health protection management to local state administrations and self-government authorities.

Sudden worsening of the population’s health, and the critical demographic situation in the country raised the problem of essential system transformations in the health protection sector. The factor that favored acceleration and more effective realization of reforms in this sector also became relative stabilization of economic situation. In approved by the President of Ukraine in December, 2000 concept of development of health protection which aims for further health care reforms have been already formed: to safeguard and to strengthen the population’s health, to increase longevity and life expectancy; to create legal, economic and management mechanisms essential for the realization of constitutional rights of citizens to health protection, medical aid and medical insurance; to ensure the guaranteed level of provision of free qualified medical aid within the limits defined by law; establishment of a regulated market of medical services, fund the activity of all forms of property health facilities; to create conditions for meeting the population’s needs related to medical services; efficient use of available personnel, financial and material resources; solidarity state’s, employers’, territorial communities’ and individual legal and physical individuals’ participation and also participation in the funding of medical services.

Reforms’ content and legislation

This section chronologically presents the basic activities relating to the development of legislation and the most significant changes in the health care system, and also briefly describes the provisions essential for reforming the health care system.

1992

As mentioned above, the Parliament passed the “Fundamentals of Ukrainian legislation related to health protection” which still remains the basic law regulating social relations in this sphere. In particular, this legislative act is the leading one for the national health care system and it defines: the citizens’ rights and duties in the sphere of health, the main principles of health care support, approaches to formation and implementation of state policy in the sphere of health protection. Relevant sections and articles of this document are devoted to the basics of health protection management and the procedure of funding of this system; basic principles of state control and supervision in this sphere, main principles of provision of healthy and safe living conditions, basics of organization of medical aid and pharmaceutical support, general conditions for medical interventions and related patient rights, protection of health of mothers and children, general principles of medical examinations, medical and pharmaceutical activities, professional rights and duties of medical and pharmaceutical workers.

In accordance with the guaranteeing reform of the health care system the important thing is: in the list of governmental guarantees of the right to health care the problem was set concerning providing free medical care to all citizens within a limited ranges which could be determined by the Cabinet of Ministers of Ukraine.

No less important is the fact that this law for the first time defined the legal opportunities for entrepreneurship in the area of health protection, the use of funds, essential for backing the health care system, of not only state but also local budgets, the funds of medical insurance, charity organizations and other sources not prohibited by the law. It was stipulated that the funds of state and local budgets, allocated for health protection, shall be used for reaching the guaranteed level of medical aid, financing of state and local health care programs and fundamental research in this area. Health facilities were allowed to use for raising the quality of their services the funds voluntarily provided by legal entities and individuals, also, given the owner’s permission (in reality most frequently — local councils), to fix the cost of medical services.

It was proclaimed by this frameworking legislative act that the state should support the establishment and functioning of the medical insurance system using the state budget funds, the funds of employers and citizens according to the procedure defined by the law.
Provisions of this act, relating to medical care, for the first time emphasized that primary medical care, being a component of medical and sanitary care shall, be rendered mainly according to territorial principle by family doctors or other practicing medical workers.

The Ministry of Health approved the curricula and the program of specialization called “general practitioner”.

1994

The Parliament passed the law “On sanitary and epidemic well-being of population”.

1995

The Parliament passed the laws “On donor blood and its components”, “On combating illegal traffic of narcotic drugs, psychotropic substances, their analogs and precursors”.

The Ministry of Health included on the list of medical positions the post “general practitioner-family doctor”.

It was approved by President’s enactment the national program “Family planning” and its logical end was the national program “Reproductive health 2001-2005” approved in 2001.

1996

The Parliament approved the new Constitution of Ukraine. It is about health care and medical service: “A human being, human life and health are recognized in Ukraine as the highest value. Each citizen has the right to health care, medical aid and medical insurance. Health care is supported by state funding of relevant socioeconomic, medical, sanitary, and health improvement and disease prevention programs. The state and municipal health facilities shall provide medical care free of charge; the existing network of these institutions shall not be reduced. The state shall support development of health facilities of all forms of ownership”.

The law “On pharmaceutical products” was adopted.

The law “On insurance” that provided opportunities for operation and development of voluntary medical insurance system” was adopted.

The government approved the list of paid services that may be provided by state and municipal health facilities. For most citizens it meant the transition to the system of payment for many services at their own expenses.

The government approved the comprehensive program for the development of the medical industry for 1997-2003.

President’s enactment approved the national program “Children of Ukraine”.

1997

By the resolution of the government the normative requirements for in-patient medical aid for 10,000 people in accordance with which the local authorities were recommended to use more efficiently hospitals in the territories under their jurisdiction. This approach led to a decrease in the number of hospital beds.

By the resolution of the Cabinet of Ministers of Ukraine the Procedure for state accreditation of health facilities was approved. It is defined in the resolution that all health facilities must be accredited irrespective of their forms of property.

Joint order of the Ministry of Health and the Ministry of Economy approved the list of domestic and foreign pharmaceutical and medical products with prices that shall not be subject to state regulation; in 2001 this list was considerably expanded.

President’s enactment approved the program “Health of elderly people”.

1998

The Parliament passed The Fundamentals of legislation on general mandatory social insurance defining medical insurance as one of type of social insurance and providing legal preconditions for elaboration and adoption of a relevant special law on general mandatory state social medical insurance.

Newly revised in accordance with the recommendations of the Council of Europe, the law “On the prevention of AIDS and social protection of population” was adopted as well as the Law “On the quality and safety of foodstuffs and related raw materials”.

The Minister of Health of Ukraine approved the standards of accreditation of health facilities which established the procedure and criteria essential for such accreditation. The standards were revised in 2000.
The government approved the measures on the prevention of sexually transmitted diseases.

The Ministry of Health issued the enactment defining the temporary unified standards for medical technologies of diagnostic and treatment processes of in-patient aid for adult population and Temporary standards of scopes of diagnostic examinations, measures and criteria intended for the treatment of children. This was done to standardize the requirements for the scope and quality of in-patient treatment.

The Constitutional Court decided that certain provisions of regulation (1996) of the Cabinet of Ministers about approval of the list of paid services that may be offered by state and municipal health facilities did not comply with the Constitution of Ukraine. By that decision, the Constitutional Court recommended to determine the program of state guarantees relating to the scope of free medical aid provided by state and municipal health facilities.

1999

The Parliament passed the law “On transplantation of human organs and other anatomical materials”.

The Target Comprehensive Program of Genetic Monitoring in Ukraine for 1999-2003 was approved by the President of Ukraine. Also The Program of Prevention and Treatment of Arterial Hypertension in Ukraine and the comprehensive program “Diabetes mellitus” were approved.

2000

The Parliament passed the Law “On buying of goods, works and services at the state’s expense” also covering medical services and in fact allows to buy medical service on the contractual basis of medical services at the state’s expense (i.e. the funds of State and local budgets, state credit resources, also the funds of the National Bank of Ukraine, state targeted funds, Pension fund of Ukraine, social insurance funds) from providers of medical services irrespective of the forms of ownership and organizational status both on competitive and non-competitive basis.

The Parliament passed the law “On psychiatric aid” which, for the first time in Ukraine set the legal and organizational principles of provision of psychiatric aid for individuals, in accordance with the priority of human and citizens’ rights. The Law also defined the duties of state executive bodies and local self-government authorities concerning organizational aspects of such aid, legal and social protection of the individuals with mental disorders, the rights and duties of doctors and other medical workers who take part in provision of psychiatric aid.

The law “On licensing of specific types of economic activity” was adopted, it defined that licensing is mandatory for the activity of any subjects (physical and legal individuals of any organizational and ownership forms) engaged in the provision of medical aid. In February, 2001, the joint order of the State Committee for regulatory policy and entrepreneurship and the Ministry of Health of Ukraine approved the licensing requirements for economic activity connected with medical practice.

The law “On protection of population from infectious diseases” was adopted.

The Parliament adopted the law of Ukraine “On state social standards and state social guarantees” which fixed the list of state social norms in the sphere of health protection which needed further development and approval.

The government issued the regulation “On comprehensive measures essential for the introduction of family medicine into the health protection system”.

The Cabinet of Ministers approved the procedure of receiving the charity contributions by budget-sustained health facilities that helped to attract non-budget funds.

President’s enactment approved the Concept of health care development.

2001

The Parliament passed the law “On control of tuberculosis”. President’s decree approved the nation tuberculosis control program for 2002-2005”.

In June 2001, the Parliament passed at the first reading the Draft Law on mandatory state social medical insurance.

The Ministry of Health approved the plan of gradual transition to organization of primary medical and sanitary aid on the basis of family medicine and other related normative documents, namely: Regulations on general practice
doctor — family doctor; Regulations on general practice medical nurse — family medicine; Regulations on general practice departments — family medicine; Regulation on day time inpatient treatment; Regulations on home inpatient treatment; Regulations on general practice out-patient treatment — family medicine; qualification characteristic of the doctor specializing in “general practice — family medicine”; Qualification characteristic of medical nurse specializing in “general practice — family medicine”; Norms of working load and services for general practice doctors — family medicine; Table of equipment of general practice outpatient departments — family medicine; List of medicines for the institutions of general practice — family medicine.

Specialty “medical nurse of general practice — family medicine” was included into the list of specialties of middle-level medical personnel.

The Parliament passed the Budget Code of Ukraine that established the procedure of funding the state and municipal health facilities pursuant to the estimate of expenditures. At the same time, the Budget Code provided the possibility of receiving the budget funds not only for budget-sustained institutions, but also for recipients of budget funds (physical and legal entities) that do not have the status of budget-sustained institution, but which are authorized by the state authorities to implement the national programs or to provide services. This means that the health facilities with the status of enterprise (including the state, municipal or private), and also the professional workers engaged in medical practice may receive budget funds. Taking into account the law “On procurement of goods, works and services at the state expense” (2000), legal opportunities were provided for the buying of medical services at the expense of state funds within the limits of the state and municipal contracts.

The Government issued the directive which approves the Formula of distribution of interbudgetary transfers (subsidies and the funds transferred to the state budget) between the state and local budgets (in particular, the directive states that the indicator of the amount of expenses of the budget of the Autonomous Republic of the Crimea, regional budgets, the budgets of Kiev and Sevastopol, major regional cities and districts are determined on the basis of financial norms taking into account the correction coefficients per capita). This also concerns the sector of health protection.

The Government for the first time approved the National list of basic (essential) pharmaceutical and medical products. However, this list does not meet the WHO recommendations and thus it cannot be considered as an efficient instrument essential for initiating a rational pharmaceutical policy.

2002

In January 2002, the Parliament passed at the second reading the Draft Law of Ukraine on mandatory state social medical insurance. The Government approved the inter-sectoral comprehensive program “Health of the Nation”, defining the principles of state health care policy for 2002-2011. The program includes 38 sections and should be implemented by 28 ministries and departments, the National Academy of Sciences, the Academy of Medical and Pedagogical Sciences of Ukraine.

President’s decree approved the measures to improve medical services in 2002-2005.

The Parliament passed the law On amending the Law of Ukraine “On sanitary and epidemiologic well-being of population”, according to which the management and funding of sanitary and epidemiologic service were centralized.

In May 2002, the Constitutional court of Ukraine approved the decision about unconstitutional payments in any form patients when giving medical aid to them in state and municipal health facilities, which considerably limited the possibility for legal payments for medical services. In accordance with official interpretation of the notion “free medical aid in state and municipal health facilities”, such notion shall mean that the institutions mentioned should provide medical care, irrespective of its scope to all citizens for free, without cash or non-cash prepayment, current payment or payment in the future by citizens. By this decision, the Constitutional court in fact deprived the Government of the possibility to define the basic medical services that should be paid by the state. The Constitutional court factually prohibited the citizens to pay for mandatory medical insurance. According to the decision, introduction of
social medical insurance does not contradict the Constitutional norm on free medical aid in state and municipal health facilities provided the mandatory insurance payments are effected by organizations, institutions, enterprises, other business entities or state funds etc. At the same time, the Constitutional court decided, that the notion “medical care”, the conditions essential for introduction of medical insurance, including social insurance, also the procedure for provision of medical services on a paid basis, not included into the framework of medical aid, at state and municipal health facilities, also the list of such services, shall be defined by the law. It is clear that in this context the most difficult is not just the definition of such notions as “medical aid” or “medical service” (which are actually identical) but the definition of the list of “medical services of secondary importance” not included into the framework of medical aid (and therefore may be provided on a paid basis).

However, in July 2002, the government approved the program of guaranteed free medical aid.

It was also in July 2002 when the government approved the revised list of paid services that may be offered by state and municipal health facilities.

In November 2002 the Parliament passed a resolution for all levels of executive bodies on measures to start radical transformations in health care system. In particular, the Parliament recommended the government to ensure implementation of the provisions of abovementioned Law “On buying of goods, work and services at state’s expense” concerning buying of medical services; the changes in economic and legal status of public health facilities in order to enhance their autonomy; acceleration of development, approval and introduction of state social norms in the sphere of health protection; acceleration of development of standard approaches to determination of cost of medical services etc.

The Ministry of Health approved the Norms of provision of medical aid for adult population in out-patient clinical establishments, Temporary norms of provision of medical aid for children in out-patient clinic establishments and Norms of provision of medical aid (obstetrics and gynecology) in out-patient clinical institutions.

2003

In January 2003 the Parliament introduced amendments to the Law “On buying of goods, works and services at the state’s expense” (2000) providing, among other things, the possibility of the use for public procurement buying of medical services not only from one provider (as it was stipulated before) but also the buying on a competitive basis.

The Parliament passed a new Civil Code and Economic Codes of Ukraine that came into effect from 1 January 2004. According to the Civil Code, the contract on provision of medical services shall have the character of a public contract which was a new provision in the Ukrainian legislation. The Economic Code for the first time included the provisions regulating the procedure of noncommercial economic activity. In particular, the Code provided the possibility of such form of economic activity as the state (municipal) noncommercial enterprise. Besides, the Economic Code stipulated that fixed or regulated prices are established for the services having considerable social significance for population, also for the services offered by natural monopolists. The list of such services should be fixed by the Cabinet of Ministers. Obviously, such list should include medical services (at least, those covered by state guarantees). However, so far such list has not been approved by the government. The fixed or regulated prices of medical services also have not been formulated and approved (with the exception of limited list of paid medical services which tariffs are established by the government of the Autonomous Republic of the Crimea, regional, Kiev an and Sevastopol’s state administrations). Moreover, one of the drawbacks of both the Civil and Economic Codes is the absence of special regulation of commitments in accordance with the contract for provision of medical services (regardless of the fact that such special regulation is applied for other kinds of contracts for provision of services). Thus, regulation of contracts for provision of medical services should be based on general provisions concerning the contract about provision of services. This fact, along with the absence of officially approved typical or framework contract for provision of medical services, especially taking into
account specificity of such contract and absence of any experience in the sphere of contractual relations, create obstacles for further practical introduction of important strategies of control over expenditures and efficient distribution of resources (competition, contractual relations and the like).

In May 2003, the Ministry of Health approved the state social norms of provision of medical aid within the framework of “general practice — family medicine”. In December, it approved the norms of provision of in-patient obstetric, gynecological, and neonatal aid.

2004

In June 2004, the draft law on mandatory state social medical insurance was rejected by the Parliament.

However, the Parliament considered two draft laws on introduction of the system of mandatory medical insurance intended for attracting numerous competing insurers represented by commercial insurance companies. Both draft laws are of extremely low quality in terms of legal practice. They are based on rather dangerous concepts and, if adopted, can negatively affect implementation of the principles of justice, solidarity and transparency within the health care system, also complicate management of this system and raise the amount of relevant expenditures. At present, these draft laws have not been considered at plenary sessions.

Draft law on health facilities was submitted for Parliament’s consideration. Its main idea is to include into in a single legislative act all basic legal norms that regulate economic activity of health facilities, including the norms concerning the possibilities of public health facilities to operate in the form of both budget-sustained institutions and enterprises, also concerning enhancement of autonomy of these institutions, introduction of contractual relations etc. In spite of the conceptual expediency and correctness of basic ideas this draft law needs considerable technical and legal revision and popularization among politicians who make decisions at the law level as among, representatives of local executive and self-government bodies and managers of health facilities.

2005

On January 13, 2005 the Parliament passed the Law on amending the Budget Code of Ukraine. These amendments among other things stipulate transfer of all financial resources for primary and secondary provision of medical aid in rural areas to the level of district budget (unlike the current situation when these resources in a district are distributed among the district budget and the budgets of small, weak rural and urban territorial communities which lack institutional capacities for adequate planning and management of resources). The above-mentioned amendments will come into effect from 1 January 2006 and can to a certain extent increase the stability of financing and raise efficiency of the use of resources provided that the functions of payer and provider of services are divided, as for district state administrations — there adequate health care management body would be established (that is, the authority in charge of payment for medical services) and control over their quality and contract based buying of medical services at state expense will be introduced.
Conclusions for Section 2.10

A relatively branching legislation was created to regulate relations in the area of health protection during the period of Ukraine’s independence.

According to the conclusions made by experts who work in the sphere of estimation of accordance of Ukrainian legislation with the norms of international law in general and with the EU laws in particular, Ukrainian laws in the sphere of health protection generally meet the international standards in the sphere of human rights and freedoms.

The standards declared by Ukrainian legislation meet the EU requirements in general, which connected with such aspects of public health care as the provision of safety to foodstuffs, protection of population from infectious diseases, environmental control, protection of consumers’ rights, also.

According to Ukrainian national legislation, basic principles of health protection system are solidarity, equality and general accessibility of medical services. In formal terms, the laws passed by the Parliament either declare or in many cases even provide direct legal possibilities for introduction of different policies and strategies aimed at raising the quality and efficiency of health protection system. In particular, in 1992, the Principles of Ukrainian legislation on health protection declared several important principles as following:

• Priority of disease prevention and development of primary medical aid;
• Multi-structural character of health care economy;
• Multi-channel funding (budget funds, medical insurance, savings of citizens, charity contribution and other funds not prohibited by the law);
• Necessity of approval of free medical services;
• Decentralization and development of self-management of health facilities and their employees;
• Private medical practice;
• Possibility for health facilities (including the public ones) to conduct different economic activities, including those in the form of an enterprise;
• Necessity of establishment and operation of medical insurance system that should be funded at state budget expense, the funds of enterprises and institutions, personal funds of citizens, etc.

However, despite the abovementioned positive factors, quite a few conflicting steps were made in development of normative and legislative framework that hindered the process of reforming the health protection system in general and the reforms of funding and management particularly in this sphere.

The most vivid example of such discrepancies was the approach to legal support of such important strategy of control over expenditures in medical service sector as fixing the basic package of services which should be provided for free by public funding sources. For the first time, the necessity of the use of this strategy was declared by the Principles of Ukrainian legislation on health protection (1992), and then this possibility was in fact canceled by Article 49 of the Constitution of Ukraine, passed in 1996. This Article stipulated that all citizens without any exception shall receive free and unlimited medical aid, and such provision became a basic obstacle for further reforms in the sphere of health protection. In fact, this provision makes it impossible to use such important strategy of control over expenditures as determination of basic package of free medical services and provision, with the help of the state guarantees in the sphere of medical services but with taking into consideration economic opportunities of the state, as well as efficiency and significance of different medical services to solve prior medical problems. The exact requirement of the Constitution also hinders introduction of such important strategy of control over expenditures as participation of population in payment for medical services (including participation in payment of social medical insurance premiums). Such approach became particularly important after the Constitutional Court’s decision on free medical aid (July 2002).
Another provision of abovementioned article of the Constitution made it impossible to reduce the number of state and municipal health facilities which is also an obstacle to efficient use of resources.

Another example of conflicting approach to development of normative and legislative framework in the sphere of health protection was government’s approval of the National list of basic (vital) pharmaceutical and medical products and the List of domestically and foreign made medicines, completely or partially financed from the state budget, which may be purchased by health facilities. These Lists absolutely do not comply with WHO recommendations on introduction of rational pharmaceutical policy. In fact, such approach reduces to zero the possibilities for practical use of rational pharmaceutical policy as an important instrument essential for efficient distribution of health care resources.

At the same time, implementation of some of aforementioned principles has not been started yet because of absence of adequate legal regulation at the Parliament’s level.

For instance, it concerns support of self-management of medical workers. Lack of legal support also impedes introduction of modern methods of payment to different categories of medical services providers that, judging from the experience of other countries, could be used for raising the efficiency of distribution of resources of health protection sector. Lack of legal support also adversely affects the development of primary medical and sanitary aid, also the orientation towards the priority use of in-patient treatment replacing technologies and rational use of in-patient aid. In particular, this concerns the absence in the Fundamentals of Ukrainian legislation on health protection of the provisions on certain aspects of work of general practice doctors (when these doctors issue the documents that are mandatory for patient’s treatment at a higher level), on general reasons for provision of in-patient treatment, rejection of hospitalization, discharge from hospial etc.

Practical implementation of other abovementioned principles is not very perfect it is so because of imperfection of the law practice. In addition, as a result of inadequate additional regulation in by-laws of executive authorities, the principles declared in the laws passed by the Parliament remain nothing but declarations due to the absence of proper executive procedures. Quite a few procedures could be applied by central and local executive and self-government bodies in their daily activity to upgrade the quality and raise the efficiency of medical protection system, to improve its management and funding at micro- and macro levels.

This is proved by the fact that for many years nothing has been done to change the economic and legal status of state and municipal health facilities, to reorganize them from budget-sustained institutions into the state (municipal) enterprises, that is, into subjects of industry with a higher level of economic, management and financial autonomy. This is another example of sluggishness (despite availability of legal possibilities for over five years) concerning the use of such important strategy as introduction of contract based purchases of medical services at state’s expense.

Legislative and executive authorities shall concentrate their attention on solution of these pressing problems.

**General conclusions to Section 2**

- Opportunities of influence of the health protection system on public health are not used in full measure
- The health protection system in Ukraine is mostly oriented toward the solution of problems of the authorities but not the problems of public health care
- Scope of funding for the health protection system from public sources is insufficient
- Structure of the medical services is deformed
- Available resources are used inefficiently
- The principles of justice and solidarity are being violated.
Part II

STRATEGIC IMPROVEMENTS IN THE HEALTH CARE SYSTEM TO SUPPORT POPULATION HEALTH

"System of health care — is a number of organizations, institutions, and resources, the main aim of which — is to act in favour of health. To act in the favour of health means any kind of help or care — individual care or public health care services, or services based on inter-sector initiatives — that have improvement of health status as their main goal.” [1].

Health care reform in Ukraine is a process that includes consistent institutional and deep structural changes that are carried out by the government to achieve clearly defined political goals.

Section 3
HEALTH CARE REFORM GOALS

The goal of the reform is to create the health care system by evolutionary steps, which will allow to improve health, to react in time on individual's problems, and to provide fair division of finances.

The key idea behind the reform is the creation of a health care model that would ensure equal and equitable access to health care services for all members of society. By providing universal access to a high quality and efficient health care system, and eliminating structural inequities within the system, satisfaction with the condition and quality of the system would be improved. The reformation of the health care system shall be based on existing world experience and at the same time must take into account the current condition and capacity of the national economy, as well as historical, cultural and political traditions of Ukrainian society.

Key elements of the reform:
- Clear identification of reform priorities
- Determination of required functional, structural, and institutional changes
- Goals of the health care policy
- Purpose, consistency, and permanency of the required changes
- Political process from the top to the bottom, directed by the national and local state administrations and local government.

Section 4
MAIN PRINCIPLES OF A FUTURE HEALTH CARE SYSTEM

European integration is the base for the direction of Ukrainian strategic foreign policy. As a consequence, the reform and further development of the national health care system should, above all, be based on the relevant generally accepted European principles and strategies. In addition, the current state of development of the national health care system should be taken into account.

Principles of organization of the health care system in Ukraine:
- Equity
- Solidarity
- Focus on status of public health improvement
- Focus on meeting the rightful needs of the population
- Focus on health care quality improvement
- Effectiveness
- Efficacy
- Community involvement in policy making.
Several scenarios of possible changes in the Ukrainian health care system have been considered:

1. Transition to a health care model that is based on a model of financing from the government budget (general taxes) with contractual relations between customers and health care providers.

2. Transition to a health care model (centralized model) that is based on voluntary medical insurance (VMI)

### Scenario 1

Transition to a health care model that is based on a model of financing from the government budget with contractual relations between customers and health care providers.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sources of financing</td>
<td>• Government budget, with co-participation of the public in payment for health care services, either directly or through voluntary health insurance or sick-funds. In cases envisaged by law, coverage of some kinds of services (for example, treatment and rehabilitation health care services to people who had been traumatized in the workplace) is done from the respective social insurance funds (in this case, from the accident insurance fund).</td>
</tr>
<tr>
<td>Payer (customer)</td>
<td>• Health care management should be modified to create a sound integrated source of financing and ensure savings due to scope. This would be accomplished by a transition from the current four level (national budget, budgets of the Autonomous Republic of Crimea and oblast budgets, rayon budgets and budgets of the oblast cities, budgets of villages, rayon settlements and towns) system of financial support to a &quot;single payer&quot; contract model. An implementation of this model in Ukraine should have all financial resources for health care concentrated on a regional level (Autonomous Republic of Crimea and oblasts, Kiev and Sevastopol as cities with a special status). Adequate resource management could be ensured through the following implementation of contractual state procurement of primary, secondary, and tertiary health care.</td>
</tr>
<tr>
<td>Relations between a financing party and providers of health care services</td>
<td>• Contractual.</td>
</tr>
<tr>
<td>Status of health care facilities</td>
<td>• Legal, economic, and managerial autonomy of public health care facilities have the status of communal non-commercial state enterprises. Private providers are allowed to provide health care services within a framework of relevant procurement on a par with public providers, both in respect to the scope, cost, and quality. There will be a transition of the contract relations between administration and employees inside public health care facilities.</td>
</tr>
<tr>
<td>Organization of health care services</td>
<td>• The priority role of primary health care is based on family medicine. In legal status and implementation, primary health care plays the role of a gatekeeper to the system. This will entail the development and active implementation of hospital substitution services and technologies, control over substantial hospitalizations, diagnostic and treatment prescriptions, procedures, and interventions. Hospitals will be classified according to the intensity of health care services and care required.</td>
</tr>
<tr>
<td>Payment for health care services</td>
<td>• Payment (with an advance) for contracted work. The main model of payment for in-patient care is a global budget, with the possible setting of clinical division budgets. For primary health care, the main model is a per capita payment. For specialized out-patient services, the main model is a fee for service.</td>
</tr>
<tr>
<td>Quality of health care services</td>
<td>• Quality is ensured through a system of activities that include standardization of health practice, departmental and non-departmental oversight, independent professional review through the self-administration of the medical profession, and the monitoring of both indicators and results.</td>
</tr>
<tr>
<td>Pharmacy supplies</td>
<td>• Ensure a rational pharmacy policy on both the macro and micro levels.</td>
</tr>
</tbody>
</table>

Section 5

**HEALTH CARE REFORM SCENARIOS**

Key strategies for further development of the health care sector in Ukraine
Scenario 2

Transition to a centralized health care model that is based on voluntary medical insurance (VMI).

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sources of financing</strong></td>
<td>• Insurance premiums from employers and employees for the employed population and government budget money for certain categories of the unemployed. Additional co-participation of the population in payment for health care services either directly or through voluntary health insurance and sick-funds.</td>
</tr>
<tr>
<td><strong>Payer (customer)</strong></td>
<td>• Health insurance fund.</td>
</tr>
<tr>
<td><strong>Relations between a financing party and providers of health care services</strong></td>
<td>• Contractual.</td>
</tr>
<tr>
<td><strong>Status of health care facilities</strong></td>
<td>• Legal, economic, and managerial autonomy, with public health care facilities having the status of communal) non-commercial state enterprises. Private providers are allowed to provide health care services within a framework of relevant procurement on a par with public providers both in respect to scope, cost, and quality. There will be the necessary transition of the contract relations between administration and employees inside public health care facilities.</td>
</tr>
<tr>
<td><strong>Organization of health care services</strong></td>
<td>• The priority role of primary health care is based on a family medicine. In legal status and implementation, primary health care plays the role of a gatekeeper to the system. This will entail the development and active implementation of hospital substitution services and technologies, control over substantial hospitalizations, diagnostic and treatment prescriptions, procedures, and interventions. Hospitals will be classified according to the intensity of health care services and care required.</td>
</tr>
<tr>
<td><strong>Payment for health care services</strong></td>
<td>• Payment (with an advance) for contracted work. The main model of payment for in-patient care is a global budget, with the possible setting of clinical division budgets. For primary health care, the main model is a per capita payment. For specialized out-patient services, the main model is a fee for service.</td>
</tr>
<tr>
<td><strong>Quality of health care services</strong></td>
<td>• Quality is ensured through a system of activities that include standardization of health practice, departmental and non-departmental oversight, independent professional review through the self-administration of the medical profession, and the monitoring of both indicators and results.</td>
</tr>
<tr>
<td><strong>Pharmacy supplies</strong></td>
<td>• A rational pharmaceutical policy on both the macro and micro levels.</td>
</tr>
</tbody>
</table>

Note that the two scenarios differ basically by one component — the main source of financing. Therefore, the SWOT analysis is dedicated mainly to the selection of a scenario by this criterion.
**Opportunities**
- Undertake certain political and legal prerequisites for the introduction of contractual relations within the framework of the budget-based health care system. A number of political and legal documents address this: Concept of Health Care Development (2000), and Multi-sector Comprehensive Program “Health of the Nation” (2002). The Law of Ukraine — “On purchasing goods, work, and services for the state budget money” (2000) directly refers to the possibility of purchase health care services through state budgetary funds.
- Of importance to local governments are:
  1) matching their obligations in health care provision with real funds allocated to health care;
  2) more freedom in health care resource management (revocation of the rigid normative approach to the planning).
- **Wide dissatisfaction of the population with the current health care system** (the sociological survey Human Development Index (carried out by the Ukrainian Institute of Social Research) shows that 63.6% of respondents stated that health care has substantially deteriorated in comparison with that in the Soviet Union.

**Strengths**
- **Creation of incentives for optimizing the delivery of health care services through the effective use of system resources.** Priorities are the development of primary health care, restructuring of in-patient care, introduction of modern models for health service operations and financing.
- **Development of an optimal system of compensation for health professionals,** which takes into account the scope and quality of the work.
- **Selection of the most effective health care providers based on cost,** and where possible through a process of competitive bidding. The would also ease potential

**Weaknesses and obstacles to implementation**
- **It is necessary to create within the management of the health care system a division responsible for health care planning and financial resource management.**
- **Insufficient sustainability of health care services due to the fact that the level of government financing (even with improved efficiency in the system) differs significantly from that required to meet the public’s substantiated need for health care services.**
- **A budget system based on revenues from general taxation is susceptible to political manipulations, because finances are not a priori targeted to the health care system.** This is in contrast to a social health insurance (SHI) model.
- **The solidarity in health care financing is substantially limited by a framework of insufficient budgetary financing.**
- **The preservation of overlapping health care services, when parallel health care systems are active in the same jurisdictions,**
political tension during the reformation of the health care system.

- An elimination of the correlation between financing of health care facilities and indicators of their capacity would allow hospital managers to actively support reductions of the hospital bed pool. Furthermore, this would mitigate resistance of health professionals to the implementation of such measures.

• The possibility of reaching higher social goals is limited (improvement of health care system equity; improvement of the public health overall status, improvement of population satisfaction with health care services).

• It is difficult to carry out a rational pharmaceutical policy because medication expenses will continue to be covered (in the near future, under the current conditions of budget health care financing system) from the pockets of the population.

• The proposed management system is more complex than the existing one.

• Managers within the health care administrations, local government, health facility managers are not trained in health care operations planning (excluding the current rigid approach) and in financial resource management.

• System of contractual relations between payers and providers has not yet been established.

• Insufficient experience working in a contractual relations environment.

• The existing information system is inadequate, resulting in a lack of detailed health and financial information on patients treated.

• There does not exist a modern management accounts system.

• Lack of experience in health care fiscal management. There are no unified requirements for pricing and modern models for and health care service financing are not utilized.

• There is no basic health care services package. Indeed, methods for drafting it have not yet been established.

• Disinterest in using financial management methods on the part of health care administrations and health care facilities managers, who are afraid to take responsibility for implementing them and do not want any weakening of their traditional leverage.

• Possible resistance of health professionals, especially those in urban areas, whose income substantially depends on “informal” payment for health care services.

Note: In the tables below, characteristics common to both scenarios are in **bold italics**.
### SWOT analysis of Scenario 2 — Implementation: "Transition to the health care model that is based on voluntary medical insurance"

#### Opportunities

- There exist certain political prerequisites, such as introduction of voluntary medical insurance as stated in a number of important political and legal documents: Fundamentals of legislation on health care (1992), Fundamentals of legislation on obligatory social insurance (1998), Concept of health care development (2000), and Multisectoral comprehensive program — Health of the nation (2002).
- The low level of state (public) expenditures for health care (around 3% of GDP) is an impediment to the goal of European integration.
- One of the ways to implement the policy of poverty reduction is through improved access to health care, because medical expenses are a significant burden for the poor population.
- Fight corruption by providing stable, universal, and legal financial support for health care.

**Broad dissatisfaction of the population with current health care system** (the sociological survey “Human development index” carried out by the Ukrainian institute of social research shows that 63.6% of respondents stated that health care has substantially deteriorated in a comparison with that in the Soviet Union)
- Example of neighboring countries.

#### Threats

- Unwillingness of politicians to abandon their declaration about free health care and address the need to limit state obligations to a basic package of services.
- Need to introduce a new tax and amend current tax legislation.
- Lack of interest on the part of a number of political and corporate groups in implementing a system of social and health insurance. For the case of employers, this is because it may lead to additional taxation. Private insurance companies are opposed, because on one hand they do not wish to have the government obligations clearly delineated and on the other hand, they wish to have access to the public financial resources of the health care system. Managers of health administrations and health care facilities are afraid of taking responsibility for implementing the reforms and do not wish to see a weakening of their traditional leverage. Pharmaceutical companies do not want control over use of medications to be strengthened.

**It is probable that certain number of personnel within the health care system would become redundant.**
- Apathy of the population in protecting their rights to health care. The public either does not understand or misunderstands the advantages of reforms in health care financing.
- Substantial black market economy and developed “informal” labor market that is a barrier to the equitable collection of tax revenues.
- Well-developed system of “unofficial” payment for health services, which comprise a noticeable share of physicians’ income. That is why many physicians oppose the introduction of an SHI system.

#### Strengths

- Strengthening of the health care system’s financial basis.
- Improvement of the health care system’s financial sustainability.
- Achievement of rather high level of universality in health care financing. This ensures general accessibility to health care services, regardless of financial means and contributes to the equitable redistribution of wealth between the wealthy and vulnerable members of society.
- Targeted nature of health care financing that provides

#### Weaknesses and obstacles to implementation

- Lack of the relevant organizational infrastructure of voluntary medical insurance and need to make certain investments for their creation.
- Lack of the established state regulation mechanisms for management of insurance fund activities.
- Insufficient number of specialists on insurance management and specialists in adjacent areas.
better protection from possible political manipulations of health care budgets.

- Increase in system transparency and reduction of corruption in the health care system due to a clear statement of the state obligations regarding free access to health care.
- Creation of conditions for a rational pharmaceutical policy. It offers the possibility of covering a certain share of pharmaceutical expenditures through the public system.
- Creation of the economic preconditions for the territorial reorganization of health care to provide the so-called common health space. Within the context of a health insurance system, it is inefficient to maintain parallel health care systems (departmental and territorial health care facilities, health care facilities for rural and urban population separately).
- Creation of incentives for optimizing the delivery of health care services through the effective use of system resources. Priorities are the development of primary health care, restructuring of in-patient care, introduction of modern models for health service operations and financing.
- Selection of the most effective health care providers based on cost, and where possible through a process of competitive bidding. This would also ease potential political tension during health care reform.
- Development of an optimal system of compensation for health professionals, which takes into account the scope and quality of the work.
- An elimination of the correlation between financing of health care facilities and indicators of their capacity would allow hospital managers to actively support reductions of the hospital bed pool. Furthermore, this would mitigate resistance of health professionals to the implementation of such measures.
- Possibility to achieve higher social goals through improving equal access to the health care system. This would lead to a reduction in differences in health between different segments of Ukrainian society and an improvement in the general state of public health. Improved public satisfaction with health care services is also expected.

- The management system becomes more complex compared to the existing one.
- Health care managers haven’t been trained in financial planning and management.
- System of contractual relations between payers and providers has not yet been established.
- Insufficient experience working in a contractual relations environment.
- The existing information system is inadequate, resulting in lack of detailed health and financial information on patients treated.
- There does not exist a modern management accounts system.
- Lack of experience in fiscal management methods in health care. There are no unified requirements for pricing and modern models for health care service financing are not utilized.
- There is no basic health care services package. Indeed, methods for drafting it have not yet been established.
- Disinterest in using financial management methods on the part of health care administrators and health care facilities managers, who are afraid to take responsibility for implementing them and do not want a weakening of their traditional leverage.
- Possible resistance of health professionals, especially those in urban areas, whose income substantially depends on “informal” payment for health care services.
- Possible dissatisfaction of the public when restrictions to the state guarantees regarding health care are made public.

Note: In the tables below, characteristics common to both scenarios are in **bold italics**.
Conclusions for Section 5

Implementation of each scenario of health care system development would require considerable effort and the solution of many political and organizational issues. Both scenarios envisage the introduction of substantial changes to legislation. A number of measures necessary for both scenarios are identical, because contractual relations are envisaged as an integral part of both the insurance model and the contract model based on financing from general taxes (i.e. this is a modified budget system). If the budget model with contractual elements is implemented without a legislative basis, it will share the destiny of many initiatives that emerged during the development of the national health care system and which have never been implemented. As an example, consider a rather pathetic scale of implementation of the most advanced idea in the current national system — primary health care based on family medicine. In addition, a substantial role in realization of this scenario would be given to the health bureaucracy, which is capable to withstand even enforcement by law. The probability of systemic structural changes is slim, without real making the financing body a real third party in a system, free from pressure on the part of health care managers to the maximum extent possible, and having a vested interest in a rational use of resources.

It is rather clear after the analysis that potential advantages of the insurance model, especially from the point of view of its social impact, are of greater value than those of the budget model with contractual elements (Insert 8). That is why it is recommended to select voluntary medical insurance as the major strategy for Ukrainian health care system development. At the same time, to ensure effective implementation of SHI, during the preparatory phase, the relevant obstacles should be removed and the contractual relations based on a model of state procurement of health care services should be worked out. At the time a law passed about SHI, it is necessary to delay its enactment for a certain period of time and make provisions in the law about need to initiate state procurement of health care services based on contracts during the transition from the current budget financing model. In this context, there is a high probability that, pressed by a need to adjust to future changes, all interested parties would start relevant preparation and begin implementation of contracting.
### Tabl. 5.1. Comparison of Different Scenarios of Health Care System Work (by imitation modeling data)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Existing health care system with substantial (up to 50% from total scope of financing) payments by the population</th>
<th>Managed health care with substantial (up to 50% from total scope of financing) payments by the population</th>
<th>Managed health care with adequate financing (population pays not more than 20–30%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of treated patients (indicator of visual comparison to the current system)</td>
<td>100</td>
<td>119.2</td>
<td>132</td>
</tr>
<tr>
<td>Number of patients treated at primary care level (indicator of visual comparison to the current level)</td>
<td>100</td>
<td>217</td>
<td>259</td>
</tr>
<tr>
<td>Number of health deterioration cases (indicator of visual comparison to the current level)</td>
<td>100</td>
<td>87.8 (reduction by 12.2%)</td>
<td>76.3 (reduction by 23.7%)</td>
</tr>
<tr>
<td>Population mortality (indicator of visual comparison to the current level)</td>
<td>100</td>
<td>87.6 (reduction by 12.4%)</td>
<td>73.3 (reduction by 26.5%)</td>
</tr>
</tbody>
</table>


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**Literature for sections 3, 4, 5**

Key strategies for further development of the health care sector in Ukraine

Section 6
HEALTH CARE REFORM AREAS

6.1. Management Organization

As mentioned above in Subsection 2.1, there have been no significant changes in the structure and organization of health care system during the period of Ukraine's existence as an independent country. Undoubtedly, one of the most important reasons for the current critical state of the health care system is that the present management model does not meet political, economic, and social standards.

Management changes must initiate any process of reform within the health care system. Only through management reforms can efficiency, effectiveness, and the public need for adequate health care be met. The reforms will require a range of new management mechanisms at both: the macro and micro levels. These new management practices will be foreign to the current management structure in Ukraine. However, by choosing and applying these new management strategies it is needed to find a “golden middle” between the hard administrative strategy of “soviet-style”, which proved its ineffectiveness and between the totally independent market approach, which is incompatible with an effective public health care sector.

The main idea is to achieve this “happy medium” by balancing market stimulus with the preservation of sufficient, but not exclusive, government control over the public health care sector. Such a scenario is often referred to as a regulated market or “home market”, with social entrepreneurship or “public competition”. Other terminology which is often used — “market of health care service providers” or a “quasi market”.

Taking into consideration the national historic traditions, social sensitivities formed during recent Ukrainian history, and the constitutional requirements, we believe that the most suitable system for Ukraine is based on a framework in which ownership and management rights to the majority of publicly available health care facilities would remain with the state and territorial communities. However, these facilities would operate with a high level of autonomy that would provide them with adequate economic stimuli for operating effectively, qualitatively, and productively.

An introduction of contractual relations provides the natural link between the state and the private sector. In these relations, the state, local self-governing bodies, or an insurance fund acting on behalf of the state acts in the public interest and plays the role of a paying party (customer or buyer) of social assets such as health care services. The executive contracting party would establish for autonomous providers of health care services the organizational and legislative norms for the contract system. Such contractual relations provide the exact instrument through which the behavior of both health care facilities and health care professionals may be influenced through stimulus based on the principles of competition. (See subsection “Increase of resources utilization effectiveness”.) In addition, internal contracts within the organizational structure of health care providers also play an important role in a model of health care financing.

The goal is to achieve a contractual form of labor agreement between the owner or authorized body (administration) of a health care facility and staff and medical professional in such a manner which will stimulate an increase of productivity and quality of work. This would also increase mutual responsibility of both the contracting parties and will provide more perfect ways of payment for personnel based on work loads, results, and quality of work.

Article 21 of the Legal Code on Labor in Ukraine foresees the principal possibility of making labor agreement in the form of a contract with certain durations, rights, liabilities and responsibilities of contracting parties, terms of financial provision and organization of employee’s work, conditions of contract termination. However, the same article states that a contractual form of labor agreement can be used only in cases strictly defined by law. This
means that the solution of the problem concerning the sphere of possible application of contractual form of labor agreement is solely the prerogative of Parliament.

Unfortunately, in accordance with the law medical personnel does not have an opportunity to make labor agreement in the form of a contract. However, for example, the possibility of contractual labor agreements for teachers does exist. As an exception, it is now the case that contractual labor agreement with managers of state and municipal health care facilities can now be used in the health care sector, but only under the conditions that these facilities are considered as households by state or municipal law. This possibility exists because of the management regulation as in the article 65 of the Household Code of Ukraine. It is without a doubt that the above-mentioned restrictions are significant defects of Ukrainian legislation if to say about creation of law opportunities for introducing really effective comprehensive contractual model of the health care system.

Reorganization of state and municipal health care facilities that have the status of budget organizations into state (municipal) non-commercial enterprises is another starting mechanism, which could introducing the principles of regulated market and social entrepreneurship into health care sector. This approach would allow increasing the level of autonomy of these medical facilities and the level of their responsibility for the results of their activity; and at the same time to maximum reduce the risk of conflict of interests connected with a concernment about receiving profit from one side, and with a necessity of fulfillment of the statute objectives concerning the provision of free medical care from another side. Again, the possibility of using this strategy is absolutely legitimate, especially after the Industry code of Ukraine from the 1st January, 2004 was came into effect. But this opportunity is also not being used. Together with that, the implementation of such approach could foster the formation of economic incentives for more effective management of financial as well as human and material resources and of the quality of health care.

In addition to the abandonment of the two key strategies to reform the abovementioned health care sector management and monitoring, the management centralization approaches in this sector are used extremely irrationally in Ukraine, although the latter is declared in the Principles of Ukrainian legislation on health care protection adopted by Verhovna Rada as one of the main policy principles in this field.

So the process of transition of the organization of primary medico — sanitary care (PMSC) to the principles of family medicine which, according to the experience of many developed countries works effectively when in the provision of PMSC privately practicing general practice doctors play an active role that work under the state (municipal) contract made according to the framework of governmental procurements. This process has been remaining a germ for many years. Thus, such important decentralization strategy as functional privatization is practically not used. This also concerns complete refusal from the use of the possibility to procure medical services on a competitive basis in frameworks of government contracts not only from individually privately practicing doctors, but also from private providers — entities. The mentioned factor (in spite of the obligation of the State to assist the development of medical facilities of all types of ownership proclaimed by article 49 of the Constitution, and of the equality in access to government contracts proclaimed by the Law on “The procurement of goods, labor and services”) remains to be one of the main obstacles on the way to introduction of the basic strategies of the regulated market and social entrepreneurship in the sector of health care services.

According to experience of the majority of countries with developed public society, development and creation and implementation of self-governance of medical profession with the referral of the range of regulatory functions that nowadays belong to the State (for example some authorizations on control of the quality of medical services and keeping the principles of medical ethics, provide the medical practice certificate, etc., taking part in development and approval of standards of medical care in the process of accreditation of health care providers, etc.) can become a creation of powerful management instrument insuring support of human dignity and observance of human rights, assistance in implementation into relations in the
Key strategies for further development of the health care sector in Ukraine

health care field of modern professional ethics standards and also increase the quality of health care services. Implementation of this strategy, that is one of the examples of self-governance, would have contributed to significant increase of the role and real participation of medical community in particular in the development of the general health care policy.

However, when talking about the inefficient use of decentralization the main attention has to be paid to decentralization of financial resources management of the health care system in such condition as it exists now in Ukraine.

As it was already emphasized, an hierarchical system of health care budget financing exists now in Ukraine; the lowest level of which is a budget of villages, settlements, small towns; and the highest is the national budget of Ukraine. The intermediary levels between them are rayon budgets, budgets of cities of oblast, republic (Crimean Autonomous republic) subordination, budgets of oblasts Kiev, and Sebastopol cities and budget of Crimean Autonomous Republic. At the same time the budgets of different levels mainly fund budgetary health care facilities of corresponding subordination levels and not different levels of health care provision. As a result of using such an approach in the most difficult situation appeared the lowest layer, that in most cases is represented by small territorial communities that, having neither sufficient financing, nor adequate abilities for management and planning of financial resources, are obliged to ensure the budget to the medical facilities belonging to them according to the communal ownership rights.

As a result of using such approach to decentralization of health care system financial sector there is no effective connection of solidarity risks of tax payers — potential patients (because of extremely small population number in mentioned territorial communities) and of effective combination of financial resources.

Changes to the Budget Code of Ukraine made by Verhovna Rada in January 2005 were directed towards certain improvement of this situation; according to them starting from the 1st January, 2006 budgeting of the village health care facilities will be ensured from corresponding rayon budgets. Although, we may foresee that it won’t lead to significant improvement of the situation, because the majority of rural areas have small population and small, low capacity budgets. Besides that, as it was already mentioned above, at this administrative level, at least at present, there are no intuitive abilities necessary for adequate professional planning and financial resources management — the presence of health care department (or administration) in rayon state administration approved by the Cabinet of Ministers is not foreseen by the typical structure.

But, even under the condition of creation of such bodies on the level of rural rayon there exist quite big doubts as for the ability of their quick provision with sufficient number of qualified managers, economists and lawyers able to conduct adequate planning of resources and their management, especially under the conditions of future transition to the practices of governmental contract procurements of health care services. Great shortage of such professionals exists even on the central and regional levels where, surely, because of different circumstances (quality of life, level of salaries, level of cultural development, accomplishment, etc.), as a rule, the best human resources are concentrated.

Besides, we have to take into consideration, that the multi-level system of health care facilities budgeting mentioned above, in a perspective, can become an essential obstacle on the way to the introduction of an effective system of contract government procurements of health care services, the crucial role of which in health care management reform was already mentioned. above...

Two approaches can be used in order to solve this situation. Both of them foresee the transition to contract model of health care sector financing according to the principles of “single payer” at a regional level.

The first of this approaches provides for the creation and implementation of the system of general compulsory social medical insurance in which the function of the single payer would lay on all-national CMI fund and its regional departments (by the way, it could be reasonable if those departments would exist on the level not lower then a regional one, that would give the opportunity to unite sufficient by its number pools of population and financial recourses).
Another variant (according to experience of many European countries where there are no social medical insurance, but the health care system is budgeted on account of general tax takings) can be seriously improved system of budget financing, in the framework of which it would be ensured that:

- a real segregation of a client (represented by regional health administration bodies) and health care services provider (public health care facilities, that are situated on the territory of a region);
- the combination of all financial resources at the level of corresponding regional budget necessary to support health care provision to the whole population of oblast or the Crimean Autonomous Republic;
- implementation of the health care services government procurements in the context of provision of care at all levels (primary, secondary, tertiary) through contracts one of the contracting parties of which would be the regional health administration bodies mentioned above, and the other one — provider of medical services — juridical persons of different ownership and natural persons — individually practicing doctors.

Unless in the nearest years in Ukraine an adequate political decision is taken to introduce social medical insurance, the second of proposed above models could become if not a permanent one, then at least a temporary and quite effective alternative to such insurance, and would help prepare the system for its successful introduction and avoid most of the problems connected with the transition to insurance. Besides, it could play the role of a certain transition model in the framework of which would be worked out such common for both models principal mechanisms and instruments as contracting relations, autonomizing of health care services providers, quality control, etc.

Thus, under the condition of implementation of any of these models profound redistribution of management authorities between the management levels existing in Ukraine has to be introduced.

So, in accordance with the Ministry of Health of Ukraine functions of strategic planning, policy development, public monitoring in health care should be preserved (public sanitary — epidemiologic surveillance, control of quality and safety of medicines and medications, etc.), and also financing of the most important all-national programs in the health care sphere (for example vaccination, struggle with TB, HIV/AIDS, financing of university clinics, scientific research institutes, capital investments in hospitals, redistribution of resources with the purpose of equalizing abilities between the regions, etc.). Also, on behalf of the State, it has the right of ownership and the right to act as an establisher for some all-national medical facilities that will provide highly specialized health care services to the whole population and can’t be transferred in possession and management to the local self-governments. The right to own and manage other health care facilities, and also the right to be in charge of their property must be given to territorial communities or their unions which by themselves, depending on the local situation and specific medical needs of the population, have to develop and reconstruct the network of such facilities, their merger, alliance, closing, etc.

Effecting the above changes will also require the development of mechanisms of citizens’ actual participation in planning and management of the health care system. A possible mechanism of such participation of citizens and their associations is to include the insured’s’ representatives in the future compulsory medical insurance fund supervising committee (in case of future development of the health care system on the basis of introduction of such insurance) or in appropriate tender committees on health services procurements for public funds, which according to law have to act as both at the Ministry of Health of Ukraine level, and at the level of local health administrations (in case of preservation of the budget system of financing and its improvement with the use of competitive public procurements). An important element of raising the role of community in management of the health care system can be the introduction of self-governance of medical profession, creation of public supervising and advisory boards on health care issues under local self-governments, trustees’ boards at public medical facilities, etc.
Depending upon the political decision concerning the choice between the model of voluntary medical insurance and the model of the health care sector financing, which was improved according to the proposals mentioned above, in terms of general taxation system with the use of contracted public procurement, the rest of authorization on health care system financing and concluding of contracts for health care services procurement with public resources should be transferred either to all-national foundation of voluntary medical insurance and its original subdivisions or to the regional health administration bodies appropriately modified in functional staffing and informational technological aspects.

Anyway, both the proposed models differ only in terms of resources generation (in the first one — target contributions to social insurance, in the second one — general taxation), at the same time ensuring the implementation of such key strategy as contractual public procurements with all consequences of this strategy in forms of incentives for more effective, productive and qualitative service delivery, as well as efficient accumulation of financial resources and risks and savings due to the volumes.

Furthermore, models that imply union of resources and self-repayment of resources and implementation of single payer principle at the regional level are more desirable considering the fact that it would be possible to solve more quickly and effectively the problem of provision the health care system bodies (institutions) with qualified managerial personnel that will be responsible for management and funding. Thus, big university cities with better living conditions are based at the level, where (as it was mentioned above) the best human resources (in terms of qualification) are concentrated.

Surely implementation of one or the other of abovementioned models requires provision of relevant legal, informational, technological support and staffing as it was mentioned above, first of all with managerial personnel.

Summing up the above one can state that management changes in Ukraine’s health care should first of all imply the increase in its funding, increase in available resources use effectiveness, limitation of unreasonable costs and as the most important improvement of accessibility, affordability and quality of health care provision, which are the main criteria of system performance assessment from the point of view consumers — patients.

The transition from command — administrative integrated model of management and funding to the contract model based on the principles of planned (regulated) market and social entrepreneurship, effective and rational use of decentralization policy should become the main direction for these changes.

The most important managerial problems that should be solved in the process of the indicated changes implementation are the following:

- redistribution of managerial and financial powers between the central level and regions;
- transition to planning of financial, staffing, and material technical resources based on the real health care needs of the population of a specific region or settlement (unlike the current approach according to which, for example, the typical staffing norms adopted approved by the Ministry of Health of Ukraine are the determining indicator for planning, and they are calculated in accordance with normative number of beds in various inpatient departments of different levels (oblast, rayon, city hospitals, etc.) and in out-patient sector — the MOH-adopted norms based on the certain number of the population in a given administrative territorial unit (village, urban type settlement, city, rayon, oblast);
- improving the system of generation and integration of funds that are intended for funding the health care system through transition to the model of “single payer”, which will ensure the creation of a powerful integrated funding source;
- improving the mechanism of financial resources transfer through:
  a) the distribution of functions between payer (buyer) and medical services provider.
  b) transition from the integrated model of providing the payment for health providers (in which public health care facilities have the economic status of budget establishments) to the system of contracted public procurements (in which public health care facilities have the status of subjects of economic activity with
higher financial and managerial autonomy — at least the status of public or communal non-commercial enterprises);

• enhancing the role of population in general and health care community in particular in the process of policy development, decision-making and quality control in the health care provision system (through implementation of medical profession self-governance, establishment of and ensuring effectiveness of public boards of trustees in health care facilities, participation of the medical community and population intender committees on medicines, medications and medical equipment procurements, etc.).

6.2 Opportunities for Public Health Care Improvement

Among the government activities to implement the state health care policy aimed at improving health, improvement of life quality and preservation of Ukrainian people’s gene pool, the Concept of the population health care development adopted by the Decree of the President of Ukraine №1313/2000 dated December 7, 2000 mandates as follows:

• Provision of sanitary and epidemiological well-being of the population, reorientation of health care provision to the essential strengthening of disease prevention activities, prophylaxis of infectious diseases, decrease of risks for human health, which are connected with pollution and hazardous impact of environment factors.

• Solving the problem of labor hygiene and safety, prevention of labor injuries and professional diseases.

• Creating specific conditions to promote healthy lifestyles, improve hygienic upbringing and education of the population, particularly children and youth; intensify combat against harmful habits; develop physical culture and sports; ensure a balanced nutrition of the population.

• Implementing an active demographic policy to encourage fertility and reduce mortality, preserve and strengthen reproductive health of the population as well as social policy to provide support for the youth and protection of disabled and elderly people.

However, the current “health protection system of Ukraine” is such only by its name, but in fact this is “the system of health care provision”. It should be gradually turned into an active system of public health care of Ukraine, which will allow meeting the health needs of Ukrainian society through public efforts and the use of latest scientific and technical achievements.

The nation’s health strengthening strategy should be aimed at turning the current system of health care objects management into a multi-component system of public health of Ukraine (supplied with highly qualified staff at the national, regional, municipal and local levels) based on the collaboration of all social sectors (education, culture, science, health care, social protection, mass-media) as well as different non-governmental structures (ecological movements, social and religious unions, etc.) and international organizations [1].

A new public health system requires broad knowledge from health workers in the area of clinical medicine, epidemiology, economy and social sciences, environmental protection and public health, management of health care provision systems and analysis of their performance because such specialists will make a serious impact on all life aspects of the society [2,4].

The creation of the public health care system in Ukraine first of all needs a new system of education the for specialists in the area of public health. “Legislative Guidelines on Health Protection in Ukraine” emphasizes the importance of such education.

In the multisectoral comprehensive program “Health of the Nation” for 2002-2011 approved by resolution #14 of the Cabinet of Ministers of Ukraine (dated January 10, 2002) it is planned: to ensure training of highly qualified specialists on health care organization and management through establishing faculties of medical management and marketing with corresponding departments of management, marketing and economy, psychology, medical law, sociology, as well as departments of social management and health care organization.”
Implementation of the concept “New public health care” in Ukraine

“New public health care” is more a philosophy than a concept, which tries to extend the old understanding of public health care through the following ideas: inclusion of the health of an individual as an additional component to the health of population, attempt to unite such targets of health care like provision of accessible and affordable health care, creation of healthy environment, adequate political management as well as social and economic development. It tries to include health into the general concept of societal development in order to protect health within the social policy” [3].

New public health care is not a substitution but more likely it is a continuation and further development of traditional public health care. “Organizational efforts of the society directed towards the provision of such health care development policy which could be oriented to health strengthening, diseases prevention, social equity adherence in the general context of sustainable development — all this reflects the content of the New public health care as well as that it “should continue to perform the traditional functions of the sanitary and hygienic surveillance, control and others as an addition to the extended functions”.

In the framework of NPHC strategy the national systems of health care have the following goals [3]:

• Improvement of the population health status indicators.
• General accessibility and affordability of health care services.
• Fulfillment of the national health care objectives.
• Regional socio-demographic equality concerning accessibility and affordability of services.
• Combination of funding increases with the control over the growth of services cost and more effective use of resources.
• Satisfaction of a consumer’s (patient’s) needs.
• Provision of good conditions for the specialist, who provides services (provider) — health worker.
• Possibility of health care transfer in case of changing the place of work or living.
• Guidance and control from community side.
• Achievement of high quality service provision.
• Primary, secondary and tertiary levels of health care.
• Systems of informing and monitoring.
• Consequent revision of policy and management.
• Provision of standards improvement concerning professional education, qualification increase and conducting of researches.
• Provision of public and private forms of servicing.

Application of health insurance principles and ensuring general accessibility and affordability of health care is not the guarantee of a better health status of the nation. They should be complemented by the activity of governmental bodies that support each individual’s health status and the responsibility of the society for healthy labor conditions and traffic safety, nutrition safety, elimination of harmful habits (alcohol addiction, smoking) and protection of the environment. These conditions are vitally important for successful functioning of the national health care system — whether public or mixed private and public, or a system of the voluntary medical insurance.

That is why the reorganization of the public health system in Ukraine should be based on a comprehensive approach to the protection and strengthening of the health of individuals and society in general. Public health care should combine:

• Sanitary activities
• Environment protection
• Population health strengthening
• Preventive programs

The activity concerning the public health (PHC) should be coordinated with the work of preventive, treatment, rehabilitation services and subdivisions of long-term observation. It implies the coordinated fulfillment of governmental and non-governmental programs at the national, regional, and local levels, the main goal of which implies the creation of healthy social and physical conditions of environment and provision of healthy nutrition to the population. Independent of the principle of health care provision, the organization of PHC should be based
on a systematic approach in order to fulfill the identified objective.

PHC uses various means for the improvement of population health including:
• activity at all levels of public health care bodies and related agencies,
• mass-media,
• groups for advocating academic, professional and consumer interests,
• private and public establishments,
• insurance,
• pharmaceutical and medical industry,
• agriculture and food industry,
• entertaining industry and sports,
• legislation, law machinery, etc.

In its activity PHC bases on certain groups of population, economic systems, which encourage the achievement of the goals set due to effective guidance and economically reasonable application of financial, human and other resources. Constant monitoring of epidemiological, economic and social aspects of the population health status is necessary for the integral part of the process of health care services management, evaluation of their activity and planning of health protection activities for the population [3].

The processes of economic, epidemiological and social economic development that take place in Ukraine require adequate decisions for ensuring the population health while using limited resources. Widening of health and health care definitions leads to the occurrence of new medical professions, and the integrity of professional education and growth become part of general health care system.

While making conclusions it is necessary to mention that public health is a specific area that has not been formed in Ukraine yet because of many reasons connected with deep-rooted traditions of the former system and with the errors in health reform. Health care by itself is not capable to ensure mass-sanitation of the nation — it is needed to give a much broader interpretation to the notion “health” and to take into consideration the entire array of problems that concern the achievement and support of an appropriate level of the population health.

It is necessary to unite organizational efforts of the society directed towards the provision of such health care development policy that would target strengthening health, prevention of diseases, preservation of social equity in the general context of sustainable development and at the same time it should continue to fulfill the traditional functions.

A closed nature and partial blindness of the current health care system, a lack of real collaboration both with social institutions and society are an obstacle to all modern opportunities including modern sciences such as: management, law, economics, social subjects, etc.

Furthermore, in order to change the public health situation it is necessary to implement a set of activities for improving life conditions, supporting material and psycho-emotional well-being of the whole population as well as active steps toward forming healthy lifestyle for the entire population (first of all among youth), improvement of the whole system of public health management.

Approaches to HIV/AIDS and drug addiction require essential reconstruction.

WHO and UNAIDS recommend addressing the prevalence of such infectious diseases like HIV/AIDS and drug addiction as public health problems. The main document on developing such an approach is “Agreement on public health care development”, which was signed in Ottawa. This document describes the situation about provision of efficient work in public health care system and notes that it is necessary to develop it in the following directions:
• Promotion of healthy lifestyles through social policy.
• Creation of the environment favorable for taking care of health in the society.
• Reorientation of health care system services.
• Strengthening of the community’s activity.
• Development of individual skills.

Measures to improve public health care activity:
• elaborate the Concept of public health care development in Ukraine.
• revise the multisectoral comprehensive program “Health of the Nation” for 2002-2011 with the purpose of implementing of the
active mechanisms of preserving and strengthening the public health.

• elaborate gradual plan of public health care system development on the basis of inter-sector cooperation at the level of Cabinet of Ministers of Ukraine (possibly through establishment (restoration) of the activity of the multisectoral coordinating council on health care) paying special attention to training of specialists in the sphere of public health care.

• revise organizational model of the sanitary and epidemiological control in order to implement modern and more efficient methods of sanitary epidemiological existing provision.

• revise organizational models of conducting of prevention examinations by the doctor’s brigades of different specialties, application of screening tests without taking their effectiveness into consideration.

• provide more incentives for primary care physicians to switch to general/family practice with a focus on prevention.

• establish an efficient control over the quality of drinking water, food, medicines, etc. and view the opportunity of creating a single body within the structure of the Ministry of Health of Ukraine on efficient control over the quality of food, medicines, etc. (for example, EMA — in European Union, MHRA — in Great Britain, French Health Product Safety Agency — in France, SUKL — in Czech Republic, National institute of pharmacy — in Hungary, Institute of medications — in Poland, FDA — in USA).

**Literature for Section 6.2**

6.3. Financing of the Health Care System and Health Facilities. Possibilities of Change

Objectives of the health care financial policy

- Improve financing of health care through engaging additional sources of financing with a focus on social financing.
- Ensure coordination of all sources of financing on a general political basis.
- In the process of creation of pool of financing and allocation of responsibilities for health care services, minimize duplication that originates from the vertical structure of parallel health care systems (public, departmental, etc.).
- Ensure accessibility of health care and financial protection for the poor and vulnerable groups.
- Ensure separation of functions of the client and health care provider.
- Implement a mechanism of strategic procurement of health care services on a contractual basis as a leading model of resource allocation between health care providers.
- Direct market incentives to reach social goals (ensure application, including that in public sector of health care, of planned market elements and principles directed towards stimulating health care quality improvement and improvement of resource use effectiveness) [1].

Strengthening financial resources of the health care system

Transition from the existing model of health care financing based on general taxation (budget model) to the model based on obligatory voluntary medical insurance could become the most effective way of meeting of the above objectives of the health care financial policy in the future. The advantage of obligatory voluntary medical insurance is obligatory for the whole population or for its bigger part. Insurance premiums are made with a special purpose: they should protect them from political manipulations. The premium amount doesn’t depend on the risk of getting sick, the array of medical services is universal for all insured, it doesn’t depend on the premium amount and is determined only by specific medical needs of the patient.

As experience of many countries of the world suggests, the latter (insurance model) provides for a high level of solidarity in health care financing (within this framework, general accessibility of health care services is attained — regardless of the financial means of a person) and equity (the mechanism of reallocation of finances between the rich and the socially vulnerable groups in the society). At the same time, transition from budget financing to voluntary insurance should be considered not only as a possibility to increase general volume of means used for health care services, but also, and most important, as a catalyst for structural changes in health care [2,4,7,8].

Social medical insurance must cover the entire population of the country. The main sources of financing are insurance premiums made by employers and employees on a parity basis. Budget funds are also used to subsidize the system of voluntary medical insurance. The budget money should be used to make insurance premiums for certain non-working categories of population.

In order to reduce tension and resistance of employers and also to increase the financial sustainability of the system the following options might be introduced:

- **the only fee for health insurance** (social health insurance and insurance connected with temporarily loss of ability to work), besides, this approach for creation of the system of medical insuring was declared in the Concept of social provision for Ukrainian population that was adopted by the Verhovna Rada in 1993, and

- **the only fee with quoting of payments for different kinds of social insurance** that will demand changes in the taxation system and organization of the whole valid system of social insurance.

Insurance forms that are based on the principle of insurance compensation equivalence or on the cash payment system result in the reduction of equity because they force socially vulnerable groups, who have limited means, to bear a disproportionately heavy burden. Typical of such insurance models regressive financing scale
results in the situation when persons with less income would be forced to pay to the health insurance system a relatively bigger share of their income than people with high income. Apart from that, such insurance models provide for different programs of services depending on insurance sum. Usually, they also imply creation of competing insurance markets where competing insurers inevitably use a phenomenon of insurance risk selection or “skimming.” All this results in the reduction of equity and accessibility of the health care system, especially for chronic or elderly patients. Also, letting many insurers enter the voluntary medical insurance market, as experience of many countries shows, leads to the reduction of financial sustainability of health care, confusion in settlements, payments, reporting, and increases documents circulation. That is why such systems require an extremely complex (from the point of view of implementation) mechanism of insurance system management.

Thus, the abovementioned indicates that in case of a political decision on transition to obligatory health insurance, it is advisable to give preference to the selection of a centralized model of health care insurance (i.e. a model oriented to the creation of one strong specialized national insurance fund). This system, as other countries experience suggests, is the most effective and is easy to manage.

All funds earmarked to cover health care expenses (insurance premiums, allocations from the budgets of different levels) come together into one insurance pool. Nowadays the world practice proves that only integration of financial flows creates conditions for strategic and current planning of financial resources, seeking optimal ratio between different kinds of health care services, forming economic incentives for every health facility, and gives possibility to look for internal system sources of resource saving (see Insert 9).

Health insurance fund is an body responsible for the organization of health insurance. This is a specialized non-commercial organization that has branch offices in every administrative unit. The Fund ensures accumulation of health insurance money and, at the same time, acts as a major insurer that covers expenses on some

Insert 9
Combining financial flows from different stable sources of financing is effective (national and local budgets funds of voluntary medical insurance, obligatory funds earmarked for special purposes, etc.).

Disintegration of financial flows may reveal itself in a separation by sources of financing:

1. either of the separate kinds of health care services (for example, in-patient care in comprehensive hospitals is covered by the city and district budgets, that in specialized hospitals — from the Oblast budget);
2. or the groups of population (health care to the working population is covered by voluntary medical insurance, other groups of population are covered by local budgets);
3. or from the separate lines of the budget.

Practice of separate use of funds from the budgets of different levels or from the budget and insurance funds revealed that, instead of raising its effectiveness, health care system faces a number of new problems created by the financing system itself. Creation of a system of different funds (health and obligatory health insurance) and related to it differentiation of financial flows, as experience (for example Russia’s experience) shows, results in health care system fragmentation and preservation — even strengthening — of structural disproportions. Additionally, the system of health care management becomes more complex; takes place unjustified growth of bureaucracy — as a result, decreases share of funds spent directly on rendering health care services.

Also, it is an unacceptable situation in reforming health care financing system when running and capital costs are covered by budget (when local administrations maintain health care facilities, purchase for them inexpensive medical equipment) and the remaining components of health care services are covered by insurance funds. This solution results in a situation when excessive resources are slow to be removed from the system. Motivation to effectively use material and energy resources is reduced, because the relevant expenses are not included into the cost of services [8]. It is advisable to allocate only a certain share of budget funds for procurement of expensive equipment that require centralized planning, for educational and research programs, capital repair, and for financing of a limited number of social diseases.
health care services to the population rendered under agreements with providers of these health care services.

The fund resources are not to be included into the state budget, other budgets or funds.

The national budget money allocated to health care are used for the needs of public health (sanitary-epidemiological service, training of specialists and medical research) and for financing of target national programs.

If the decision is taken to employ the health care system model which is based on the model of financing from budget sources (at the expense of the general taxes) with the contract-based relations between the customer and the health care provider for a quite long period of time, it is expedient to consolidate all budget sources allocated for health care at the regional level. To manage these consolidated budgets it is necessary to create relevant Health Care Planning and Financial Resources Management divisions at the regional health care administration bodies with appropriate workforce, and material and technical provision.

**Enhancing resource use effectiveness**

Now it is considered to be scientifically proven that key strategies of effective allocation include the use of:

- contract model of health care services that ensures payment for services within the framework of contracts between the payer and provider,
- methods of payments to the service providers that are geared toward improvement of effectiveness and efficiency
- rational pharmaceutical policy at a macro- and micro-level.

As was mentioned in section 6.1 in the modern health care system, a special role is given to contractual relations. They are viewed as a coordination mechanism that is alternative to the traditional command-and-control models of health care management, both in insurance and budget models. Generally speaking, the availability or absence of this extremely important element is the main difference between integrated health care model by Semashko (in fact this model is still working in Ukraine) and a model of contract financing adopted in a number of developed European countries. The latter model, as well as the Semashko one, is based on a financing due to general taxation.

A system of health care provision is used under the contractual relations system of health care provision which envisages the availability of contracts between the three separate parties:

- a) the beneficiaries (patients);
- b) fund owners (or customers) who act on behalf of the beneficiaries (the patients), the model on the basis of financing at the expense of general taxes, and the regulatory bodies or local authorities perform as customer, payer; and in terms of insurance model — fund of public medical insuring;
- c) health care providers.

Thus, in contrast to the model which is currently being used in Ukraine, it is necessary not to sustain public health facilities at the expense of budget or public allotments within the strict budget line limits, public contracts, but to employ the mechanism of public purchases, public contacts, and state awards.

Agreements are concluded between a financing party (fund of voluntary medical insurance or health administration before SHI was introduced) and health service providers (general/family practice physicians or their associations in the form of groups or trusts of primary health care; health institutions — ambulatories, outpatient clinics, hospitals, etc.)

Contracts obligate both health providers and the financing party, it makes possible to balance scope of responsibilities with the financial resources, serves as an instrument of management of the health care profile, facilitates implementation of monitoring systems of health care and estimation of the results of health facilities and health facilities personnel performance.

Contractual relations in a non-competitive environment, when market mechanisms in health care are not developed or there is only one health care provider in the region (rural ambulatory, central rayon hospital, etc.) may be used, first of all, to improve planning, use of resources, and health care management. In competitive environments, possibility of informed choice of health care provider, including selection by price/quality criteria, are added to the aforementioned list.
Use of contractual relations makes it possible to decentralize management of the real state policy component.

The experience of many countries with different levels of economic development, in which health care financing system is social in nature, shows that the most acceptable approach as to the implementation of agreements in this sector is contacted purchases of health care services using state or public money.

The role of health service consumers may also be transferred to primary health providers if they are given the extended authority and control over getting services over other branches of health care (when a general practitioner’s referral is needed to get services of secondary and tertiary level of care) and they are funded under the fundholder scheme (see infra). In this situation, primary health providers establish contractual relations with other branches of health care:

• for specialized out-patient care — with physicians of an out-patient clinic or hospital;
• for in-patient care to the catchment area population — with hospital health professionals;
• for additional diagnostics and treatment procedures — with para-clinical services of a hospital.

Legislative basis for creating a contractual relations system was set by the law of Ukraine “On procurement of goods, work, and services from the public funds” (2000). This law proclaimed that any services, including medical ones, can be purchased with public funds. Such status of the health service provider as public, communal, or private shall not restrict possibility of this provider’s participation in a tender. However, this law, which is actively used in procurement of medications and medical equipment, isn’t used for purchasing medical services. The reasons lie in a reluctance of executive authorities and local self-governance to make decisions on the provision of the realistic state health care guarantees and elimination of existing excess of health care facilities and personnel that would inevitably grow even more after the introduction of contractual relations and the following intensification of these facilities activities, their striving for the most effective and rational use of available labor, material and technical, and financial resources. The medical bureaucracy isn’t interested in contractual relations either; it can’t and even doesn’t want to assume responsibility for meeting obligations.

Introduction of contractual relations requires changes in the allocation of funds between health care providers.

Change of health care facilities financing pattern in the process of reconstruction of the health care system should be based on the following imperative: ensuring health improvement as much as possible given the resources available. Here the principle of health care facilities support is replaced by the principle of payment for their work depending on its scope and quality.

The authority which is responsible for health care facilities financing (this role may be given to health administrations as well as to insurance fund with its branch offices) is turned into purchaser of health care that represents interests of the population and ensures forming requirements to the scope, accessibility, and quality of health care.

Selection of a financing method of health care facilities is driven by requirements to create incentives for optimization of health care services structure and by acceptability of these mechanisms for the national health care system [3,4,6,7,8].

Potentially the most effective method of financing of primary health care is a fund holding scheme of payment for primary health care — per capita financing of primary health care for the whole scope of expected out-patient care and a partially for the in-patient care (partial fund holding) or per capita financing of the total scope of health care (complete fund holding). The main idea of financing through a fund holding scheme is to motivate primary health care providers to assume responsibility for organization of all kinds of health care to the population they render services to, and, on this basis, to improve effectiveness of resource utilization and ensure real protection of patients’ rights. Fund-holding creates possibility for primary health care to function effectively and for integration of different levels of health care because of financial responsibility of primary health care not only for its direct activities, but also for the effectiveness of organizational and dispatcher
functions. Within a framework of fund holding model, environment is being formed to manage health care system services in a way when selected kinds of health care services are adequate to acuteness and complexity of the disease, and when the most cost effective medical technologies are used. Procurement of services and setting contract agreements promote: on the one hand, the expansion of the primary care institutions scope of authority regarding hospitals and sub-specialists; on the other hand — ensure more stringent control over the spending of resources, allocated for hospital and specialty care.

Scheme of per capita financing with elements of partial fund holding was tested in town Komsomolsk, Poltava Oblast and, in spite of the number of obstacles, showed encouraging results regarding improvement of resource use effectiveness in health care.

During the first stage, before the needed “economic environment” will be created in the health care system, it is advisable to finance primary health care based on per capita norms, when financing is calculated based on assessment of expected scope of activities of primary health care.

Involvement of the population’s money in primary health care should be minimal, so that not to provoke any delay in patient primary visits due to financial barriers and to reduce such negative social consequences as exacerbation of a disease due to late visits to the health professionals. At the same time, co-payments by the population for prescribed medications from the recommended list of the basic medications is envisaged at all phases of primary health care reform.

The analysis results show that the global budget method is the most acceptable method of hospital financing. The essence of this method is that the hospital, after negotiations with the financing party, receives a fixed annual budget for the agreed scope of work. The financing of the hospital doesn’t depend on the number of hospital beds or other capacity indicators. The budget recipient bears the main share of financial risks for exceeding the actual scope of work over the planned one.

Financing of hospitals through global budget method belongs to the most effective tools that stimulate hospitals to optimize the volume and profile of in-patient care. Strict requirements of a financing party to hospitalization substantiation encourages hospitals to objectively assess out-patient clinic referrals, refuse to hospitalize when it is not needed, create substitution forms of care (daycare hospitals, out-patient surgery), seek cooperation with out-patient services up to creation of their own divisions of out-patient care. Higher level of substantiation in hospitalization creates conditions for better resource allocation for complicated in-patient cases. Using the global budget method results in the reduction of hospitalization cases, rise of cost per one in-patient case with simultaneous rise of workload in the out-patient care sector, i.e. results in structural changes.

The fact that financing isn’t linked to the number of hospital beds allows hospitals, on their own, to reduce and change their bed capacity structure as a response to economic incentives and with minimal participation of administrative leverage. It should be mentioned that nowadays the majority of European countries are inclined to use this global budget method for financing of hospital care.

Limitation of the state obligations and introduction of additional payment for health care. The fundamental characteristic of the reformed health care system in Ukraine should be an agreement of state guarantees regarding health care services with the financial resources of the system. Currently, the state health care obligations towards the population are excessively high and they not backed by real financing. In the current economic situation, keeping the universal state obligations concerning free health care (i.e. all kinds of health care services for all groups of population) isn’t realistic, even if engage additional sources of financing to the national budget.

The scope of responsibilities in the budget system with contractual relations between the customer and the health care provider acquires a format of the basic package of health care services, in social health care insurance system (SHI) — the format of the basic SHI program. The basic package of health services includes the limited set of medical interventions from the overall number of those available at the current stage of health care technologies development;
the interventions are selected to the packet not arbitrarily, but as a result of prioritization and have to serve the solution of the determined medical and social objectives; interventions are included into the package in such a way as to complete and to reinforce one another [5]. Basic SHI program is a guaranteed by the state scope, level, and conditions of health care services within a SHI system, including level of people's co-financing of the selected types of health care services. Development of the basic program should be carried out by the Ministry of health; it should draft its contents and its financial and economic substantiation. The basic program should be approved by the Cabinet of Ministers together with a guaranteed financial support in a form of a minimal norm of financing per capita per year. Several versions of the basic program should be drafted — depending on the expected scope of financing. The basic program, after its approval, acts as a minimal social standard, so that scope and conditions of health services of regional SHI programs cannot be lower than this basic program.

The insurance premium should be set at such level that would cover not less then 70-80% of health care expenditures included into the basic SHI program (including expenses on medications); it should be set by the Parliament on the basis of the Government submission and be calculated as a percentage from the income: it should not be linked to the health condition.

To ensure complete coverage of health care costs, the legislation should identify forms (for example, fixed single payment in cash (with adjustment for inflation) that is paid in case of hospitalization; fixed rate (with adjustment for inflation) for one-day stay in a hospital; payment for hotel service in hospitals with advanced level of comfort) and amount of population participation in expenditures covering. The total volume of population share shouldn't be more than 30-20% of the total expenditures on health care and it shouldn't directly correlate with one's health status. As research suggests, population is able and ready to contribute this amount.

In developing the basic health care services package or basic program, it is necessary to follow the identified and declared health care priorities — directions of development of facilities and services that correspond to the priority tasks of the system in solving identified or anticipated problems. Need to prioritize is determined by the generally accepted understanding of the fact that health care system resources in any country are always limited, plus there are additional reasons for resource deficit in the Ukrainian health care system that are caused by particularities of transitional economy. Health care priorities should be set by the government based on the substantiated medical and sanitary needs of the population, cost and effectiveness of medical interventions, and political realities in the country, public opinion, opinion of the patients, managers, and health professionals.
Obstacles and problems on the way of financing change and introduction of strategies of resource utilization effectiveness improvement in health care

Organizational

- Health care facility managers, specialists in health administration and local self-governments are not trained in the sphere of planning and managing financial resources; they are not trained to work in the contractual relations environment, and, as a result, obvious legal opportunities to introduce state buying of medical services and to gradually make a transition from the integrated model of health care financing to the contractual one are ignored.
- There are not enough specialists in insurance management and related fields.
- Status of health care facilities such forms of ownership as public and communal as well as budget facilities that are financed from the budget.
- Number of current legislative documents (enactments of the Ministry of health, enactments of the government, etc.) slow down or obstruct sectoral reforms: staffing norms, specifically: linking number of health professionals to the normative number of beds, payment to the health professionals based on salary scale, regulation of use of specialists’ counseling, etc.)
- Lack of the relevant organizational structure (infrastructure) for SHI.
- Lack of elaborated mechanisms of national regulation to manage the insurance fund and its subsidiaries, lack of experience of work in a contractual relations environment; lack of necessary informational system.
- Lack of typical or tentative agreement concerning the state purchase of health care services.

Economic

- Approaches to forming insurance premiums have not been worked out.
- Lack of uniform requirements to pricing.
- Lack of a single technique for costing health services.
- Lack of tariffs for health services.
- Lack of a modern system of management accounts that would make it possible to get a general picture of on health care expenditures.
- Lack of detailed medical and financial information on patients treated.

Political

- Unrealistic state guarantees regarding health care (Article 49 of the Constitution regarding free health care provision in public and municipal health facilities);
- Existence of the Constitutional Court judgment concerning the breach of the law by citizens and insurance penalties within a framework of SHI concerning the rules of payment for health care service;
- Lack of interest on the part of a number of political and corporate groups in implementation of social and medical insurance (employers, because this is related to additional taxation; private insurance companies, which on the one hand, don’t want to have state obligations clearly delineated, on the other hand, they want to get access to public financial resources of the health care system; managers of health administrations and health facilities who are afraid of responsibility for implementation of the obligations and don’t want weakening of the traditional leverage; pharmaceutical companies who don’t want strengthening of a control over use of medications);
- Passiveness of the population that doesn’t understand or misunderstands the prospects of the reforms in health care financing and their role in financial support of health care.
Activities needed to effect changes in health care financing and resource use

Political

• Revise Article 49 of the Constitution regarding free care health care service at public and municipal health care facilities or, at least, ensure second trial by the Constitutional Court of Ukraine of a case on free nature of health care in relation to additional circumstances in the case that hadn’t been subject of consideration, but existed at the moment during consideration of the case and making a judgment on this case.
• Prepare draft laws of Ukraine “On social medical insurance”.
• Develop regulatory and legislative documents to change organizational and legal status of health care facilities granting them a right to independently carry out economic activities (provide for changes in a legal status of health care facilities from the budget organizations to the state medical enterprises).
• Make changes in the Budgetary Code of Ukraine, in the laws on “Local self-governing”, “Local state administration”.
• Effect changes in the tax legislation that would enable: to review amounts and structure of deductions of the businesses for the various kinds of obligatory social insurance, including social medical insurance, and introduce obligatory personal payments of the employed citizen for social medical insurance; give tax remissions to investments into the health care, including those into private health care that is based on the assumption that broadening health care opportunities for the wealthy citizens reduces the load on the public and municipal health care systems.
• Provide for the introduction of target taxes on tobacco and alcoholic products or allocation of a share in excise duties on these commodities earmarked for the needs of health care
• Develop and approve priorities in heath care based on substantiated medical and sanitary needs of the population, cost and effectiveness of medical interventions, and political realities in the country, public opinion, opinion of the patients, managers and health professionals.
• Organize informational campaign regarding goals and contents of the reforms — carry out explanatory work among different groups of population and heath professionals.

Economic

• Develop mechanisms of contract payment for health services. Develop a rigid mechanism of contractual relations between a financing party and health care facilities; between health facilities, specifically: between primary health care and other levels of health care. Develop and approve a set of standard agreements that regulate contractual relations. Identify criteria of provider selection for purchasing health services for public money that are based on the “price vs. quality” principle.
• Develop a basic package of health services (or a basic SHI program).
• Develop common pricing requirements that rule out shifting on buyers the expenditures for maintenance of the health facility’s capacity that is not used; accept a unified technique of assessment of health services cost.
• In order to ensure adequate planning of resources, develop a classification of health services with indication of their basic cost.
• Develop a modern, based on the substantiated international approaches, system of the management accounts in health facilities that would make it possible to get a general picture of expenditures of health care services, ensure review of the system of expenditures accounting with fixing expenditures all way down the technological chain of health care delivery: from primary health care to follow up and rehabilitation services — for it to be used as a basis in financial management of the health care system.
• Develop and try out modern health financing methods (payment for services) that are directed towards effective resource allocation: per capita financing and per capita financing with partial fund holding — for organization of primary health care; global budget — for in-patient health care facilities. Make a transition from line-item financing of health facilities to the financing based on the scope and structure of the health services.

• Develop and experimentally test the systems of compensation of work for health professionals and support staff of facilities (departments) taking into account the scope and quality of their work with further approval of the respective regulation.

**Organizational**

• Create systems of specialists training (managers, economists, analysts for insurance fund, institutions and health care settings that share the health reform ideology and are able to implement strategic and financial planning, act as purchasers and providers of health services).

• Review current regulatory acts (MOH orders, directives of the government, etc.) that slow down or obstruct reforms in the field: staffing norms, specifically linking the number of health professionals to the normative number of beds, payment to health professionals based on salary scale, regulation of use of specialists’ counseling, etc.)

• Create infrastructure of voluntary medical insurance: the VMI fund and its branch offices

• Develop a classification of health services, identify basic and additional services

• Develop an informational system that includes data on morbidity as well as a detailed medical and financial information on patients treated.

• Develop a formulary system of drugs provision for health facilities.

**Literature for Section 6.3**


The importance of health care system in community health maintenance and recuperation is very great. Specialized research data demonstrate that a well-organized health care system could decrease the rate of potential losses of man-years of life by 16% [2]. Moreover, such a system also performs an important socio-political function, since it promotes the feeling of security in the future. That is why current requirements to the organization of health services worldwide are quite high (Insert 10).

The main objective of the organizational reform in the Ukrainian health care system is to provide the highest possible level of public health using the available resources, for which purpose there is a need to rationalize a set of components, which make up the system and to increase the efficacy of the mechanisms of interaction between them.

In implementing the health reform, one should understand that without a balanced strategy, aimed at ensuring rationalization of the health care structure and the optimization of the relationship between primary, secondary and tertiary care, it would not be feasible to improve the situation in healthcare, even with the involvement of additional funds.

The priority areas are structural and functional reorganization in the two main sectors of the system: the primary health care sector and the hospital care sector.

Development of the primary health care sector

At the current stage it is considered proven that a system in which the key role is played by general/family practice is the most efficient format of primary health care organization [4, 8]. The basic WHO European regional bureau policy to achieve health for everyone by the year 2010 sets the goal to establish comprehensive family medicine/general practice based primary health care services in at least 90% of the countries in the region [1]. According to US experts, in a well-organized system general practitioners can directly or indirectly control 70 -80% of total health care spending, expending around 20% on their own activities [7].
Over the past years Ukraine has eventually defined its strategic direction for the development of primary health care (PHC), based on the general practice/family medicine model. Regulations, outlining the needs for the priority development of family based PHC have been passed.

However the development of the strategy for the transition to family medicine based primary health care cannot be limited to the issues of medical and technological nature (training of doctors, opening and equipping primary health care facilities). It should be understood that even a well-trained and equipped doctor will not be able to fulfill his tasks, if he does not have autonomy in decision-making, economic motivation and will not face the risk of losing his patients.

According to the findings of the years of studies, conducted in Ukraine [3], the goals for PHC reform were determined and the model developed and tested in the organizational experiment conducted in the city of Komso-molsk, Poltava oblast.

The goal of the primary health care reform is to create the most cost-efficient PHC performance format proven to be efficient, to form a basis for remove severe structural disproportion in the health care system and for seeking sources of economy within the system while maintaining the accepted level of social guarantees for the people.

Main modules of the developed model include:
- status of organizations providing PHC;
- ways to form the population group to be served by a general practitioner/family doctor;
- mechanism of interaction between family doctors and sub-specialists and hospitals;
- PHC clinics financing and medical personnel remuneration for their work;
- approaches to health care quality assurance, etc.

Module one — change of the legal status of PHC institutions.

In Ukraine the state-owned and communal health facilities, including those providing primary health care, exist as institutions administratively managed by state executive bodies and in fact do not have the right to make independent economic decisions.

The model stipulates the creation of independent primary health care organizations at polyclinics and their branches and vesting them with the status of state enterprises, which should trigger primary health care reform.

The purpose of these changes in the organizational and legal status of HF is to create opportunities and incentives for efficient economy and conditions for competition between health care services producers, thus increasing the effectiveness of resources utilization in the system (see also subsection 6.1).

Module two includes ways to form population groups to be served on the basis of the patient's free choice of the doctor. Opportunity to choose and to change the general practitioner is considered as an indispensable right of the patient and is a mandatory prerequisite for the health care system shift from the needs of health care organizations towards population needs. This choice is documented and is a sort of an agreement between the patient and the doctor.

Module three. The structure of the health care services consumption and distribution of resources between health care services depends on how the patient enters the system and moves within it.

It is proved that only a primary care practitioner can determine the most rational way of health care services delivery and the most optimum care pathway for his patient. That is why in this model patients do not have free access to sub-specialists, or to the hospitals. (This practice is quite common in the European countries).

General practitioner performs check-point functions (the so-called gatekeeper) and organizes secondary and tertiary care delivery for his patients.

Self-referral (without referral) of the patient to sub-specialists or to the hospital, except some cases (urgent care, dental care, etc.), has to stipulate economic liability in the form of partial (or total) reimbursement for the services provided by the patient. At the same time the patient must have the right for the arbitration of explanation of the limits at directions.

Gatekeeper functions which are performed by the primary care practitioner improve organization and coordination of health care at every
level of patient services are one of the most important conditions of its manageability, which would manifest itself in providing care at that level and by that specialist who suits in the best way to the condition and level of health of the patient.

Module four: Intensity of reform in PHC system and its efficacy are determined by the financing procedure (or to use the European term — payment for services procedure).

The main requirement to the system of the primary health facilities financing is to stimulate patient access to high quality medical care, simultaneously increasing the effective utilization of resources and curbing costs.

Capitation with partial fund ownership scheme was proven to be such a primary care financing method which creates stimuli for more effective utilization of resources and allows directing the market mechanisms towards achievement of socially meaningful goals (see subsection 6.3, “Changes in the health facilities financing”).

Module five: Changing the remuneration for work of the medical personnel is the next module of this model, because without this component PHC reform will be incomplete. Reform outcomes are quite closely related to how economic motivators will motivate the health care personnel to efficient performance.

The goal of the primary health care workers remuneration system reform is the formation of such social conditions according to which the behavior of the practitioners on the micro-level would provide control over the expenditures on the macro-level that is on the overall system level. To achieve this goal two interrelated issues should be addressed:

• increase of the level of bonuses for physicians and nursing staff;
• development of remuneration mechanisms, which will promote efficient utilization of the sectors resources.

Unless measures are taken to address the second objective, the reform outcomes may be quite unexpected. For example, introduction of fee for services in Czech Republic and Slovakia led to the actual bankruptcy of the healthcare system (all the funds were spent in six months), despite a twofold increase in total financing due to transition to voluntary medical insurance.

The basic change strategy in the remuneration of labor of primary care practitioners is the transition from the model when the doctor works for his salary and is hired by the state, to contractual relations when remuneration is stipulated in the contract, and first of all depends on the scope and quality of work done.

The sixth module is PHC quality assurance that includes:

• standardization of medical practice;
• outside control;
• internal control;
• development of quality indicators and monitoring of outcomes.

Standardization of medical practice requires the development and implementation of approved clinical algorithms, clinical pathways and clinical guidelines, developed on the basis of syndrome (not nosological) approach utilizing evidence-based medicine and successful practices databases (see details in section 6.7).

Utilization of the above model for primary health care (PHC) organization in accordance with forecasting calculations will allow:

• ensuring real responsibility of the primary health care for the population health,
• decreasing the need in secondary and tertiary care;
• creating a competitive environment in the secondary and tertiary care sectors;
• actually forming a unified medical environment for health care services delivery.

The implementation of the family-based PHC model does not mean liquidation of such an institution as a polyclinic, but its qualitative change. The main task of the polyclinic should be support of the primary health care system. Using its technical and workforce capacity, the polyclinic can significantly expand the scope of diagnostic, treatment and recuperation capabilities of medical practices, provide specialized consultative and medico-social care, and administrative support. To perform these functions the following divisions may be retained/created in large polyclinics:
• specialized care;
• medical and social care /support;
• disease prevention;
• daycare service;
• out-patient surgery;
• para-clinical services (diagnostic, treatment and recuperation) and others.

These departments may be part of the polyclinic as its structural divisions with certain economic autonomy, or operate as independent economic entities either creating or not creating a legal entity. Interrelation of the general practices with these subdivisions should be built on contractual basis.

Possible transformations in the hospital care sector

Achieving structural efficiency requires building relationships between different parts of the health care system within the scheme, based on collaboration instead of contradictions. Partly this issue has been discussed above (gatekeeper principle, financing through partial fund ownership), however the directions of hospital sector reform deserve specific attention, first of all due to its being resource-intensive, as well as to the special role performed by hospitals in the healthcare system.

Despite the unprecedented administrative measures implemented in 1996–1997 to curb the hospital sector costs, the number of hospitals in Ukraine remains quite high, the indicators of supply with beds and length of hospital stay is still the highest in Europe.

Main goals of hospital sector reform include:
1) Decrease hospitalization rates;
2) Increase efficiency of bed capacity utilization.

To decrease needs in hospitalization a broad scale of different substitution strategies is recommended.

Comparative analysis revealed that to substitute for the determined portion in hospitalization needs it is expedient to implement a set of interventions including:
• Improvement of timely and high-quality of primary health care;
• Substitution of hospital care with out-patient care using modern treatment practices;
• Development of home care system, primarily for elderly and disabled patients;
• Development of alternative forms of health care provision mainly in the form of home based clinics, out-patient surgery centers, etc.

World experience shows that activities aimed at quality improvement of out-patient, home care and other services can lead to significant reduction of hospitalization rates and periods of hospitalization.

Recent development in the Ukrainian health care is rapid, although a bit chaotic, creation of hospital substituting facilities based at outpatient clinics or polyclinics. In 2000 almost 2.5 million patients received care in home based and daycare health care services (26% out of those hospitalized). However, it did not have any significant impact on the demand in hospital care, primarily due to low interest of the hospitals. That is why experts consider it inexpedient to limit hospital-substituting types of health care to polyclinics only, as it is the current case. It is necessary to provide health care facilities with the opportunity to set up their own outpatient diagnostic services, to open their own full-day health care services and to provide specialized out-patient services.

To address the second task — “improving the effectiveness of bed capacity utilization” work should be done in the following directions:
• implementation of structural reform in the hospital care system, aimed at the increase in the effectiveness of bed capacity utilization;
• creation of an optimum local network of hospitals;
• change of the legal status of the hospital;
• ensuring effective hospital care financing, first of all using the global budget method;
• improvement of integration between hospitals, primary and social care.

Structural hospital sector transformations include:
1) differentiation of hospital beds in accordance with intensity of treatment and care;
2) concentration of tertiary high-tech care;
3) creation of a unified medical environment with liquidation of departmental system of health care provision to certain population groups and optimization of the network of in-patient facilities.
The most promising direction in the structural reorganization of hospital system is differentiation of the operating institutions (hospital beds) by the level of medical services intensity designating:

- hospitals for mostly intensive short-term treatment and care for patients with acute illnesses and acute disorders;
- departments and hospitals for long-term stay for treatment of chronic diseases and rehabilitation;
- nursing care hospitals and hospices [3,5].

Intensive treatment hospitals for acute patients should become, as in the majority of European countries, the main type of hospitals. Hospital care in these facilities is the most expensive, because they have sophisticated diagnostic and treatment equipment, utilize intensive technologies, provide clinical care 24 hours a day. That is why it is very important to use organizational and economic methods to ensure the conformity of the patient population to the hospital mission. Acute care hospitals are mainly general facilities, providing integrated package of medical services. The proportion of intensive care beds in them should be significantly higher than in currently operating in-patient departments, and the majority of beds should be general/medical (tab. 6.1).

The proportion of convalescence beds is also significant. Usually the final stage of treatment of patients with acute illnesses and disorders is provided at the patient’s home, at home-based clinics, where the usual home environment promotes recovery. Early discharge from the hospital in conjunction with intensive nursing care, and if needed physician care is an effective way to decrease length of hospital stay. However, in Ukraine the lack of developed services for home care and medication supply at home, unsatisfactory living conditions of some patients, remoteness of the patient’s home from the hospital, especially in the rural areas, the increasing number of people living alone require the creation of departments for convalescence in acute care hospitals; the patients are transferred to them on completion of the main stage of treatment.

With the development of in-patient hospitals substituting forms and corresponding public services part of the hospitals for acute care beds...
can be transferred to specialized departments (obstetrical, psychiatric — for patients with acute mental disorders, geriatric — for short-term hospitalization of the elderly patients with acute disorders, TB — for short-term evaluation and short treatment regimens, etc). Assessment of general hospitals comprising departments with different profiles and international experience, including that of healthcare reform in the former USSR countries (Estonia, Kirgisia, Moldova) makes it possible to conclude that closing down specialized hospitals or merging them with general facilities is a promising reform strategy.

Complex reorganization of hospital care also includes revision of the existing territorial infrastructure with similar hospital facilities in the same territory — either those belonging to different departments (railway, internal affairs and other), or meant for providing services to only rural or only urban population (for example, a number of cities, which are rural rayon centers, have a Central City and a Central Rayon Hospital). Such territorial organization of hospital care leads, on the one hand, to duplication of health services for different population groups, and on the other hand — to dissipation of the scarce health care resources.

It is proved that centralized or regional planning of integration of the duplicating territorial and departmental institutions at more powerful hospitals is an effective strategy for the optimum organizational territorial structure of hospital care. In addition, it would be useful to consider the possibility of enlarging (making bigger) general hospitals in which emergency in-patient care is provided, with the creation of hospital districts with population from 100 to 200 thousands of people. It allows to expand diagnostic and treatment capacity of hospitals through the concentration of material resources and reduce some beds without limiting the accessibility of hospital care.

Hospital care reform also requires revision of the organizational and legal forms of operations of its providers. In order to enhance operational efficiency it is expedient to grant hospitals the status of state enterprises and give them certain administrative and economic autonomy, which will allow reducing the number of limitations in the institutional operations as traditionally faced by health care facilities.

Carrying out structural transformations is a very complex and painful process. As a rule, attempts to increase structural effectiveness, made within healthcare sector are of little avail because some corporate groups are not interested in it and even oppose it, health care managers and medical personnel, primarily clinicians (doctors) are among these groups. That is why the reform context should include the mechanisms for activation and change management, which may include primarily implementation of contractual relations in the health care system and transition to the social medical insurance model.

Given historical and socio-cultural background of Ukraine, and the need to implement the reform within a short period of time, it is expedient to implement structural and functional reform of health care utilizing both administrative and economic methods. Complexity of the changes, the potential emergence of unforeseen situations requires the development of a clear action plan and its stage by stage implementation.
Barriers and problems in health care reform:

A. In the primary health care sector

- Complications in provision of patient home care due to the potential expansion of the service area related to free choice of the doctor.
- Potential dissatisfaction of patients with the limitation of free access to specialists they are used to.
- Resistance on the part of primary care practitioners and specialists because they fear losing workload, and subsequently jobs.
- Redundancy of some doctors and the need to address their employment issues.
- Unstable and poorly practiced PHC financing methods.
- Predisposition to high financial risks (especially for individual practicing physicians).
- Psychological and professional unreadiness of doctors to work in competitive environments and run financial risks.
- Problems and barriers associated with health facilities financing (see subsection 6.3).

Measures needed to implement healthcare reform:

A. In the primary health care sector

- Promote the development of the peripheral PHC infrastructure in the form of general practices, family practice clinics located as close as possible to the places of residence of the population.
- Promote the enhancement of the material and technical base of the PHC. To provide material and technical equipment for PHC facilities and divisions in accordance with the approved equipment inventory.
- Provide staffing of the PHC facilities and divisions with trained family doctors and family medicine nurses.
- Open family practice clinics only after they have been objectively licensed.
- Ensure financial sustainability of primary health care to create associations of general/family practices or of general/family practice clinics in a form of primary health care groups of trusts, with which the financing party will set contracts for provision of health care services.
- Provide training of professionals (managers) to manage funds in general practices.
- In developing approaches to primary care practitioners’ remuneration envisage the use of mechanisms relating the remuneration of a PHC doctor with the size of the assigned population and include bonus for doctor’s organizational activities.
- Make changes in article 38 “Principles of Legislation of Ukraine on Healthcare” regarding free choice of the doctor and health care facility by the patient himself, changing it to the norm on free choice of a primary care practitioner only.
- Develop a technology (procedure) for patients’ choosing a primary care practitioner and determine geographical limitations on the freedom of patients’ choice of a primary care practitioner.
- Develop mechanisms compensating for PHC doctor monopoly in case when the choice is geographically limited (for example in rural areas).
- Develop population registration to prevent possible assigning of one patient to several doctors.
- Develop mechanisms regulating the number of patients served by one PHC doctor.
- Develop clear criteria for referrals to different health care levels (to specialists, hospitals).
- Develop mechanisms of economic liability of patients for self-referrals to specialists and for specialists for providing services to those patients who were not referred by the primary care practitioner.
- Review existing orders and other regulations pertaining to specialty consultations.
• Provide primary care practitioners with vehicles to serve patients in their homes.
• Ensure extensive involvement of midlevel personnel in home care delivery.
• Organize broad explanatory campaigns for the population about the conditions and possibilities of free choice of a primary care doctor, about the benefits of medical care in which primary care practitioners play the leading role.

B. In the in-patient care sector

Stage I
• Develop criteria (indications) of hospitalization and discharge of patients from the in-patient hospitals (departments) of different intensity.
• Determine optimum admission rates into intensive care in-patient units (departments), chronic care in-patient units (departments), nursing care hospitals (departments) and hospices.
• Identify community needs for hospital beds in accordance with the level of medical care intensity.
• Review equipment inventories and medical personnel workload norms based on the multilevel organization of in-patient care.
• Conduct licensing of health care facilities irrespective of the type of their property and to determine the types of medical care to be provided based on the availability of the conditions required for their delivery.

Stage II
While the implementation factor of in-patient care accessibility (settlement type, transportation accessibility), established habits of people in terms of the places where they receive care are being taken into account:
• Transfer departmental health care facilities to the communal level.
• Ensure territorial integration of the hospitals in different jurisdiction; to decrease the number of hospitals and to increase the size of hospitals where emergency in-patient care is provided.
• Reorganize some hospitals into institutions (departments) for chronic patients care, facilities (departments) for provision of medico-social care — houses of nursing care and hospices. In the rural areas — these are first of all district and regional hospitals; in the cities — first of all those hospitals which failed to receive the license for providing health care in the scope required for patients with acute illnesses and acute disorders.
• Conduct material and technical reorganization (reconstruction) of the in-patient units of the health care facilities, basing on the specificity of their further utilization.
• Conduct gradual, careful closing down of some specialized secondary level health care facilities, taking into account local conditions, with the subsequent opening of the respective departments in the general hospitals.
• Concentrate high-tech tertiary care at the regional level.
• Ensure the development of social support services and their accessibility, to improve coordination between health care and social sectors.

Stage III
• Complete the transition to multilevel system of in-patient care.
• Complete the development of a common medical environment for health care delivery.
• Identify redundant hospital capacities and facilities, which do not meet current standards with their subsequent close-down/sale.

For both sectors:
• Implement relevant interventions, related to changing medical facilities financing (see section 6.3).
• For administrative bodies and medical associations develop a set of interventions in the area of social security of health care personnel.
Literature for Section 6.4

6.5 Human Resources Development

Personnel policy objectives for the health care sector:

- Identification of real needs for human resources.
- Creation of a human resource planning system to meet the needs of the sector.
- Speeding up training of those specialists who are in great demand in health care system (general practitioners/family physicians, health care managers and economists).
- Multi-sector approach to creating conditions for dynamic and proportional human resource development, removal of the main disproportions in human resource structure.
- Monitoring of the human resource management process.

It is known that European governments insist on the regulation, identification, and meeting of the real needs for health human resources; they also insist on support, direction and control over activities aimed at personnel education and training and efficient use of human resources by the society.

The World Health Organization (WHO), in its strategy of the 21st century highlights the need to regulate supply and real demand for health professionals in the labor market (Insert 11). Using China as an example, the WHO considers an issue of reaching equilibrium of existing human resources — it is achieved through reduction of admission quotas at medical schools (without closing them), and the money saved is spent on retraining existing working health professionals to work in more needed specialties [1].

The aim of the National and regional human resource policy, as an integral part of the Ukrainian health care system reform strategy, should be the creation of conditions for a streamlined, balanced development of human resources, removal of the main human resource disproportions (Insert 12).

Policy of human resource development in Ukraine should be directed towards meeting needs for qualified and experienced personnel and taking into account development of medical

Insert 11

In the WHO strategy “Fundamentals of the policy of attaining Health for All in Europe” ("Health-21") it is stated that by 2010, all European countries should have situation when health professionals and employees of other sectors have gained needed health care knowledge and skills. Meeting this objective will ensure the following:

- ensuring health professionals’ education based on the “Health for All” policy principles; their training for provision of recreational, preventive, treatment, and rehabilitation care of high quality; facilitating the approximation of clinical practice to public health practice;
- availability of planning systems that would make it possible to ensure necessary quantity and variety of health professionals and account for current and future needs of health care;
- availability, in all European countries, of the potential that is needed for specialized training in public health management and practice [2].

Insert 12

Ukrainian human resource situation

In recent years, human resources are declining in Ukraine. According to January 1, 2004 data, for the period from 1995 till 2003 the total number of economically active population aged 15-70 years had decreased by 2.9 million (11.5%) and was 22.6 million. More intensively, work load has decreased in rural areas by 27.9% in comparison with 7.8% in urban areas. Also, ownership reforms in public sector became the main factor that contributed to the general trend of employment reduction in the public sector during last eight years (number of employees of public enterprises during the mentioned period had decreased by 43.2%; number of employees of private sector however has almost doubled. Reduction of public sector employment was accompanied by increasing number of self-employed persons. Specifically, since 1995 number of self-employed persons had doubled and by 2002 was 6.2 million [3].
science and technologies. Specifically, it is necessary to identify an optimal ratio between the number of medical personnel and a country’s population in the modern conditions; it is also necessary to assess a long-term need for health professionals of different categories.

To realize health care system development strategy, it is important to give the lead to training of health professionals with the specialty “general practice/ family medicine” and ensure their employment. It should be taken into account that physicians providing specialized medical care may become redundant due to decrease in demand.

A shortage of adequately trained managers is one of the main obstacles in the health care system reform12. Thus, one of the main activities is to create a system for training specialists — health care managers (administrators), economists, analysts, who should have ideology of health care reform and be trained to do strategic and financial planning, to act as buyers and providers of health services.

Also, human resource reform in health care implies that health professionals’ training should be better, human resources should be re-allocated according to current social and economic conditions and real needs of the regions; specifically, physician/nurse ratio should be higher.

Development of salary payment mechanisms should play a key role and become a driving force of changes in health care human resources; it should facilitate more efficient use of resources and ensure qualification differentiation in compensation of work, etc.

It should be mentioned that current human resource policy in health care of many countries is based on joint responsibility of the state and the society, including responsibility of professional medical associations.

It is a known fact that human resource planning is an important element of overall health care development — that is why it should be continuously supported politically, professionally, and financially. More and more counties opt for human resource planning based on adequacy of health care personnel development to national needs and resources and society’s economic realities — as well as based on regional planned indicators. Human resource development planning should take into account socioeconomic, demographic, cultural factors, and ethnic particularities of the population.

The following approaches to human resource management are suggested:

- health professional’s structure forming should be viewed as part of the field reforming;
- personnel structure formation should include three interrelated components: planning, training, and human resource management;
- not only adequate quantity of health professionals is needed, there should be balanced distribution by the following criteria: geographical, by health facility, by specialty, etc.;
- all management levels should be engaged in the process of planning — it would make possible to manage informational flows and coordinate management decisions.

Human resource forming should include a number of components:

- planning of human resource needs (how many health professionals, what qualification, when and where will be needed?);
- planning of personnel motivation (how is it possible to create incentives for necessary human resources to employ as well as to take into account social aspects?);
- planning of human resource use (how is it possible to use employees adequately to their talents?);
- planning of personnel development (how is it possible to provide purposeful support in personnel qualification improvement and their knowledge adjustment to changing requirements?);
- expenditures for personnel training and maintenance (what expenditures are needed for planned personnel’s activities?).

Measures needed to introduce changes in human resource generation:

- Review the traditional functions and structure of shared responsibility between different categories of health professionals; stop unsubstantiated use of highly qualified personnel and transfer their less complex responsibilities to those health professionals, who have more adequate qualification for such kind of responsibilities.

- Develop a long-term projection technique for assessment of the health care system needs in different categories of health and other personnel — it should be tailored to with the strategy and the speed of changes in the system.

- Develop long-term plans for training and retraining of health care professionals taking into account the natural decrease of human resources and migration.

- Give priority to training of general practitioners — family physicians, family nurses and social workers.

- Introduce a wide-scale, modern, based on the latest international experience training of health care managers; as well as training of administrative personnel for the health care system and provide guarantees concerning social demand and real employment of the health care managers.

- Develop a range of activities to motivate for the selection of specific health professions, including development of salary payment mechanisms that improve resource use efficiency in the health care system and ensure differentiation in salaries based on qualification.

- Develop social protection activities — first of all, develop a system for retraining the specialists who may become redundant due to layoffs.

Literature for Section 6.5


6.6. Approaches to Improving Pharmaceutical Security Drug Provision

To improve the provision of the population with drugs and medical products it is necessary to resolve a number of problems. These include [4, 5]:

• Agree on a plan (program) to harmonize legislation in the pharmaceutical sector with the requirements of the European Community (including changes in the Law of Ukraine “On medications”).

• Review the regulatory framework that regulates the activity of the pharmaceutical sector, considering the entire process chain — starting from creation of a drug, its registration, production (import), to distribution, with a gradual implementation of international standards.

• According to the WHO recommendations analyze the implementation environment of the National program of provision of the population with medications. Develop a set of actions to development of home production of basic (essential) medications following the production terms corresponding to GMP standards.

• Review and adapt to the WHO requirements the National list of basic medications, including in the list those medications that proved to be effective and safe, those which can be used to treat most infectious, chronic and surgery diseases. The National list will be used as a basis in the framework of the program of provision of the population with medical care, during the development of standards, treatment protocols, and clinical guidelines.

• Using medical — sanitary approaches and production of medications review the National list of medications of domestic and foreign production that can be procured for public funds.

• On the basis of National lists develop and introduce a formulary system for the provision of medications to health facilities as an effective and economic instrument of supply and utilization of essential medications.

• Develop a list of harmful medications (i.e. those, the use of which was proved as ineffective or harmful).

• Take measures to reduce liberalization of drugs sale by pharmacies, and introduce a prescription-based sale, primarily for those drugs the cost of which is (fully or partially) covered from public sources.

• Develop comprehensive public measures to control spending on pharmaceutical production (considering the development of pharmaceutical — economic standards of medications use, taking into account their substitution and economic effect, i.e. with the determination of bio-equivalent generics).

• Create a National database of medications’ provision to the population.

• Introduce registration and monitoring of whole-sale prices of drugs and medical products of domestic and foreign production.

• In order to increase effectiveness of national regulation, develop a system of base prices of medications and mechanisms of differentiated coverage of costs related to the procurement of medications from public sources.

• Develop a range of actions to meet the needs of pharmaceutical sector for highly qualified national professionals (i.e. introduction of the position of clinical pharmacologist at health care facilities).

• To expand the authority of the State Services for Medications and Medical Products and create on its basis an of FDA (Food and Drug Administration) to harmonize the existing authorization and control system with international standards.
I. With the aim to improve the medications provision system in a short-term perspective (2005–2007):

1. Elaborate and adopt the essential medications List and the List of medications for treating socially — dangerous diseases in accordance with WHO recommendations.
2. Decide on the sale of prescription-based essential drugs.
3. On the basis of the List of essential drugs for socially — dangerous diseases it is necessary to form the government order.
4. Simultaneously with the development of those lists it is necessary to develop a mechanism to introduce a compensatory system to provide consumers with drugs, medical products and equipment.
5. Develop and implement an effective system of government control over prices of drugs with an adequate application of privileges for local producers that produce medications according to the essential medications List and the list of medications for treating socially — dangerous diseases.

II. In an average-term perspective (2008–2010) it is necessary to:

1. Establish comprehensive control spending on pharmaceutical products with the use of different approaches — introduce a ceiling on spending on pharmaceuticals, system of base prices, and control over prices.
2. In order to reach the maximum clinical effect in the treatment of diseases by using the most cost-effective methods of pharmaceutical therapy, create and introduce a formulary system of drugs that includes a complex of interconnected activities: design of formulary lists, creation on their basis of formulary reference-books and standards of pharmaceutical treatment, introduction of assessment of medications use.
3. During the development of medical care provision standards (clinical pathways) include medications, first of all, high-quality and highly-effective home-produced drugs.
4. Elaborate and introduce into practice mechanisms that regulate the prescription of medications by doctors, for example, include in the per capita normative for general medical practices — fund-holders’ expenditures for medications and medical products.
5. Elaborate and introduce mechanisms to refund the cost of drugs and medical products with a differentiated co-participation of the community.

Literature for Section 6.6

6.7 Approaches to Organizing a Medical Care Quality Maintenance System

It is expedient to subdivide the activities related to the organization of health care quality assurance and maintenance system in Ukraine into the preventive and the current ones:

1. Preventive measures in the sphere of health care quality assurance:
   a) Licensing of medical practice.
   b) Accreditation of health facilities.
   c) Appraisal (certification) of medical personnel.

2. Current measures to ensure health care quality:
   a) Implement quality assurance programs in every health facility.
   b) Comparative performance analysis (profile development). Information provision for the health sector (data collection, analysis and distribution).
   c) Set organizations (structures) to manage health care quality.
   d) Implement evidence-based diagnosis and treatment standards and organize patient-oriented health care delivery.

**Preventive measures to ensure health care quality**

**Licensing of medical practice**

*It is proposed* to determine (to make changes in the relevant regulations) that health care can be provided by a health facility (which can be represented by an individual or a legal entity of any type of property) or by an individual — a subject of economic activity — a subject of economic activity subjects; (for example, out-patient services in surgery; hospital care in internal medicine, etc.)

Hence, the license will become a mandatory document for health facilities of all types of property certifying that a health care provider of any type of property meets the clearly defined, similar for the analogous HF licensure requirements (personnel qualification and logistics of the health care delivery process requirements and infection control standards). It is expedient to ensure the participation of professional medical associations and consumer rights protection organizations in assessing compliance with licensure requirements. This will significantly increase credit to health care providers and will allow preventing unjustified litigation in case of dissatisfaction with health care quality.

**Effecting these changes will:**

- provide prerequisites for the delivery of quality medical care at the level of economic activity subjects;
- stimulate license owners to invest additional funds into the development of material and technical resources of health facilities;
- improve the quality of health care through removing those health facilities that do not meet the licensure requirements in terms of their material and technical resources, personnel competency and infection control from the health services market;
- lead to the optimization of the institutional network through reorganization and conversion of those institutions that do not meet the licensure requirements;
- promote the development of fair competition in the health services market.

**Accreditation of health facilities**

*It is proposed:*

1. To make changes in respective regulations — Cabinet of Ministers’ resolution “On the accreditation procedure”, regulation concerning the fact that a health facilities of any type of property can take part in contractual relations in health care delivery only if it has been accredited by the state, which includes evaluation of the institution’s performance according to the scheme “resources — process — outcome”, in accordance with the standards (or provisions) of state accreditation approved at the governmental level.

2. To develop and have approved at the state level the regulation on accreditation boards experts, which will regulate the process of their training, certification and remuneration of labor.
3. To improve and amend standards (provisions) of state accreditation of Ukrainian health facilities in accordance with the current requirements.

4. To ensure participation of non-governmental organizations (medical and nursing associations and other NGOs) in the state accreditation process, which will allow making the results more objective and will ensure a subsequent gradual transfer of the accreditation process to the civil professional organizations.

After these activities have been implemented the accreditation certificate will become a document certifying that the institution actually meets the state requirements to health care quality, the types of which are stated in the license. Those health facilities that fail the state accreditation may undergo a certain “reorganization” procedure, if the accreditation board finds it possible, or conversion. In this case the decision is made by the owner of the health facilities on the accreditation board application. It is also expedient to monitor the accreditation process to prevent certain non-state owned institutions from evading it (for example through change of the institution title, specialization, etc.). For budget-funded institutions it is possible to introduce a differentiated system of personnel remuneration for labor depending on the institution’s accreditation category.

Effecting these changes will allow:

1. stimulating an ongoing monitoring of the health care quality at the health facility level, thus preventing organizational and medical mistakes in health care delivery;
2. promoting the improved organizational structure of health facilities, especially of those which are in the state or communal ownership;
3. fostering the development of fair competition in the health care market.

Medical personnel evaluation (certification)

It is proposed:

Since appropriate competency level of health care personnel is one of the important components of quality-assured health care, there is a need to switch from formal evaluation, where work experience in a given specialty serves as the main criterion for qualification category award, to evaluation (certification) based on the actual level of professional expertise and professional performance results. For this there is a need to develop and have approved by the pertinent regulations the criteria of aptitude for a certain qualification category, basing on the performance results assessment. This will be the first step on the way to the implementation of widespread in the developed countries system of physicians’ licensing and accreditation, which in turn is a significant step forward on the way to addressing the issue of optimization of the sector’s workforce capacity building. The key role in this area should be played by the medical self-governance system (currently — professional medical associations). Until an efficient medical self-governance is established in Ukraine, it is expedient to consider the possibility of introducing a legislative regulation as to the mandatory review of the papers submitted to the certification board and testing skills of the candidate for the evaluation category by the authorized representatives of the association.

A system of interaction between health care workers and the institution’s administration needs to be significantly improved, namely a transition to the contractual system (changes should be made in the Code of laws on occupational safety and health). In this case the contract should clearly specify qualification requirements for the personnel; inability of the worker to demonstrate the required qualification would allow the administration to cancel the contract earlier. The current Ukrainian system of evaluation by categories should be gradually supplanted by a more effective system of professional certification, evaluation of the professional’s knowledge and the quality of performance.

If introduced, a such system of evaluation will make it possible raise professional efficiency. Those doctors, whose qualification is lower than the required level will have to either raise their profession level or to be transferred to nursing positions, or in the worst case, leave the system. Under certain conditions they can be retrained to become clinicians in deficit health-specialties. We also believe it expedient to consider the possibility of introducing in Ukraine the “physician’s assistant” position.
The system of health care workers evaluation, certification and licensing of medical and pharmaceutical workers needs significant improvement both legislatively and organizationally. A significant step forward in addressing the above issues is the implementation of the effective medical self-governance system (one of the conditions for it being the adoption of the “Law on Medical self-governance in Ukraine”).

**Current measures to ensure health care quality**

**Implementation of the quality assurance program in every health facilities**

**(Proposals:**

A new approach to quality assurance in the national health care system may be identification of the three main groups of factors, determining the overall performance of the health care quality system:

a) New forms of organization and administration.

b) Quality control methods.

c) Improvement of the health facilities’ material and technical HF resources and automation of the technological processes.

It is no coincidence that organizational and administrative factors play a major role as compared with other health care quality determinants. The experience of the developed countries demonstrates that the use of up-to-date technologies is appreciably advantageous only in those cases where administrative issues are resolved, and, primarily, the basic concepts of the administration philosophy aimed at addressing health care quality are implemented.

It is necessary to minimize the impact of forces that prevent the adoption of a new management philosophy by health facilities and health administrations. First of all, this applies to medium-level management, and various controlling services. It is common knowledge that managers, who are accustomed to command management, suffer from the necessity to abandon it. Further use of such managers should be viewed only after their special retraining as quality assurance program managers or consulting experts who help health providers (physicians and nurses) organize self- and mutual control.

The above principles of the new approach to health care quality management can be implemented through a set of activities, among which the following should be emphasized:

1. **Personnel training in statistical analysis methods.** This process should start with training of health facility top managers health facilities and then gradually come down to the lower levels.

2. **Radically new approach to quality management.** Its essence can be formulated as orientation to the consumer’s satisfaction with health care quality. However, within this concept not only the patient can act as the health care consumer, but also any participant in the health care delivery process in the health facilities. In other words, assuring such quality of work that lives up to the expectations of both the patient and the subsequent participant in the medical care delivery process becomes the main objective of a health care worker activity. It’s understood that, ideally, commitment to this principle at every stage of health care delivery guarantees the satisfaction of the end-consumer, i.e. the patient.

3. **Recognizing the importance of implementing new quality management approaches at the stage of medical technology development and the outcomes of the doctor’s (nurses’), HF division, overall health facilities activities.** Upgrading of medical and organizational technology at the HF should be carried out only by those staff workers who have clear understanding of all the weaknesses in the area of medical and organizational technologies of their hospital, polyclinic, emergency medical services station, etc. Besides, significant attention should be paid to the development and implementation of computer systems, allowing analyzing the quality of outcomes and effectiveness of the diagnostic and treatment approaches being implemented.

4. **Setting up the autonomous quality teams ("quality circle" in Japanese terminology) at the HF, usually at its individual divisions.** The team’s responsibility for quality stimulates it to improve the treatment process and to save time needed for more accurate fulfillment of technological requirements and standards. Studies conducted by the social psychologists...
and HF practice have demonstrated that those doctors who set their own tasks for themselves, are more demanding in implementing them, than in those set by someone else.

5. **Making “quality” concept the key term in the new management philosophy.** By this we mean that providing high level of quality will become the prior task for every manager. For this purpose there is a need to change the common stereotypes of the administrative thinking, primarily orienting health care managers towards implementation of resource saving technologies. This process will be faced with serious resistance on the part of the most of health care managers, who are not psychologically ready to accept the idea that quality improvement results in lower costs at the end stage of the diagnosis and treatment process. This issue should be addressed through providing training in economics for the health care managers. It should be noted that training programs should be differentiated for different categories of the workers.

Healthcare Administrations should develop **comprehensive programs in the area of health care quality management at the regional level.** Ukrainian Health facility managers should focus on the development of comprehensive continued quality improvement programs at health facilities in their jurisdiction. Such programs should address at least the following administrative issues:

- Personnel orientation towards quality-assured health care delivery to the community.
- Statistical analysis of the performance indicators (parameters) of each division.
- Mandatory introduction of the course in health care quality improvement into the program of continued education for health care personnel, provided at the level of a health facilities, territorial medical unit and the like.
- Creation of functional quality groups (teams, circles) at health facilities with the participation of all the services and functional categories of the personnel, including the ancillary staff (housekeeping service, accounting department, engineering service and so on).
- Priority-setting staging of activities to improve health care quality.
- Organization of feedback: provision of information to medical and non-medical personnel about implementation of the health care quality assurance program.
- Orientation of the incentives systems and workforce policy towards encouraging quality-assured health care delivery to people.

The biggest expenditures needed to address health care quality assurance should be planned to the introduce defect-free health care technologies and encourage quality performance rather than to provide expert assessment. Major attention should be paid to the identification of low health care quality causes, which are related to the inadequacy of the technologies at health facilities. For this purpose control of the technological process should be provided through identifying deviations from the standards. This allows identifying potential problems before they lead to unsatisfactory results, which are to find the causes for deviation from standards and to make necessary corrections in the health care delivery process.

It is necessary to consider the fact that the majority of health care technologies include tens and hundreds of individual manipulations and procedures, each of which changing under the influence of many variables. That is why only sophisticated statistical analysis methods, utilizing standard mathematical packages of applied programs for medical and financial data processing, will allow singling out factors actually affecting the decline in health care quality parameters from among multiple interrelated factors.

**Comparative analysis (profile development)**

**Informational support of the sector (data collection, analysis and dissemination)**

In accordance with the current requirements to health care quality it is necessary to analyze performance outcomes both of an individual doctor and of the overall health care system.

One of the up-to-date instruments of comparative analysis of performance indicators and health care performance efficiency of different health care providers (health facilities, doctors) is the development of profiles, that is conducting comparative analysis through obtaining relevant data.
The purpose of developing such profiles is to stimulate doctors to economically utilize services, to assist doctors in the evaluation and improvement of health care quality, to identify and improve the performance of the doctors demonstrating the worst outcomes, to provide health facilities owners with the opportunity to conduct ‘cost-benefit (effectiveness) analysis’.

It is proposed:
Activities of individual doctors, medical organizations are pointless if there is no way to compare them with the absolute performance norm, or with the performance of others. That is why the profile using system should play the most important role in the quality management and assurance process in the health care system of Ukraine. Profile development will make it possible to:

• do away with useless or inappropriate variants of health care delivery (identification of doctors prescribing certain procedures much more often and much more seldom than the average level; to create conditions indicating the prescription of the relevant procedure; to inform doctors about the performance outcomes of those doctors whose practice is considered adequate);
• to increase the general level of health care (to provide training for doctors in necessary procedures — for example for family doctors in some procedures performed by gynecologists, which will reduce the number of referrals outside physician’s practice);
• to do away with unacceptable performance (if it is revealed that some doctors’ performance is below the accepted level, the term contract with them may be not renewed).

As was mentioned above, profile development needs objective and quite detailed data. That is why without the revision of the informational support system implementation of neither comparative analysis, nor other instruments and mechanisms of quality management is feasible.

Creation of quality management and assurance system needs structural reorganization, adjustment of the funding system, development or adaptation of standards and criteria, implementation of the automated informational, expert-analytical systems and the creation of a common informational environment. This system must help administrative bodies to direct health care activities to meet the community needs for quality and safe health care, ensuring control of the outcomes, promoting establishment of interface and coordination between state and public structures in the area of ensuring adequate community health level.

Creating organizations (structures) to manage health care quality

It is proposed:
Department for Licensing, Accreditation, Standardization and New Health care Technologies created at the MOH, Ukraine Department of Health Care Administration may become the governing body of health care quality management at the state level. It could bring together the efforts of practitioners, health care managers, workforce specialists, representatives of the medical associations and consumer rights protection organizations in the area of developing clearly defined strategy and policy for health care quality improvement in Ukraine. Main objectives of this department should include organizational and methodological support for the licensing, accreditation, standardization and implementation of new health care technologies processes considering international experience and national features. Creation of such a department will allow managing the process of development and approval of quality indicators (criteria), regulating documents pertinent to health care quality assurance, licensure provisions, procedure of state accreditation of the health facilities, development of new and evaluation of the existing technologies and standards of the diagnosis and treatment process (clinical pathways).

At the level of regional health care administrations and of Kiev and Sevastopol oblast state administrations it is expedient to develop a separate Department (or division) for Licensing, Accreditation and Standardization, which will be implementing the strategy and policy of health care quality improvement at the regional level.

At the level of health facilities it is expedient to create at individual departments autonomous quality teams ("quality circles" in Japanese terminology) gradually phasing out the multilevel
quality control system.

Significant improvement of the departmental (internal) and outside quality control can be accomplished only by participation of civil professional organizations (associations) and, after the development of the national strategy and policy in the health care quality improvement sphere. A number of national conferences (seminars) on the health care quality improvement issues should be held under the leadership of the Ministry of Health. Development and implementation of the training programs and certification of accreditation boards’ experts remain a critical issue, which needs to be immediately solved.

Implementation of the evidence based standards of diagnosis and treatment and organization of patient-centered health care delivery

Standardization of medical practice and its organization is important for health care quality improvement, being oriented at the transition from the intuitive or stereotype practice towards the evidence based one, to make the treatment and prevention process outcomes less dependent on the individual features of a health care professional (primarily the inexperienced one or with low level of expertise), but based on the current advances in medical research.

Today the efforts of many researchers and practitioners are focused primarily on the development of technological standards for different diseases. At the current stage of development technological standards are viewed as the guaranteed provision of the currently optimum treatment to any patient with the diagnosed pathology in order to achieve the best positive outcome.

Proposals:

First of all, while developing national health care standards there is a need to take into account professional standards accepted in developed countries (the so called “golden standard”). At the same time the implementation of high medical technologies should be balanced with financial resources of the health care system and should not be in conflict with the community health maintenance goals.

Leading international specialists working in the area of quality assurance give preference to such clinical decision making methods as algorithms. Algorithm assessment is specifically valuable in the case of nonspecific symptoms, such as chest pain, abdominal pain, back ache, cough and the like.

Algorithm rationale forms the basis of the so-called clinical pathways- a form of the health care standardization, currently considered the most effective one.

A clinical pathway is a concurred in time process of diagnosis and treatment of a patient, which encompasses a whole set of necessary health care elements, including patient care, patient education and the like. Clinical pathways offer a method of analysis of the typical course of treatment in any nosology to doctors, the purpose of which are both maintenance and improvement of medical care quality, and the impact on its efficiency and effectiveness.

Clinical pathways are developed for each individual disease entity considering its clinical development and include a set of the types of medical care needed: out-patient and hospital care and rehabilitation services. The probability of complications and the need for additional interventions are also taken into account. The choice of medical technologies takes into account the baseline condition of the health facility assets, availability of workforce, financial, material and intellectual resources and organizational methods of performance. A detailed set of diagnosis and treatment procedures and medications (technology of the diagnosis and treatment process) is formed on the basis of alternative medical interventions comparison using the criteria of clinical and economic (cost) efficiency. Effectiveness analysis allows to select the most appropriate healthcare methods and technologies and to prove evidence-based necessity and substantiation of these or those types of health care and of specific interventions.

In contrast to medical and economic standards (needed to control health care costs and pricing of health care service) existing in many countries, clinical pathways should be developed based on the Evidence-Based Medicine principles.

The main differences between clinical pathways and medical standards (quality standards)
Key strategies for further development of the health care sector in Ukraine

being used by national health care, lie in the following:
1. Services are chosen on the basis of cost comparison for alternative medical interventions (based on cost effectiveness — the maximum outcome per unit of cost).
2. The set of diagnostic and treatment procedures is presented in the format of detailed technology of the diagnosis and treatment process with detailed specification of services and medications, the utilization of which is organized in time.
3. They are based on evidence of necessity and substantiation of every intervention included into the pathway.
4. The most practiced variants of clinical pathways include probability assessment of clinical outcomes associated with various medical interventions.

Presentation of a clinical pathway is not limited to a table (chart) format only. It may be supplemented by decision-making algorithms, explanations and recommendations regarding selection of alternative interventions.

A combination of algorithms, clinical pathways and instructions related to a certain class or group of illnesses is called **Clinical guidelines**. The majority of health care professionals believe that clinical guidelines only provide the most up-to-date and complete coverage of approaches to standardization in medicine.

Clinical Guidelines (CG) are intended for practitioners and serve as an instrument allowing transformation of research results into recommendations on the best practice as the basis for health care quality improvement. However, according to a research conducted in Russia at the World Bank initiative, demonstrates that the results of the activities of many authors engaged in the development of CG (professional associations, medical professionals of the national and international levels) are very ambiguous; ranging from well-developed CG, basing on sound evidence, to those which base on the ideas or experience of individual experts [1,2,3]

The abovementioned information allows recommending **the following procedure of up-to-date medical standards development** for implementation in Ukraine:

1. Determine the group of illnesses for which standards are developed.
2. Study the current technical and technological resources of health facilities and their divisions, which treat particular illnesses.
3. Study research literature to identify the most effective medical technologies and medications for a specific illness.
4. Develop diagnosis and treatment algorithms based on the results of randomized, placebo controlled prospective trials, conducted according to Evidence Based Medicine principles.
5. Assess different variants of effective interventions on the basis of outcomes and costs comparison, typical equipment and resources of health facilities.
6. Develop clinical pathways, instructions and explanations to them.
7. Develop a clinical guideline.

In developing Clinical Guidelines and assessing their effectiveness, it is necessary to use international standard AGREE (Appraisal of Guidelines Research and Evaluation or questionnaire on the evaluation and appraisal of Guidelines), which is a strictly structured methodology for the development of such documents [1].

Medical practice, which makes use of technologies with evidence-based effectiveness, was entitled Evidence Based Medicine. Its utilization will allow improving both quality and economic efficiency of health care, and using limited healthcare resources more effectively [2,3]. Underestimating the role of clinical epidemiology and evidence-based medical practice — is today one of the most serious barriers to Ukrainian healthcare reform, no less important than funds deficit or obsolete equipment (Insert 13).

Clinical epidemiology convincingly confirms that not all medical interventions are effective and that their effectiveness can be best evaluated with outcomes [5]. As was already mentioned, standardization of all intervention schemes and medical technologies — is a positive process, however actual the national standards often include recommendations, which are not evidence based, but reflect the views or the experience of their authors regarding the effectiveness of certain medical interventions. If the standard of medical process quality is formed by doctors
or even by scholars in the absence of reliable evidence of its relevance to health improvement, then adherence to the standards potentially acquires formal semblance without any real impact on the community health, this leading to waste of time and money. Existing differences in the health care delivery approaches, which cannot be explained by patients’ needs and which are not associated with respective changes in clinical outcomes, shifted the focus to the issue of evaluating the clinical effectiveness of different interventions in selecting priorities and development of health care standards.

**Stages of the health care quality assurance promotion**

Promotion of a quality assurance system requires structural reform, adjustment of the financing system, development or adaptation of standards and criteria, implementation of automated expert-analytical systems, formation of an informational system according to the common informational environment principles, training and retraining of medical and technical personnel, which needs certain resources and time. That is why it is expedient to reform the health care quality assurance system stage by stage [2,6].

**At the first stage**, it is proposed to create, on the basis of the Ukrainian Department for Health Care Organization of MOH, the Licensing, Accreditation, Standardization and New Health Care Technologies Departments, in order to create in Ukraine a national policy of health care quality improvement. This department will ensure organizational and methodological support of licensing, accreditation, standardization and implementation of new medical technologies taking into account international experience and national specificity. The establishment of this department will allow managing the development and concurrence of quality indicators (criteria), regulations in the area of health care quality assurance, licensing conditions, procedure of state accreditation of health facilities, development of new and evaluation of existing medical technologies and standards of diagnosis and treatment (clinical pathways).
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At the first stage it is envisaged to:
• develop and have approved a national health care quality improvement strategy;
• create standing working groups consisting of the leading professionals to develop and approve the uniform methodology in medical standards development based on the international standard of Clinical Guidelines development AGREE (Appraisal of Guidelines Research and Evaluation or the questionnaire on the expert assessment and appraisal of the guidelines);
• adapt the existing and develop the up-to-date medical standards (clinical pathways and Clinical Guidelines), to evaluate the effectiveness of health care technologies, to coordinate the indicators (criteria) of health care quality;
• establish an informational Evidence Based Medicine Center in Ukraine;
• create conditions for a health facilities operation irrespective of the type of its ownership only on the basis of a valid license for clearly defined types of health care;
• improve licensing provisions and licensure process to make it transparent and to allow participation of the professional associations representatives and the public in it;
• increase objectivity and efficiency of the state accreditation process through setting up a body of accreditation boards experts with the relevant training and certification and involvement of professional associations and public representatives into this process;
• revise and improve accreditation standards;
• develop qualification aptitude criteria based on the assessment of performance outcomes and have them approved at the national level;
• equip health facilities with computers with the data collection and data analysis software;
• organize specialized retraining for the midlevel managers of the administrations and health facilities as leaders of quality improvement programs or consultants-specialists.

At the second stage it is planned to develop a typical health care quality management program for health facilities utilizing forecasting skills and modeling, coordination of all the levels ensuring the required level of quality, which will enable to conduct performance outcomes analysis both for individual doctors and for the overall healthcare system. The “cost-benefit” assessment will form the basis for evaluating managerial decisions. At this stage there is a plan to implement quality management programs at health facilities of all types of property and to conduct comparative analysis (performance profiles development).

At this stage it is expedient to review typical equipment inventories for the health facilities in order to bring them closer to rational medical standards.

At the third stage, we propose to implement a system of health care professionals’ licensure and accreditation (certification) with mandatory participation of the medical community and patients, and with a subsequent complete transfer of these functions to the non-governmental professional organizations.

Literature for Section 6.7
Section 7
POSSIBILITIES OF DEVELOPMENT OF THE HEALTH CARE INFORMATION TECHNOLOGY

Attempts to reform the health care system require integrated, effective information systems that provide exact and relevant information, in a timely manner. Such systems are an integral part of any decision-making process.

Information policy priorities in the health care sector include the:
• Modern communication capability.
• Determination of real information needs at all levels of health care management, medical workers, citizens, and executive state bodies
• Information exchange between various levels within the health care system
• Adoption of European and international protocols and standards for interoperable health care information systems.
• Identification of priorities in developing an information technology plan.
• Integration with the European and global health information infrastructure, allowing access to resources from a wide spectrum of information services.

7.1. Increasing Efficiency of Information Provision through the Introduction of Accounting Systems

Health care reform must be based on real informational needs and should promote the strengthening of such aspects in health care system, as:
• Management of available resources;
• Resource allocation planning;
• Coordination of medical, management and financial staff actions [7].

Management accounting and control is becoming increasingly important both for the entire health sector and for individual health facilities. The introduction of management accounting helps to ensure management effectiveness and mitigates difficulties arising when the needs of managers for decision-making change [8]. Its value lies in enabling managers to receive objective information for making a decision based on methods of limited resources management. In addition, it provides committed workers with information and knowledge. Accounting information is utilized by many users, including decision-makers, official authorities, citizens, managers, ordinary employees, fund-holders, investors, banks, tax inspectors, etc. The general accounting scope can be divided into three subject areas, each of which corresponds to the needs of various decision-makers:
• management accounting, including cost calculations;
• financial accounting targeted to consumers of accounting information;
• tax accounting [2].

Management accounting consists of the following components:
1. Budget calculation.
2. Estimation of costs and pricing.
4. Self-repayment and profitability.
5. Internal control [5] (fig 7.1.)

Budget development, cost estimation, management of case profiles, and basic productivity analysis are closely inter-connected and are more useful when used in combination in an integrated decision-making environment that contains clinical, as well as financial information. The main role of management accounting
Key strategies for further development of the health care sector in Ukraine

in health care lies in the determination of financial risks and possibilities from a short-term prospective. The current budgets of health care facilities are developed using activity data of previous years.

**Budget development requires:**
- analysis of previous years data in order to forecast specific resource requirements;
- analysis of spending, which depends on the amount of care, price, and productivity;
- monitoring of indicators of health care volumes, productivity, and quality of services in order to be sure that the budget is used effectively [4].

The budget must represent a strategic plan based on actual resource needs. For example, a decision to make a contract for the provision of a health care service package to employees is strategic by its nature, but more obviously requires a forecast of expected financial and operational results to assess the real resource needs for this strategic choice. Management accounting information is also instrumental in the development and analysis of a capital budget.

**The compensation and pricing** analysis provides a comparison of spending with compensation (or remuneration) and is important for understanding how to use the limited funds optimally.

Compensation is the method through which doctors receive remuneration from budget payers, insurance companies, and other fundholders. Management operations information may be a basis for pricing and developing a medical care package contract with enterprises or adequate payment from fund-holders. Apart from that, management accounting can be useful for such purposes, as:

- forecasting and evaluation of alternative pricing methods;
- identification of previous payment rates;
- comparison of profits and losses in all payment areas, in the light of factual expenses [4].

Productivity management and cost control have to be focused on self-repayment and profitability. This means that accounting information can be used for the analysis of correlation

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Fig. 7.1. Management Accounting Components
between services that are produced (results) and inputs (costs) into the health care process.

*Medical statistical accounting* must be based on real needs and not on the fulfillment of administrative tasks. It must foresee also the management of clinical cases and clinical service groups. Management of a clinical case is a set of logical steps of medical and service provision processes to the patient that is served from day to day in medical facilities. Management of clinical service groups is one of the typical ways to use management accounting information in those cases that are specialized in some particular group of services, for example, gynecological, orthopedic, etc.

*Internal control* includes the coordination of methods and measures created in a health care facility to assess the reliability and exactness of pricing data, improvement of effectiveness and productivity, and to assess a developed management policy.

Internal control pursues three goals. First, it increases the probability of receiving better results from decision-making. Second, it confirms the validity of reports to other organizations according to existing laws. Third, internal control is also focused on the prevention of fraud, or at least on its quicker detection.

In order to achieve these three goals, control procedures must be put in place in all key spheres of that health care system, which influence clinical and financial success of the health care structures in the context of both internal and *external control*.

It is worth adding that management accounting information may flow horizontally, in addition to supporting vertical decision-making structures [4].

A horizontal flow of information allows individual medical structures to compare their activity with other similar structures. In the same way, departments within medical structures can compare their costs for a bed-day, or of visits. This serves to evaluate whether there is enough staff, medical supplies, or medicines for the number and type of services that are provided.

Vertical support can be characterized as support for decisions at the level of regional or national authorities in the health care sphere and the ability to provide support to decision-making within the corporate structure for (e.g. between high and middle levels of managers). This infrastructure, which is based on management accounting, provides objective information intended to improve the capability for health care managers in making sound decisions.

The problem in Ukraine lies not so much in the application of a management accounting system and in health care services price management, but in particular approaches to using them in the best way, and to who exactly will take responsibility for their implementation. In turn, the application of data in the management of price categories for health care services requires that basic requirements be met. First, all data must be complete, specific and mean the same thing for each health care facility that uses it. It is not anticipated that it would be necessary to change or modify the data provision forms.

Coding of medical is recommended; however, there must be a direct connection between codes for conducted procedures and payment for provided health care services (with the exception of systems that foresee the payment based on the number of patients served). Even though this does not exclude cases of misuse or frequently used upward distortion of data, such accounting will help create a general picture of medical and economic health care process constituents.

Data that are analyzed must also be directed and received for a considerable period of time. [7]. To deal successfully with information data it is necessary to decide on the type and form of accounting and report documentation of health care structures, and its correspondence to the abilities of automated medical information systems (AMIS) [1, 6].

The majority of managed programs on provision of health care services use *reports containing information about individual doctors*. Such reports may contain data on doctors, for example of primary health care, that directly examine patients or act as coordinators of medical work. They also may contain information concerning organization of population health status support or organization of priority health care service providers.

Reports on the activity of individual doctors have to be treated with certain prudence. The manager has to evaluate the situation in a wider
context than simply on the basis of provided data. The manager always has to think about reasons that motivate the doctor to act in a such or different manner [1].

Service reports (or reports on health care service providers) show the work of a medical structure through listing of different forms of health care service provision (for example, hospitals or consulting doctors). Reports that reflect activity of such structures (also called “sellers of health care services”) are extremely useful in negotiation of contracts with individual service providers and for the organization of control over the use of resources. Such reports also help detect weaknesses or strengths of the program in general [1].

Reports for buyers of health care services contain information on the frequency of service use by clients in a given medical program. For those programs that conduct the assessment of applications, such a type of report is necessary for planning of actual price levels of services proposed.

Reports on medical service utilization can be divided into two categories: daily registration and short monthly reports. At present many medical service programs use an automated system of medical service use management. Besides the preparation of reports, those systems allow receiving through a computer network much bigger amounts of information than could be provided in a printed report. For example, a journal of daily registration of the use of medical services is a necessary form of report documentation for each health care program. This document is an integral working instrument for the nurse responsible for management of health care service utilization and for managers to manage adequately the use of facility resources.

With regard to out-patient services, daily reports are essential as part of medical service use management. It should be mentioned that current control over the use of out-patient services is applicable only to strictly controlled medical service programs. In general, control over the use of out-patient services has to be provided through monthly reports.

It is noteworthy that systems characterized by open access to health care services or medical programs, in which the model of doctor-manager (gatekeeper) of primary medical care is not used, are characterized by a set of specific problems connected with the maintenance of control over the use of hospital and out-patient services. The individual workload of each doctor that could be used as a starting point for analysis cannot be determined in the case of priority health care services provided by the organizations and also, in terms of managed programs on insured compensation of medical services. In the organization models of population health support, in which open access of patients to specialists is practiced, specialists may independently resolve issues of repeated admission of a patient or of a referral to another specialist consultant. In this case, it is impossible to determine the level of consultants’ service utilization according to a calculation of the number of serviced patients. Such a calculation can be only done with regard to the primary health care doctor, but it is impossible to do the same with regard to specialist consultants [3].

In such cases, only relatively unreliable data on counseling services and specialist consultants involvement would be available. Reports should contain data only on the relevant control over the work of primary health care doctors and consultants.

Profiling of health care services providers implies the comparison and analysis of data on health care services providers, with the help of a parameters (characteristics) list. The process of profiling should be applied widely. However, its main purpose is to select health care services providers for working in health care facilities, based on whether a given institution corresponds to the strategic directions and goals of this program. In addition, profiling may be applied to the selection of specialist doctors, which the health program anticipates using as consultants. This provides feedback to the consultants and gives specialist doctors the opportunity to assess independently the extent to which their work meets the criteria and requirements of a health program (see also sub-section 6.7, Current activities for assuring of health care quality).

Profiling helps avoid cases of misuse on the part of health care providers. It further identifies ways to implement the program of management of available resource utilization, to develop remuneration principles based on delivery of
services, and also to conduct economic modeling of the health care system. Initially, the profiling principle of private doctors (individual health care providers) was only used for in-patient practice, although lately profiling has been applied to out-patient treatment. This is due to the realization that the medical process is a continuum and not simply a set of differentiated episodes. In many cases, the profiling process implies comparison of health care delivery by service providers with well-known norms. It is noteworthy that profiling of medical service management needs not be limited solely to the managing branch. The establishing feedback relations with all providers of health care services is an integral part of the management process in general.

In summary, the application of information management and technology at the health care system must be specific, understandable, clearly presented, and most importantly, it has to be realistic.

7.2. Implementing Information Technologies in the Health Care Sector

It is well-known that in European countries, new information technologies in the health care sector lead to significant changes. Modern approaches are targeted on “electronic health care protection”, that is a description of procedures and services of the health care system that are available on-line [1, 4, 5, 9]. Among these services there are “electronic versions” of procedures that at present are completed manually (Insert 14).

New technologies can be used to provide doctors and patients with up-to-date information, as well as streamlining communication between hospitals, doctors and providers, such as pharmaceutical companies [3]. Besides the simple transition from manual to electronic processes, the concept of electronic health care also includes a significant reorganization of most relations typical of modern health care systems and also leads to changes in patients’ attitude towards their personal health and life-style. Electronic health record technology makes available information on the health status of a patient at any time and any place, and provides health care providers and patients with access to an almost unlimited flow of information [6].

An electronic health care system gives more opportunities for choosing when and where patients can be treated. Complete information on services available at health care facilities is available, which provides patients with necessary information. Furthermore, the system raises the population's awareness about health care by providing information on healthy life-style choices, such as the importance of physical exercise and having a nutritious diet [2].

Findings of a research conducted by the Harris Interactive company in the United States in June 2002 showed that 110 millions of adult Americans were using internet to get access to health care information. In 1999 the Planet Medica Goldman Sachs company published a report that showed that by 2005 55% of Internet users living in Europe will have used use Internet to receive medical information. This leads to well-informed and demanding clients of health care services. Search engines such as Google or Yahoo provide a long list of information sources dedicated to medical or around-medical topics. Therefore, at the present time the Internet is one of the main instruments of medical information dissemination. This information is provided by health care financing organizations, pharmaceutical companies, patients’ support groups, and medical facilities. On a wider scale, the Internet is becoming the main means of communication between government authorities and the public [1].
Just as in other areas in society, the Internet and information technologies provide opportunities for the health care sector to reform traditional organizational structures and developing new relationships. In a system of electronic health care protection, the patient becomes the core of the health care process [6]. A knowledgeable patient will take a more active role in choosing methods of treatment and will have an opportunity to participate in an informative dialogue with the doctor. This will become the driving force for future development in the health care system.

An electronic health care system can provide significant advantages to citizens, health care bodies, and government institutes:

- Reduction in the number of patient–doctor visits through preventive health care on the part of patients.
- Streamlining medical decision-making.
- Creation of a common aid system for overtime treatment and emergency care.
- Integration of the health care system, ambulance, and social security provision.
- More reliable information on the comparison of different treatment methods, leading to improvements in the quality of care.
- Reliable information on the management of clinical and administrative activities.
- Greater flexibility in the allocation of human resources and the number of beds in health care facilities [6, 7].

A certain level of opposition to such significant changes in the health care system is anticipated. These changes will impact the entire health care sphere and its relationship with patients. The Internet will play an important role, in that. It will help promote the necessity of these changes and the opportunities offered by them (Insert 15).

Internet users have a great demand for information on medicine and health care. In the past, health care professionals frequently neglected the potential opportunities of the worldwide web. Furthermore, the unreliability of information from many of health-related web sites produced an impression on users that this was the quality of all worldwide web health care resources. However, currently a number of different countries and medical associations are developing useful and reliable web resources [8].

Information and network technologies may change the system of health care protection by reforming it to a system which is integrated and oriented to the needs of patients. In such integrated environments, specialists would be able to use tele-health technology to remotely plan treatment course, make prescriptions, assign analysis and receive their results without delays. Doctors would receive common access to information about patients, that is constantly updated through secure networks. Health care facility managers would have more reliable financial and clinical information, which will help them use available resources more effectively. A reliable and interoperable system for information exchange would enable effective health service planning, without the constraints created by organizational barriers. Patients would be assured that all medical specialists involved in their treatment would have access to the latest information concerning their health. In addition, patients would be able to receive health information via telephone or the Internet and make appointments to visit a doctor 24 hours a day [4].

To take advantage of the opportunities offered by electronic health records, health care facilities require a standard basic information infrastructure. Everyday administrative processes should be automated and provide information for integrated decision-making. Information technology planning should take into account the development and common use of information standards. The adoption of the SNOMED (Systematized Nomenclature of Medicine, http://www.snomed.org/) and HL7 (Health Level 7, http://www.hl7.org/) technological standards is imperative.

Standardization of data and messaging protocols will permit the creation of a single source of information on every patient, to which authorized users of the system will have secure access. This contrasts with the present situation, where a doctor may not have any access to information about previous treatment methods and medications that were prescribed to the patient. A unified database system will provide the opportunity to conduct clinical and administrative activity at a national level within the health care system. Information contained in a patient’s case history is confidential and rigorous security
and authentication protocols must be implemented to safeguard the patient’s right to privacy.

In summary, to meet abovementioned objectives it is necessary to create small, easily managed administrative systems, providing data standardization within the framework of separate health care branches. Then, gradually these systems should be combined into a All-Ukrainian health information system.

**Introduction of changes in information management within the health care sector:**

- develop a concept of a health care information system;
- identify a information needs of each level and branch of the health care system;
- identify a list of indicators, according to the medical classifications, that is to be used to profile health care service providers;
- elaborate and introduce a management accounting system;
- adopt accounting and report documentation according to real needs;
- substantiate and elaborate detailed plans for a health care information system;
- develop a strategy for integration into the European and global information infrastructure and to conduct the necessary modernization of the current information and communication infrastructure with the health care system.

**Literature for Section 7**

Section 8

LEGISLATIVE FRAMEWORK FOR FURTHER HEALTH CARE DEVELOPMENT AND REFORM

Ukrainian legislation in the health care arena consists of a bodies of civil, administrative, and criminal legislation, which are designed to protect social and individual rights to health care. The legal framework is characterized by a relatively high level of systematization and an enactment codification, which take into account the key international requirements of codification legislative acts and by-laws passed by the governmental executive bodies.

On the whole, despite certain drawbacks, it is suitable for the realization of a multisectoral state health care policy. This conclusion holds at least the majority of roles played by legislation in health care policy and primarily, for the legislative prohibition against activities harmful to human health; legislative approval of programs or services to protect or improve population health; legislative solution of the majority of ethical issues emerging in the health care delivery process; and legislative determination of at least the main principles of public health care system financing in a broad sense of this concept.

It is difficult to deny that declared in the national legislation of Ukraine are principles and approaches to the political and moral aspects of public health care, which basically meet the norms of international law. However, the fact remains that the implementation of many laws already adopted in the Ukraine needs cardinal improvement. Also there are shortcomings in those parts of legislation which deal with financing and administration in the public health care sector.

It has been emphasized several times that Ukrainian legislation created formal conditions to start a gradual transition from the integrated command and administrative model of financing and administration in the health care sector to a contractual model, based on regulated market principles, social entrepreneurship, contractual relations, and a high level of health care providers’ autonomy. Despite this, there exists an entire range of legal issues related to ensuring actual realization of these principles. There is a paramount need on the part of both the Parliament and the Ukrainian Government to address these issues. Initially, a legislative framework should be adopted for increasing the level of health care system financing, the use of up-to-date strategies to control expenditures, effective distribution of resources, improvement of health care services quality and accessibility, and increasing the role of the public in the policy development process and administration.

With regard to further developments of the legislative framework for the health care system, the highest priority is the need to accelerate the choice of a health care financing model — a political choice between a system of contractual state purchases of health care services, which is financed through general taxes, and a system which is financed through social health insurance.

Further structuring of the health care system, as well as the nature of the administrative and financial authorities of the key participants in this system, depend on whether this issue is resolved. In addition, the prioritization of other legal and practical aspects of health care reform cannot proceed until the funding model has been established. In particular, the incorporation of appropriate changes in the Budget Code of Ukraine, in the Laws on Local self-government and on Local state administrations, as well as in numerous by-laws regulating the structure and authorities of the Ministry of Health and local health administrations depend on the funding model. It should be emphasized again that once either of these two models is selected, it is expedient to ensure the generation and accumulation of funds to finance the health care system at the regional level (either at the level of current health care administrations and those modified with the purpose of performing new functions, or at the level of regional branches of the voluntary medical insurance fund) through the adoption of necessary regulations and laws. The expedience of this approach and the implementation of a “single payer” on the regional level as was detailed in Section 6.1 above.
Other activities related to the development of the necessary legislation are universal by their nature and a prerequisite for both the funding models. The highest priority are the reforms directed towards strategies to control expenditures and an effective distribution of health care system resources.

Measures on the development and improvement of legislation in the sphere of health care should envisage:

**A. On the part of Verhovna Rada of Ukraine:**

1) effect changes in Constitution Article 49 in order to ensure effective regulation of the scope of state guarantees in the sphere of free health care provision to people (by determining the basic package of the free health care services either through establishing it by a law or by a Governmental decision), as well as the effective planning of the network of state owned and communal health facilities;

2) effect changes in the Ukrainian Framework Legislation on Health Care in order to define the concepts of “health care/medical service” and “health/medical care” at the legislative level; use international approaches to define these concepts and eliminate unjustified contrasting of these concepts in explaining and application of the legislative regulations;

3) develop and approve a separate special law on the organization of health care delivery and health facilities or make changes in the Ukrainian Framework Legislation on Health Care to determine in detail the process of health care delivery at all levels (primary, secondary and tertiary), the performance of economic activities by the health care service providers (either individual persons or legal entities), and the order and methods of payment for the activities of different providers taking into account the transition to the system of contractual state purchasing. Among other things, these legislative changes have to envisage the implementation of the “gatekeeper” principle when one is seeking secondary or tertiary health care, as well as determination and approval of clear criteria for in-patient care, hospitalization, and discharge of patients;

4) effect changes in Ukrainian Framework Legislation on Health Care, which would lead to the conclusion of labor agreements between the administration and health care professionals within the contractual format. This will promote the creation of a truly effective and complete contractual model of financing and administration in the health care delivery sector, with remuneration for health care professionals based on the quality of their work;

5) review the expediency of introducing changes to the Economic Code of Ukraine, aimed at providing special regulations for the purchasing of health care services;

6) effect changes in the Budget Code of Ukraine, aimed at mutual settlements between the budgets of the territories in case of unplanned health care delivery to citizens, who are not permanent residents of the territory providing this care at the expense of its budget (assuming a budget financing model is retained);

7) introduce an earmarked tax on the sale of commodities harmful to health (tobacco and alcohol products) and allocating the revenues to funding national health care programs;

8) retain in the process of further tax legislation development (including the adoption of a Tax Code) the existing exemptions regarding VAT on the delivery of health care services within the scope of state contractual purchases and medical commodities. In addition, income tax credits for the payment for health care services will promote private spending on health care by the high income groups of the population. This will reduce the burden on the public health care sector and will save resources for those who cannot afford for care;

9) develop and adopt a legal framework for self-government within the medical profession, with the transfer to the latter of a number of the regulatory functions now currently belonging to the state (for example, some aspects of quality control of health care services, issue of permissions for health care procedures, adherence to medical ethics, development of health care standards, and the process of accreditation of health care providers).
B. **On the part of the Cabinet of Ministers of Ukraine, Ministry of Health, Ukraine and other relevant central executive power bodies:**

1) develop and approve a common uniform catalog of health care services;

2) develop and approve a common uniform method to assess the health care services cost;

3) develop and approve of the state fixed or regulated prices for health care services, which should be used during state contract-based purchases of health services;

4) develop and approve a model or tentative statute of public non-profit health facilities;

5) develop and approve model or tentative agreements concerning state purchases and provision of health services within primary, specialized out-patient, and in-patient health care. This would include unified specifications of services to be provided at different levels of health care, as well as approaches to determination of payment methods for these services and criteria for providers’ performance evaluation;

6) revise health care standards approved by the Ministry of Health in order to bring them in accordance with the principles of Evidence Based Medicine and ensure implementation of the Clinical Guidelines based on the above-mentioned principles;

7) taking a number of decisions aimed at an effective implementation of rational pharmaceutical policy principles to the practice of the principles of rational pharmaceutical policy (in correspondence with the WHO recommendations for National Essential Drugs and Medical Commodities List and state registration of medical commodities prices, which are included in the list);

8) revise the enactment of Cabinet of Ministers of Ukraine and Ministry of Health which impedes the implementation of cost-control strategies in the health care sector (e.g. staffing norms for state owned and communal health care facilities are based on the number of beds, etc.);

9) make appropriate decisions to ensure social demand for the profession of a health care manager and provide appropriate employment guarantees for representatives of this profession. This would include introduction of this profession into the Nomenclature of Professions and the State Catalog of Professions. The level of mandatory professional-qualification required to obtain this position within the health care system should also be defined.

Moreover, there are a number of changes — both instructive and methodological by nature — to the economic and legal status public health facilities which might significantly promote this accelerated implementation of new fiscal strategies in the health care sector. These include the implementation of a purchasing policy, developed by the Ministry of Health, possibly in conjunction with other relevant central executive power bodies, such as the Ministry of Economy and European Integration, Ministry of Justice, Ministry of Finance, and the State Tax Administration.
Section 9
RECOMMENDATIONS FOR UKRAINIAN GOVERNMENT ON THE PLAN OF ACTIONS TO IMPROVE THE HEALTH CARE SYSTEM

The socio-economic development of Ukraine at this stage is accompanied by difficult conditions within the public health care system. Deteriorating living conditions of the majority of the population, along with both inadequate funding and endemic inefficiencies within the health care system are leading to an increased rate of general mortality of the population in practically every age group and from all the causes. In addition, life expectancy is decreasing and there is an increased morbidity from both non-infectious and infectious diseases. The rate of infectious diseases such as TB and syphilis — almost forgotten until recently — is growing dramatically. New threats, such as the rapid spread of HIV-infection and drug use have emerged alongside older problems. Natural population decrease rate in Ukraine is the highest across the European continent.

Major increases in medical care demands are occurring with the context of very limited financial resources available to the public health care sector. This results in a significant burden of health care spending (over 50%) that falls on the people’s shoulders, with a large proportion of under-the-table payments. The existing system of health care, grounded predominantly on the old soviet principles, is not capable to adequately respond to the challenges brought by this changing environment.

Major problems of the current health care system in Ukraine include:

• Focus on addressing the sector’s needs, instead of meeting the medical needs of people.
• Inadequate funding from public sources.
• Inefficient utilization of the available health care resources.
• Lack of transparency and equity conditioned by broad-scale under-the-table payments.

The goal of the reform is an evolution of the health care system, based on equality and solidarity, to respond in a timely fashion to the well-grounded and socially meaningful medical needs of the population and to ensure fair and efficient distribution of funds.

Given the abovementioned goal and taking into consideration the strategic national priority for European integration, the following should become realistic principles for the health care system in Ukraine:

• Equity (fairness)
• Solidarity
• Focus on public health improvement
• Focus on meeting fair needs of the population
• Focus on improving health care quality
• Efficacy
• Effectiveness
• Public participation in healthcare policy development.

PRIORITY AREAS OF REORGANIZATION

1. Reconciliation of the scope of state medical care commitments with the financial resources of the health care system, which envisages:

• Revise Constitution article 49 which stipulates that state owned and communal health care facilities provide health care of whatever scope to all citizens free of charge, or at least ensuring that the Constitution Court of Ukraine re-hear constitutional proceedings of the case regarding provision of health care free of charge, in the light of additional circumstances not considered during the previous hearing and make a decision on this case.
Key strategies for further development of the health care sector in Ukraine

1. Identify and approve health care priorities, based on the well-grounded medical and health needs of the population, cost and efficiency of medical interventions, political reality in the country, attitudes of the community, patients, healthcare policy makers and professionals.

2. Identify and approve the basic package of free medical services to be provided to people at the expense of public funding sources.

3. Identify the legal framework for the nature and scope of co-payments to cover the cost of medical care.

2. Structural reorganization of the health care services with the priority development of family medicine based primary health care, for which there is a need:

1. To transfer narrow departmental health care facilities to the community level and provide for territory-based integration of hospitals of various affiliation.

2. To intensify reorganization of primary health care based on general practice/family medicine. To accelerate the development of a network of general practices in rural and urban areas.

3. To change the procedure of forming the contingent of individuals to be served by a primary care doctor from the catchment area principle to the one allowing the patient to freely choose the doctor and conclude a contact between the patient and the doctor.

4. To legally vest a primary care doctor with the responsibility to organize the medical route of his patient, which envisages that general practitioner/family doctor should use a system of obligatory referrals (except emergencies) for a patient to receive medical care at a higher level (specialized out-patient or hospital care).

5. To initiate the reorganization of hospital sectors on the basis of functional differentiation of beds and the subdivision of the hospitals into facilities to provide: urgent care, elective treatment for chronic cases, recuperation and rehabilitation, and medico-social, including palliative care (hospices). This is to be accomplished by the consolidation of general hospitals where emergency care is provided, along with the formation of hospital catchment areas covering population of 100 to 200 thousand people. It will also be necessary to reorganize part of hospital facilities into facilities (departments) for chronic patients, facilities (departments) for provision of medico-social care (nursing homes), and hospices (in rural areas these will initially be the district and rayon hospitals; in urban areas these will initially be hospitals that could not obtain a license to deliver care in the scope required for acute conditions and dysfunction).

6. To conduct material and technical reorganization (reconstruction) of the in-patient sector of health care facilities, based on their intended subsequent use.

7. To gradually and prudently close some second-level specialized health care facilities, taking into account local needs and opening corresponding departments within general hospitals.

8. To concentrate hi-tech highly specialized care on a regional level.

9. To ensure the development of social support services and their accessibility, and to improve coordination between the health care sector and social sector.

3. Transition from an administrative and command model of health care services management to the provision of medical care on agreement (contractual) basis, for which it is necessary:

1. To develop uniform requirements of pricing and to approve a uniform means of determining the value of health care services.

2. To develop a catalog of medical services with specification of their basic cost and in accordance with Article 191 of the Economic Code of Ukraine to determine the government fixed or regulated prices for health care services, which are to be used when these services
are purchased in accordance with the procedure stipulated by the Law of Ukraine On Purchasing Commodities, Labor and Services for Government Funds.

• To develop a mechanism for contractual payment for medical services.
• To determine provider selection criteria to purchase medical services with public funds on the “best buy” basis.
• To develop and approve typical or tentative contract templates for buying medical services at the primary, secondary, and tertiary levels of health care.
• To change the organizational and legal status of health facilities from government budget funded to that of a state (communal) non-profit medical enterprises.
• To implement the mechanism of strategic purchases of medical services on a contractual basis.
• To switch from line-item budget funding of health care organizations to payment for services, depending on the scope and structure of the health care services provided. This is to be accomplished through the implementation of modern methodologies, aimed at the effective distribution of resources: capitation and capitation with partial fund ownership for the primary health facilities; global budget for hospitals.
• To implement a system of remuneration for doctors, and nursing and auxiliary personnel, based on the scope and quality of their work.
• To review the standing regulations (Ministry of Health orders, governmental enactments, etc.), which hinder or prevent reform. Examples include: standard staffing patterns, in particular the correlation between the staffing and the standard number of beds, procedure for the remuneration medical personnel remuneration, limitations on the utilization of specialty consultations.

4. Strengthening the financial basis of health care, for which it is necessary:

• To implement stage by stage transition from the system of government budget funding to the model of voluntary medical insurance. The first phase is to introduce changes to those aspects of the Budget Code of Ukraine, laws on local self-government and on local state administrations which concern financial authority in the area of health care. Management of regional budget resources and the purchasing of health care services on a contractual basis will be delegated to regional health care authorities through the creation within their structure divisions for planning health care delivery and managing financial resources. The second stage is to have the Law of Ukraine On social medical insurance passed with the introduction of an earmarked contribution or with the dedication of a certain share of the unified social contribution to the needs of voluntary medical insurance. This requires the creation of an infrastructure for social medical insurance.

• To foresee the introduction of a target tax concerning tobacco and liquor, or the deduction of a target portion from excise duties on these commodities for health care needs.

• To develop and implement in the health facilities appropriate interoperable information systems to ensure patient tracking, calculation of the value of medical services, records and reports for medical statistics, and for operations management of the health care sector on both the macro- and micro levels.

5. Developing a system to ensure and support healthcare quality, for which it is necessary:

• To create a vertically organized system of health care quality management. This will be achieved through the creation at the MOH, Ukraine Department of Licensing, Accreditation, Standardization, and New Health Care Technologies and to set up Departments of Licensing, Accreditation and Standardization at the Oblast Health Administrations, and Kyiv and Sevastopol City State Administrations.
• To establish an Evidence Based Medicine Informational Center.
• To implement mandatory licensing of medical institutions, irrespective of the type of property.
• To develop in conformity with the international standard AGREE (Appraisal of Guidelines Research and Evaluation) a consistent methodology for clinical guidelines development.
• To adapt or develop in conformance with international requirements and to implement standards of diagnosis and treatment, as well as the organization of health care delivery (clinical guidelines) based on evidence based medical practice.
• To develop model programs of health care quality management for health facilities.

6. Implementation of a rational pharmaceutical policy at the macro- and micro levels, for which it is necessary:

• To review the National Essential Drugs and Commodities List and to add to it medications proven effective and safe, and effective for the treatment of the majority of infectious, chronic and surgical problems. The National List should be used as a basis for the state program, which guarantees delivery of health care services to people in accordance with the development of standards, treatment protocols, and clinical guidelines.
• To develop and implement on the basis of the National List formulary system for medication supplies to medical organizations. This will aid in the efficient and economic supply and utilization of medications.
• To develop a negative list of medications (i.e. those whose use is proven to be ineffective or harmful).
• To take measures to limit the unrestricted sale of medications in pharmacies and to implement prescription drugs, especially those, which are covered (entirely or in part) at the expense of public sources.
• To enhance the effectiveness of state regulation in developing a system of basic drug prices and mechanisms to ensure differentiated coverage of medication costs at the expense of public sources.

7. Implementation of an active human resource policy, for which it is necessary:

• To develop evidence-based projection of the anticipated need for medical professionals of different specialties, taking into account the trends and rates of structural and functional reforms in the health care sector of Ukraine.
• To provide advanced training for the primary health care professionals: family doctors, family nurses, and social workers.
• To create system to train professional managers, economists, analysts for health care agencies and facilities, who will share health care reform ideology, implement strategic and financial planning, and function as buyers and providers of health care services.
• To develop a system of social security measures, with priority given to a system for retraining those specialists who may become redundant due to staff reductions.

8. Managing healthcare reform:

• Make the Ministry of Health of Ukraine responsible for pursuing the policy of reform strategy implementation, conducting strategic analysis, prognostication, and monitoring developments.
• Organize educational activities for different population groups and health care workers concerning the goals and content of the reforms.
THERE IS A NEED TO ENSURE THE PACKAGE IMPLEMENTATION OF THE FOLLOWING KEY STRATEGIES

1. Change the organizational and legal status of health facilities from government budget funded institutions to state (communal) not-for-profit health care enterprises.
2. Ensure free choice of a primary care doctor by the patient.
3. Implement in accordance with legal framework to vest the primary care doctor with the gatekeeper function (organizer of the medical route of the patient).
4. Establish procedures to purchase health care services with public funds on a contractual basis.
5. Transition from budget line-item funding of health care organizations to pay for service funding based on the scope and structure of the medical services rendered.
6. Remunerate doctors, midlevel, and ancillary personnel of health facilities on the basis of the scope and quality of their work.
7. Revise the current regulations hindering or preventing the health care sector reform.
Key strategies for further development of the health care sector in Ukraine
Annex 1

REQUIRED SUPPORT FROM THE INTERNATIONAL COMMUNITY

| 1. Informing population, health professionals, and administrations about the reform through mass media (TV, radio, newspapers, etc), printed materials and Internet |
| Component Description |
| Health care system and health care reform. |
| Creation of system for informing on available health care services. |
| Advantages of a general practitioner/family doctor over physicians who specialize in certain fields. |
| Process of in patient and out patient health care optimization. |
| Public health care. |
| Project Inputs and Resources |
| Technical assistance in development, printing, dissemination of materials; creation of informational system; maintenance of an info center; training of specialists. |
| • Creation of an information center for population (MOH, State Committee on Television and Radio, Association of Health Professionals, NGOs ). |
| Main Measures, Legal Changes (Responsibility for Implementation ) |
| Improvement of population awareness regarding possibility to improve population health status as a result of the reform. |
| Output |
| Expected difficulties |
| Inadequate quantity of trained personnel (information technology specialists, sociologists, physicians, nurses). |
| Inadequate funding. |

2. Promoting healthy lifestyle and involving population in provision of primary health care

| Component Description |
| Determining activities with regards to implementation of healthy lifestyles. |
| Interdepartmental education on improving health of people (students, teachers, parents). |
| Organization of evidence-based self-help and mutual aid. |
| Project Inputs and Resources |
| Technical assistance for preparation, publishing and distributing printed materials on healthy lifestyles; for preparation, publishing and distributing materials on self-help and mutual aid. |
| Main Measures, Legal Changes (Responsibility for Implementation ) |
| • Restarting work of the whole vertical of healthy lifestyle facilities (Health Centers) (MOH, Ministry of Education and Science, Ministry of Family and Youth, Ministry of Labor, State Committee for TV and Radio). |
| • Developing mechanisms of incentives for healthcare workers for preventive work. |
| • Using up-to-date methods in training healthcare workers on issues of healthy lifestyles. |
| • Developing training programs for population on providing self-help and mutual aid. |
| • Training public in using techniques of delivering self help and mutual aid. |
| • Establishing and support of patient organizations (MOH, Association of General Practitioners/Family Physicians). |
| Output |
| Increasing awareness of population and improving professional knowledge of health care workers. |
| Developing up to date algorithm based manuals on self help and mutual aid. |
| Creating a network of organizations of patients with different diseases. |
| Time framework |
| 3 years |
| Expected difficulties |
| Lack of general comprehension of health as universal value, orientation of health care system to disease and not to health, lack of interdepartmental interface of all elements involved in building-up healthy lifestyles |
| Disrespectful attitude of healthcare workers towards non professional medical aid |
| Inadequate funding |

3. System of health care funding

| Component Description |
| Mechanism of receipt, distribution and effective use of funds of health care system |
| State budget funding of guaranteed minimum and the most important problems of health care |
| Social medical insurance |
| Selection, negotiation and approval of efficient funding model |
| Financing of health care facilities and services (payment for medical services) |
### Annexes

#### Project Inputs and Resources

- Technical assistance regarding:
  - determining the basic package of health care services,
  - development of a unified procedure of determining the cost of health care services;
  - setting unified prices for health care services;
  - developing regulations on operation of sub-divisions of regional health authorities, responsible for planning health care and managing financial resources;
  - introduction of insurance;
  - introduction of contractual relations into the health care system;
  - introduction of effectively proven methodologies of funding of health care facilities and medical services oriented to effective distribution of resources;
  - conducting social marketing, "Round tables" and "brainstorming sessions" with participation of project experts and key representatives of state authorities responsible for decision-making in the area of funding reforms;
  - trainings for state authorities, local authorities and managers of health care facilities.

#### Main Measures, Legal Changes (Responsibility for Implementation)

- Separation of purchaser and provider, transition to "single payer" model, change or improvement of the system of collection and pooling of funds (depending on the selected model — establishing a single national voluntary medical insurance fund and legal introduction of a new earmarked contribution due to the type of social insurance or allocation of a certain share of the unified social contribution, or in case of selection of a tax-based model — entrusting purchaser functions to regional health care authorities (level of AR of Crimea, Oblasts, city of Kiev and Sevastopol) (Committees of Verkhovna Rada of Ukraine on health care, on social policy and labor, on budget, on finances and banking activity, Cabinet of Ministers, MOH, Academy of Medical Science of Ukraine, Ministry of Finance, Ministry of Economy, Ministry of Labor and social policy, Council of Ministers of the Autonomous Republic of Crimea, Oblast administrations, Kiev and Sevastopol city administrations, local self-government bodies).

- Change of the model of reimbursing cost of health care services — separation of functions of purchaser and provider of health care services, introduction of financing methods for health care facilities and services oriented to fund's effective allocation (in case of introduction of medical insurance — the appropriate newly-created fund of medical insurance if a tax-based model is selected — MOH, Academy of Medical Science of Ukraine, Council of Ministers of the Autonomous Republic of Crimea, Oblast administrations, Kiev and Sevastopol city administrations, local self-government bodies).

- Evaluation of needs, setting priorities and identifying a basic package of health care services.

- Introducing contracting relations and salaries according to the extent and quality of care.

- Development of a methodology to cost health care services;

- Establishing unified state-fixed or regulated prices for health care services that have to be used under state contracted purchases of health care services;

- Making amendments to the Constitution of Ukraine regarding free-of-charge health care services at state and municipal facilities (Article 49) (MOH, Ministry of Finance, Ministry of Economy).

#### Output

**Phase I**

Model chosen and approved by key participants, legal implementation of the model ensured through:

- the adoption of a law on voluntary medical insurance or
- changes in the Budget Code of Ukraine, Laws on local self-government and on local state administrations concerning financial authority in the health care sector

**Phase II**

Model of reimbursing cost of health care services has been changed:

- status of public health care facilities ensured by their reorganization into non-profit state and community facilities having a higher level of autonomy compared to the operating budget facilities

- subdivisions within the structure of regional health authorities created for planning health care and managing financial resources with their appropriate staffing and logistics support;
Key strategies for further development of the health care sector in Ukraine

| Output | c) transition from current integrated model of budget funding of healthcare facilities to contracting model ensured, within the framework of the legislation on state purchases;  
d) transition from item-by-item financing of health care organizations to financing (paying for services) according to the volume and structure of services has been secured;  
e) training and education of key people of state power authorities, local self-government and health managers ensured;  
f) instructions and guidelines prepared and distributed to local recipients.  
Accessibility of health care services to all population groups.  
Phase I — 3 years,  
Phase II — 10 years |
|---|---|
| Time framework | Possible differences between political forces, especially inside the Parliament, regarding the goal, principles and priorities of the reform.  
Possible differences between executive power authorities (for example, between MOH on the one hand and Ministry of Finance and Ministry of Economy, on the other hand).  
Lack of trust on the part of the population, lack of cooperation between healthcare workers and specialists in local level reforms.  
Low level of computerization of health care facilities and lack of respective specialists. |
| Expected difficulties |  
4. System of providing health care services |
| Component Description | Restructuring the system of healthcare with priority given to family-based PHC. |
| Project Inputs and Resources | Technical assistance in determining forms and methods of restructuring the system of medical care delivery.  
Logistics support for adequate equipment of family-based primary health care facilities. |
| Main Measures, Legal Changes (Responsibility for Implementation) | Transfer of narrow departmental health care facilities to the community level and provide for territory-based integration of various affiliated hospitals.  
Legalization of the “gatekeepers” principle, specifying the procedure of using the right for free choice and change of a physician, conditions of providing in-patient and specialized care by introducing the respective changes to the Basic Laws of Ukraine on health care or adopting a separate Law on organization of medical care delivery.  
Development of the institution of family medicine with its integration into the existing health care system.  
Reorganizing in-patient sector based on principles of functional differentiation of hospital beds.  
Consolidation of general hospitals where emergency care is provided, along with formation of hospital catchment areas covering from 100 to 200 thousand population (Committees of Verhovna Rada of Ukraine on health care, on social policy and labor, on budget, Cabinet of Ministers, MOH, Ministry of Finance, Ministry of Economy, Ministry of Labor and social policy, Council of Ministers of ARC, Oblast State Administrations, Kyiv and Sebastopol City State Administrations, local self government bodies). |
| Output | Creating a network of general practices in rural and urban areas and forming adequate organizational territorial structure and potential of health care facilities.  
Optimizing the structure of resources distribution among levels of health care with increased proportion of primary health care funding.  
Optimizing structure of health care services in accordance with population’s real needs. |
| Time framework | 10 years |
| Expected difficulties | Possible counterraction on the part of narrow specialists and in patients departments’ staff because of their possible dismissal.  
Possible dissatisfaction of population with change of their traditional access to higher levels of health care.  
Inadequate funding to implement changes. |
| 5. Personnel |
| Component Description | Staffing with qualified specialists in accordance with the needs of health care.  
System of incentives for healthcare workers to assure their efficient and qualitative work.  
Improvement of personnel training. |
| Project Inputs and Resources | Technical assistance in creating a system of planning for personnel needs.  
Technical assistance in training of family physicians, managers (organizers) in health care, and public health care specialists. |
<table>
<thead>
<tr>
<th>Main Measures, Legal Changes (Responsibility for Implementation)</th>
<th>Creating a system of planning for personnel needs to ensure the required number and diversity of health professions considering current and future requirements of health care. Priority training of general practitioners, family physicians, managers and economists in health care. Developing mechanisms of labor remuneration of health care personnel that will promote efficient use of health care resources. Ensuring qualification differentiation in terms of labor remuneration (MOH, Ministry of Education and Science, Ministry of Labor, Ministry of Finance, Ministry of Economy Medical Trade Unions, Medical Associations).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Output</td>
<td>Necessary health care personnel number and structure has been estimated according to the phases of health care system development. In accordance with the estimation (prognosis), the health care personnel was trained, first of all general practitioners/family medicine specialists (physicians, nurses) managers, economists in the area of health care, public health specialists. The real needs of health care for personnel of necessary qualification are being satisfied. System of remuneration of labor of healthcare workers has been developed that corresponds to the amount, complexity and quality of their work.</td>
</tr>
<tr>
<td>Time framework</td>
<td>10 years</td>
</tr>
<tr>
<td>Expected difficulties</td>
<td>Inertness of healthcare workers' training processes. Poor preparedness of higher educational establishments for training healthcare workers in accordance with the required number and quality. Lack of funding for arranging working places for primary healthcare workers.</td>
</tr>
<tr>
<td>6. Ensuring quality health care</td>
<td></td>
</tr>
<tr>
<td>Component Description</td>
<td>Organization of the system of health care quality assurance and maintenance with its standardization, and review of standards on a regular basis. Introducing evidence-based medicine providing quality patient-oriented health care.</td>
</tr>
<tr>
<td>Project Inputs and Resources</td>
<td>Technical assistance in developing a unified procedure of developing clinical guidelines; developing standards of diagnostics, care and organization of medical care; establishing the Informational Center of evidence-based medicine.</td>
</tr>
<tr>
<td>Output</td>
<td>Within the structure of MOH and health departments of Oblast and the city of Kiev and Sebastopol state administrations there have been established divisions responsible for health care quality, licensing and accreditation of health care establishments. Evidence-based Center established. Procedure of developing health care standards approved. Clinical guidelines for principal diseases developed. 7 years</td>
</tr>
<tr>
<td>Time framework</td>
<td></td>
</tr>
<tr>
<td>Expected difficulties</td>
<td>Inadequate resources of health care system. Lack of experience of working in the conditions of health care practice standardization on the part of healthcare workers.</td>
</tr>
<tr>
<td>7. Informational support</td>
<td>Support with medical and economic information in the scope and format necessary for efficient management of the system operation and development on macro- and micro levels.</td>
</tr>
<tr>
<td>Component Description</td>
<td>Technical assistance in the development of informational systems. Logistics support in providing computer equipment.</td>
</tr>
<tr>
<td>Project Inputs and Resources</td>
<td></td>
</tr>
</tbody>
</table>
### Key strategies for further development of the health care sector in Ukraine

<table>
<thead>
<tr>
<th>Main Measures, Legal Changes (Responsibility for Implementation)</th>
<th>Output</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development of up-to-date communication policy for the system, Development of appropriate unified informational systems for patient registration, costing of health care services, registration and reporting medical statistics as well as management of the system on macro- and micro levels (Cabinet of Ministers, MOH, Ministry of Economy, State Committee of Statistics).</td>
<td>Appropriate informational systems developed, certified and referred to the local level</td>
</tr>
</tbody>
</table>

| Time framework | 7 years |

<table>
<thead>
<tr>
<th>Expected difficulties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insufficient number of specialists in the system who can be involved in development of the appropriate informational systems.</td>
</tr>
<tr>
<td>Lack of money for adequate equipping health care establishments and facilities with computers.</td>
</tr>
</tbody>
</table>

### 8. Pharmaceutical support

<table>
<thead>
<tr>
<th>Component Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bringing pharmaceutical policies in accordance with the up-to-date requirements and introducing rational pharmaceutical management on macro- and micro-levels allowing for expanding access of the most vulnerable groups of population to pharmaceutical coverage</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Project Inputs and Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical assistance in training and education of health care personnel.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Main Measures, Legal Changes (Responsibility for Implementation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of the National List of Essential (vital) drugs and health products approved by the Cabinet of Ministers and bringing it in accordance with WHO recommendations (Cabinet of Ministers, MOH).</td>
</tr>
<tr>
<td>Introducing a record system on the level of specific health care facilities (MOH).</td>
</tr>
<tr>
<td>Review and optimization of the system of purchasing health care products by health care facilities by maximally possible and reasonable decentralization of such purchases (Cabinet of Ministers, Ministry of Economy, Ministry of Finance, MOH).</td>
</tr>
<tr>
<td>Introduction of basic prices for medications that have to be procured for budget funds, and state monitoring of prices for such medications on domestic and foreign markets.</td>
</tr>
<tr>
<td>Creation of a system of information about availability of medications to health professionals and population (Ministry of Economy, MOH).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Output</th>
</tr>
</thead>
<tbody>
<tr>
<td>The National List reviewed and brought into accordance with WHO recommendations with its annual updating.</td>
</tr>
<tr>
<td>Appropriate instructions and guidelines prepared and sent to local level.</td>
</tr>
<tr>
<td>System of purchasing health care products reviewed and optimized with the purpose of its adjustment to the needs of specific healthcare facilities and population they serve, and with the purpose of rational selection of health products based on optimal correlation between their price and therapeutic effect.</td>
</tr>
</tbody>
</table>

| Time framework | 5 years |

<table>
<thead>
<tr>
<th>Expected difficulties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative lobbying on the part of pharmaceutical producing companies and distributors interested in keeping in the Essential drugs list as many drugs they produce and present as possible.</td>
</tr>
<tr>
<td>Opposition on the part of the central power authorities responsible for current centralized purchases.</td>
</tr>
</tbody>
</table>

### 9. Meeting the requirements of current laws and regulations, review of current statutory acts that slow down or obstruct health care reform as well as expansion of the basis for ensuring patients and health professionals’ rights

<table>
<thead>
<tr>
<th>Component Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensuring a comprehensive analysis of the national laws and regulations aimed at assessment of their adequacy for reform implementation and adaptation to the European legislation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Project Inputs and Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical assistance in developing necessary regulatory documents.</td>
</tr>
<tr>
<td>Technical assistance regarding adaptation of regulatory documents in accordance with the European legislation.</td>
</tr>
<tr>
<td>&quot;Round table&quot; and &quot;brainstorming&quot; sessions held jointly with project experts and decision-makers from the state and executive bodies responsible for reform implementation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Main Measures, Legal Changes (Responsibility for Implementation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification of the ultimate goal, principles and priorities of the reform, particularly legal and regulatory basis for its implementation (Cabinet of Ministers of Ukraine (upon submission by the MOH, Ministry of Finance, Ministry of Economy, and Ministry of Justice of Ukraine)).</td>
</tr>
<tr>
<td>Identification of the list of legal acts and their legal norms preventing implementation of the planned reform (MOH, Ministry of Finance, Ministry of Economy, Ministry of Justice, and (if needed) other central bodies of executive authority).</td>
</tr>
<tr>
<td>Annexes</td>
</tr>
<tr>
<td>---------</td>
</tr>
</tbody>
</table>

10. Pilot implementation of the reform in some pilot regions of Ukraine

<table>
<thead>
<tr>
<th>Component Description</th>
<th>Working through all components of the reform</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Inputs and Resources</td>
<td>Technical assistance through equipping facilities and training personnel in pilot regions</td>
</tr>
<tr>
<td>Main Measures, Legal Changes (Responsibility for Implementation)</td>
<td>Integration of all previous components (All aforementioned agencies’ responsibility)</td>
</tr>
<tr>
<td>Output</td>
<td>Summarizing experience of reform introduction and its dissemination across Ukraine</td>
</tr>
<tr>
<td>Time framework</td>
<td>3 years</td>
</tr>
<tr>
<td>Expected difficulties</td>
<td>Summarizing all the aforementioned difficulties</td>
</tr>
</tbody>
</table>

11. Monitoring and evaluation of changes

<table>
<thead>
<tr>
<th>Component Description</th>
<th>Economic, political, social, organizational, and qualitative components of reform. Analysis of economic and statistical health indicators.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Inputs and Resources</td>
<td>Technical assistance through material and technical support of the monitoring with use of modern IT systems</td>
</tr>
<tr>
<td>Main Measures, Legal Changes (Responsibility for Implementation)</td>
<td>Development of indicators and monitoring strategies, data study and analysis, publicizing the monitoring results through mass media, organization of feedback (MOH)</td>
</tr>
<tr>
<td>Output</td>
<td>Development of a reporting system and ensuring its operation. Development of a database for making managerial decisions.</td>
</tr>
<tr>
<td>Time framework</td>
<td>Continuous</td>
</tr>
<tr>
<td>Expected difficulties</td>
<td>Lack of necessary IT and material and technical support</td>
</tr>
</tbody>
</table>
Annex 2

INDICATORS FOR MONITORING CHANGES IN THE HEALTH CARE SYSTEM

In short-term prospective (2005-2006)

<table>
<thead>
<tr>
<th>Direction</th>
<th>Indicators</th>
<th>Change tendency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of medico-sanitary care facilities per 100 000 people</td>
<td>Increases</td>
</tr>
<tr>
<td></td>
<td>Number of general practice doctors that practice in PHC facilities.</td>
<td>Increases</td>
</tr>
<tr>
<td></td>
<td>Average number of out-patient contacts per capita</td>
<td>Decreases</td>
</tr>
<tr>
<td></td>
<td>Average number of in-patient contacts in PHC facilities per capita</td>
<td>Increases</td>
</tr>
<tr>
<td></td>
<td>Number of in patient facilities per 100 000 people</td>
<td>Decreases</td>
</tr>
<tr>
<td></td>
<td>Number of beds per 1000 people</td>
<td>Decreases</td>
</tr>
<tr>
<td></td>
<td>Number of hospitalized per 100 people</td>
<td>Decreases</td>
</tr>
<tr>
<td></td>
<td>Average duration of stay in an in-patient facility</td>
<td>Decreases</td>
</tr>
<tr>
<td></td>
<td>Number of in-patient treatment days per capita per year</td>
<td>Decreases</td>
</tr>
<tr>
<td></td>
<td>% of expenses from public sources on PHC facilities</td>
<td>Increases</td>
</tr>
<tr>
<td></td>
<td>% of expenses from public sources on in-patient care</td>
<td>Increases</td>
</tr>
<tr>
<td></td>
<td>% of expenses from public sources on medications</td>
<td>Decreases</td>
</tr>
<tr>
<td></td>
<td>Standardized mortality coefficients from particular diseases (appendices, hernia, intestinal obstruction, unfavorable impact of medications, etc.)</td>
<td>Decreases</td>
</tr>
<tr>
<td></td>
<td>Population’s satisfaction with health care services</td>
<td>Increases</td>
</tr>
<tr>
<td>Forming the system of provision and maintenance of health care services quality</td>
<td>General expenses on health care from public sources (% GNP)</td>
<td>Increases</td>
</tr>
<tr>
<td>Strengthening of health care system financial base</td>
<td>General expenses on health care (PPS$ per capita)</td>
<td>Increases</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Direction</th>
<th>Indicators</th>
<th>Change tendency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of smokers per 100 people</td>
<td>Decreases</td>
</tr>
<tr>
<td></td>
<td>Annual alcohol consumption (liters of neat alcohol per capita per 1 year)</td>
<td>Decreases</td>
</tr>
<tr>
<td></td>
<td>Number of abortions per 1000 infants born alive</td>
<td>Decreases</td>
</tr>
<tr>
<td></td>
<td>% of children immunized against manageable epidemics</td>
<td>Increases</td>
</tr>
<tr>
<td>Mortality</td>
<td>Standardized mortality coefficients: major non-infectious diseases (cardio-vascular diseases, respiratory diseases, tumors, diabetes and etc.)</td>
<td>Decreases</td>
</tr>
<tr>
<td></td>
<td>Mortality (0 to 65 years)</td>
<td>Decreases</td>
</tr>
<tr>
<td>Infant mortality</td>
<td></td>
<td>Decreases</td>
</tr>
<tr>
<td>Maternal mortality</td>
<td></td>
<td>Decreases</td>
</tr>
<tr>
<td>Average life expectancy</td>
<td></td>
<td>Increases</td>
</tr>
<tr>
<td>Morbidity (new cases): tuberculosis, AIDS per 100 000 people : Health status differences between socio-economic groups of the society (by mortality, morbidity, disability indicators)</td>
<td></td>
<td>Decreases</td>
</tr>
</tbody>
</table>