

UKRAINE REVIEW OF HEALTH FINANCING REFORMS 2016–2019

WHO–World Bank Joint Report



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Abstract

In 2015, the Government of Ukraine initiated transformative reforms of its health system to improve population health outcomes and ensure financial protection from excessive out-of-pocket payments. This was to be achieved through increasing efficiency, modernizing the obsolete service delivery system and improving access to better quality of care. This report is based on a joint WHO–World Bank review carried out in April–July 2019 looking at progress implementing health financing reforms in Ukraine towards these objectives. It concludes that the overall design of Ukraine’s health financing reforms is in line with international good practices to improve access, quality and efficiency of health services. Implementation has successfully moved forward, the National Health Service of Ukraine has been established as a critical change agent and tangible benefits are beginning to emerge in primary health care. However, serious challenges are on the horizon. Ukraine’s overall macro-fiscal environment remains difficult. As a result, efficiency gains, particularly via hospital restructuring, will be key to demonstrate results from the reforms. Ensuring overall stability of the health budget envelope and prioritizing public health (health promotion and disease prevention) and primary health care will be essential to ensure improved frontline services. Local governments have an important role to play as facility owners and financing agents, but further policy dialogue is needed to align decentralized roles and national health policy priorities. Building distributed ownership for the reforms among key stakeholders including local governments, providers and the population is important for sustainability. With consistent implementation and careful policy dialogue, these challenges can be overcome and the reforms can be expected to yield tangible benefits in terms of improved health outcomes and reduced financial burden for the population in coming years.

Keywords

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Contents

Acknowledgements	v
Abbreviations	v
Executive summary	vi
Objectives and scope of the joint review	1
CHAPTER 1. A SNAPSHOT OF HEALTH FINANCING REFORMS IN UKRAINE	3
CHAPTER 2. A REVIEW OF PROGRESS AND CHALLENGES IN GOVERNANCE	5
2.1 Introduction	5
2.2 Overview of key policies	5
2.2.1 Legal status, management and supervision structures of the NHSU	5
2.2.2 Setting objectives and providing coherent, stable policy and strategic direction for the NHSU	6
2.2.3 Clear assignment of decision-making authority	7
2.2.4 NHSU institutional development: skilled human resources, data and information systems	8
2.2.5 Firm and credible fiscal constraint	8
2.2.6 Holding the nhsu accountable for performance	9
2.2.7 Reform process, interagency relationships and communication	10
2.3 Alignment with other areas of health system strengthening and public sector reforms	11
2.3.1 Alignment with other areas of the health system	11
2.3.2 Alignment with public financial management	11
2.3.3 Alignment with local government policies	12
2.4 Emerging impact of policies on reform objectives	13
2.5 Anticipated challenges	13
2.5.1 Setting realistic objectives and a credible fiscal constraint	13
2.5.2 Developing mature governance oversight bodies for the NHSU	14
2.5.3 Developing coordination mechanisms between the nhsu and ministry of health and local governments	14
2.6 Policy recommendations	15
CHAPTER 3. EVOLUTION OF FISCAL SPACE, REVENUE COLLECTION AND POOLING ARRANGEMENTS	17
3.1 Introduction	17
3.2 Overview of key policies	18
3.3 Alignment with other areas of health system strengthening and public sector reforms	21
3.4 Emerging impact policies on reform objectives	25
3.5 Anticipated challenges	27
3.6 Policy recommendations	28

CHAPTER 4. INTRODUCING STRATEGIC PURCHASING OF PHC AND CATALYSING SERVICE DELIVERY TRANSFORMATION	31
4.1 Introduction	31
4.2 Overview of key policies	31
4.3 Alignment with other areas of health system strengthening and public sector reforms	37
4.4 Emerging impact policies on reform objectives	37
4.5 Anticipated challenges	40
4.6 Policy recommendations	42
CHAPTER 5. GEARING UP FOR ROLLING OUT STRATEGIC PURCHASING BEYOND PHC	45
5.1 Introduction	45
5.2 Overview of key policies	45
5.2.1 Organization of hospital services in Ukraine	45
5.2.2 Pilot purchasing of hospital care	48
5.2.3 Preparations for the roll-out of purchasing of hospital care in 2020	49
5.2.4 Purchasing of outpatient secondary services	51
5.2.5 Purchasing of the emergency care	52
5.3 Alignment with other areas of health system strengthening and public sector reforms	53
5.4 Emerging impact of policies on reform objectives	54
5.5 Anticipated challenges	55
5.6 Policy recommendations	58
CHAPTER 6. DESIGNING TRANSPARENT AND FAIR BENEFITS	61
6.1 Introduction	61
6.2 Overview of key policies	61
6.3 Alignment with other areas of health system strengthening and public sector reforms	65
6.4 Emerging impact policies on reform objectives	65
6.5 Anticipated challenges	67
6.6 Policy recommendations	68
CHAPTER 7. SUMMARY OF KEY POLICY MESSAGES AND POLICY CONSIDERATIONS	71



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On the World Bank side, the team consisted of Ajay Tandon (Lead Economist), Iryna Postolovska (Economist), Olena Doroshenko (Economist) and Feng Zhao (Programme Leader).

The mission informing this report had inspiring and insightful discussions with representatives of national and local government agencies (Ministry of Health, National Health Service of Ukraine (NHSU), Ministry of Finance, Kyiv city government). Mission members also participated in a visit to a primary health care facility (Polyclinic No. 1 of Pechersk district of Kyiv City). The mission took part in a Ministry of Health–NHSU event in Lviv with local government and provider representatives of four regions (Ivano-Frankivsk, Lviv, Ternopil and Zakarpattia) to discuss next steps in rolling out the contractual model. Finally, preliminary observations of the mission were shared with representatives of the United States Agency for International Development and the European Union.

Abbreviations

CEB	central executive body
DRG	diagnosis-related group
EMS	emergency medical services
GDP	gross domestic product
ICD-10	International Classification of Diseases, tenth revision
Law 2168	Law on “Government Financial Guarantees of Health Care Services”
MTBF	medium-term budget framework
NCDs	noncommunicable diseases
NHSU	National Health Service of Ukraine
OECD	Organisation for Economic Co-operation and Development
OOP	out-of-pocket
PCC	Public Control Council
PFU	Pension Fund of Ukraine
PHC	primary health care
PMG	medical guarantees programme
USAID	United States Agency for International Development

Executive summary

In 2015, the Government of Ukraine initiated transformative reforms of its health system with the goal to improve health outcomes of the population and ensure financial protection from excessive out-of-pocket payments through increasing efficiency, modernizing the obsolete service delivery system and improving access to better quality of care. The overarching strategy consisted of focusing on health financing reforms first to catalyse transformation in service delivery (both individual and population), incentivize results and outcomes, and use information solutions as accelerators. Following the development and cabinet approval of the strategy, parliament passed the new health financing Law on “Government Financial Guarantees of Health Care Services”. The National Health Service of Ukraine was established to begin strategic purchasing with health care providers for services stipulated in the benefit package.

A joint WHO–World Bank review was carried out in April–July 2019 with a joint mission to Ukraine from 20 to 24 May 2019 to take stock of and review progress in implementing health financing reforms since 2016. The joint review aimed to document the impact of the reforms on the stated objectives (access, quality, efficiency and financial burden), identify good practices from an international perspective, highlight future challenges and provide policy recommendations on how to overcome them.

The joint review covered the following six technical areas: (i) governance challenges in health financing; (ii) assessment of the evolution of fiscal space, revenue collection and pooling arrangements; (iii) evaluation of the introduction of strategic purchasing and catalysing service delivery transformation in primary health care including using digital solutions to accelerate progress; (iv) review of options to gear up for strategic purchasing beyond primary health care with outpatient specialist clinics and hospitals; (v) progress in developing an explicit benefit package both from a process and content perspective; and (vi) identification of lessons learned regarding the reform process so far for the next generation of reformers.

The joint review team of WHO and the World Bank have made the following main conclusions regarding the implementation of the health financing strategy 2016–2019, future challenges and opportunities.

Message #1

Reform design

The overall design of Ukraine’s health financing reforms is in line with international good practices to improve access, quality and efficiency of health services. If implemented consistently, the reforms can expect to yield tangible benefits in terms of improved health outcomes and reduced financial burden for the population in coming years.

Message #2

Alignment with development objectives

Health financing reforms are well-aligned with Ukraine’s overall development objectives and if implemented consistently should also yield dividends in terms of improved economic outcomes and ensuring fiscal discipline.

Message #3

Implementation progress

Implementation of health financing reforms has successfully moved forward. A single purchaser, the National Health Service of Ukraine, has been established. Primary health care-related reforms – including the design of an explicit primary care benefits package, conversion of primary health care centres to autonomous entities, implementation of capitation-based payment, free enrolment of

the population and reimbursement of selected medicines on an e-prescription basis – have progressed well. Passing the 2020 budget law by parliament will enable uninterrupted continuation of the reforms.

- Message #4** **Success factors** One key reason for successful implementation of reforms to date has been a strong political commitment and good interagency relationships between the Cabinet of Ministers, Ministry of Health, National Health Service of Ukraine and Ministry of Finance. Looking forward, it is critical that these relations continue to be strengthened and maintained.
- Message #5** **Change agents** The National Health Service of Ukraine is now a critical change agent in the system, and continued institutional and capacity development will be necessary in order to enable it to play a key role in furthering Ukraine's health system transformation.
- Message #6** **Fiscal context and efficiency gains** Ukraine's overall macro-fiscal environment remains challenging. As a result, efficiency gains will be key to demonstrate results from the reforms and provide space for the continued support of priority actions; in particular, efficiency gains via hospital restructuring will be essential and will require political support and stamina.
- Message #7** **Stability of the budget envelope** Ensuring overall stability of the health budget envelope will be key for continued implementation of health system reforms to safeguard resources from efficiency gains and translate them into better quality coverage and services.
- Message #8** **Priority setting** Financing and prioritization for public health (health promotion and disease prevention) and primary health care need to be protected within the budget envelope so that hospital reforms do not take the focus away from financing of frontline services.
- Message #9** **Alignment of national and local health policies** Local governments have an important role to play as facility owners and financing agents, but further policy dialogue is needed on how to align decentralized roles and national health policy priorities.
- Message #10** **Focus on service delivery** Strategic purchasing and new financial incentives are well designed, and implementation is going well; however, to achieve changes in clinical practice on the ground, a wider range of instruments, such as institutionalized mechanisms to improve quality, are needed.
- Message #11** **Stakeholder agreement** For sustainability, it is important to build distributed ownership for the reforms among key stakeholders including local governments, providers and the population.

OBJECTIVES AND SCOPE OF THE JOINT REVIEW

A joint WHO–World Bank review took place in April–July 2019 with a joint mission from 20 to 24 May 2019 to take stock of progress implementing health financing reforms since 2016. The review aimed to document the impact of the reforms on stated objectives, identify good practices from an international perspective, highlight future challenges and provide policy recommendations on how to overcome them. The joint review covered the following six technical areas:

- 1.** review of governance challenges in health financing considering the evolution of institutional roles and relationships with the introduction of the National Health Service of Ukraine, health care provider autonomy and local government ownership;
- 2.** assessment of the evolution of fiscal space and prospects considering revenue collection and pooling arrangements with attention to local government spending on health;
- 3.** evaluation of the introduction of strategic purchasing and catalysing service delivery transformation in primary health care including using digital solutions to accelerate progress;
- 4.** review of options to gear up for strategic purchasing beyond primary health care with outpatient specialist clinics and hospitals;
- 5.** progress in developing an explicit benefit package both from a process and content perspective; and
- 6.** identification of lessons learned regarding the reform process so far for the next generation of reformers.

This report contains the main findings of the review. The report is organized as follows. Chapter 1 provides a brief background on the key health financing reforms. Chapters 2–6 provide in-depth analysis of key health financing policies focusing on governance (Chapter 2), fiscal space, revenue collection and pooling arrangements (Chapter 3), strategic purchasing of primary health care (Chapter 4), gearing up for strategic purchasing beyond primary health care (Chapter 5) and benefit design (Chapter 6). Chapter 7 concludes with a synthesis of the key policy issues emanating from the previous chapters and highlighting the resulting policy considerations for the future.



A SNAPSHOT OF HEALTH FINANCING REFORMS IN UKRAINE

In 2015, the Government of Ukraine initiated transformative reforms of its health system with the goal to improve health outcomes of the population and ensure financial protection from the burden of excessive out-of-pocket (OOP) payments by increasing efficiency, modernizing the obsolete service delivery system and improving access to better quality of care. The overarching strategy consisted of focusing on health financing reforms first to catalyse transformation in service delivery (both individual and population) and to use information solutions as accelerators.

The health financing strategy was articulated in a concept paper, which was approved by the Cabinet of Ministers of Ukraine.¹ In October 2017, parliament adopted the new health financing Law on “Government Financial Guarantees of Health Care Services”² (Law 2168) and a package of related by-laws. These set of documents created a strong legal and political framework to implement new health financing arrangements (Table 1.1). The implementation of the reform was envisaged in a phased approach. The first phase of the reform focused on primary health care (PHC), while the second phase will target secondary and tertiary care with roll out planned for 2020.

Table 1.1. Key legislation and regulatory acts

Variables	Name of document	Date of approval	Level of approval
1013-p	Cabinet of Ministers Decree on Approval of the Health Financing Reform Concept	30 November 2016	Cabinet of Ministers
180	Affordable Medicines Programme	16 March 2017	Cabinet of Ministers
2168-VIII	Law of Ukraine on Government Financial Guarantees of Public Medical Services	19 October 2017	Parliament
2206-VIII	Law of Ukraine on Improving Affordability and Quality of Medical Services in Rural Areas	14 November 2017	Parliament
1101-2017-п	Establishment of the National Health Service of Ukraine	27 December 2017	Cabinet of Ministers
2246-VIII	State Budget Law of Ukraine 2018	7 December 2017	Parliament
503	Ministry of Health Order on open enrolment to PHC doctors and procedures of signing declarations	19 March 2018	Ministry of Health
504	Ministry of Health Order on PHC provision	19 March 2018	Ministry of Health
407	Cabinet of Ministers Order on PHC financing	25 April 2018	Cabinet of Ministers
2696-VIII	State Budget Law of Ukraine 2019	28 February 2019	Parliament

¹ Cabinet of Ministers Decree No. 1013-p on Approval of the Health Financing Reform Concept (<https://www.kmu.gov.ua/ua/npas/249626689>, accessed 22 August 2019, in Ukrainian).

² Law of Ukraine on Government Financial Guarantees of Public Medical Services No. 2168-VIII (<https://zakon.rada.gov.ua/laws/show/2168-19>, accessed 22 August 2019, in Ukrainian).

WHO and the World Bank have expressed their support for the health financing reform strategy. In a policy dialogue forum in 2016, together with other development partners including the Canadian Government, European Commission, the Global Fund, Swiss Agency for Development and Cooperation, the United Nations Children's Fund, WHO and the World Bank delivered a joint statement highlighting that "Ukraine's vision of health system reform is inspiring and has been developed based on a transparent democratic process." The United States Agency for International Development (USAID) also underscored these messages in a separate statement. WHO and the World Bank as well as other partners have been supporting the Government of Ukraine in implementing the ambitious set of health financing reforms.

With legislative and regulatory acts in place, implementation of the new health financing system began rapidly. On 1 April 2018, the Government of Ukraine established a new single purchasing agency, the National Health Service of Ukraine (NHSU), and approved the regulations required for the functioning of the agency. The NHSU is a national insurance agency providing coverage for a set of explicit benefits for the population within the available fiscal space. The chief executive officer of the agency was appointed, and soon a core team began operationalizing the health financing strategy with a focus on primary care.

Implementation of contracting with PHC facilities started a few months after the NHSU was established. In July 2018, the NHSU began contracting³ with PHC providers using a capitation formula. The population has free choice of providers and can register with any PHC provider. Primary care providers converted into autonomous entities to sign contracts. Ninety-seven percent of all public PHC providers and over 100 private-owned PHC practices have signed contracts with the NHSU. According to the Ministry of Health, as of February 2019 more than 26 million Ukrainians have signed declarations with their PHC doctors.⁴ Results from a recent survey show that 76% of the population is satisfied with the quality of care at primary level.

Parallel to these efforts, the Government launched coverage for essential outpatient medicines under the Accessible Medicines Programme in 2017. The Programme provided millions of people with subsidized essential drugs mainly for primary care sensitive conditions such as cardiovascular disease. In its first phase, it was implemented through local governments. The NHSU took over administration of the Programme from 2019 with the aim to improve variations in regional uptake. The positive list of essential outpatient medicines under the Programme will be part of the Medical Guarantees Programme (PMG).



³ Cabinet of Ministers Decree No. 283 of 28 March 2018 on Approving the Procedure of Using the Funds Provided in the State Budget for the Provision of Primary Health Care to the Population (<https://zakon.rada.gov.ua/laws/show/ru/283-2018-%D0%BF>, accessed 22 August 2019, in Ukrainian).

⁴ More than 26 million Ukrainians have signed declarations with their doctor. Kyiv: Ukrinform. 27 February 2019 (<https://www.ukrinform.ua/rubric-society/2649656-ponad-26-miljoniv-ukrainciv-pidpisali-deklaracii-zi-svoim-likarem.html>, accessed 22 August 2019, in Ukrainian).

REVIEW OF PROGRESS AND CHALLENGES IN GOVERNANCE

2.1 | Introduction

A critical aspect of redesigning health financing arrangements relates to governance: the roles, functions and relationships of institutions involved in policy setting and implementation in the financing of the health system. The main governance functions are the arrangements for setting policy and strategic direction for the NHSU, and for holding it accountable for performance and the use of resources. This chapter reviews progress and prospects for implementing the changes in roles, responsibilities and relationships envisaged by the 2017 health financing Law on “Government Financial Guarantees of Health Care” (Law 2168). Clarity, coherence and coordination in the NHSU’s key relationships with other actors in health policy, regulation and financing are critical success factors for successful reform implementation. First, the key relationships considered are the changed roles and the relationships among the NHSU, Ministry of Health, Ministry of Finance and Cabinet of Ministers in the areas of policy and strategy. Second, the changes in the role of local governments in health finance and the relationship of the NHSU and local governments are discussed.

2.2 | Overview of key policies

2.2.1 Legal status, management and supervision structures of the NHSU

In 2016, the Ministry of Health undertook a rigorous process to evaluate options for the legal status and management of the purchaser. The options considered were:

- a department within the central office of the Ministry of Health
- a central executive body (CEB)
- a state nonprofit enterprise
- an off-budget trust fund (nonprofit self-governing organization).

The Ministry of Health concluded and the government agreed that a CEB would be the preferred option for a new single purchaser, funded from general taxation through the state budget. Elements of regulation applied to the Pension Fund of Ukraine (PFU) would be adopted to ensure fiscal discipline. This conclusion emerged after considering existing Ukrainian laws, lessons learned from Ukrainian examples of each type of legal status and international examples of use of these four models for single purchasers for health care.

Specifically, after assessing options, consensus emerged on the following key design features:

- to create a CEB with a two-level structure that includes an executive management team of a chief executive officer and other senior managers responsible for day-to-day management of the NHSU, and the higher-level Supervisory Board with representatives of key ministries, parliament, patients' groups, experts and professional associations;
- that Supervisory Board responsibilities would be carried out by representatives of the state and insured persons; participation of employers in the Supervisory Board (as in the PFU and found in some countries' single purchasers) was not seen as necessary or appropriate since unlike the PFU, the source of NHSU financing is general taxation rather than contributions from the wages fund paid in part by employers; participation of service suppliers' representatives in the customer's management structures also was not seen as appropriate as this would create a conflict of interest that should be avoided;
- establishment of CEB territorial units at the level that will be chosen according to the process of administrative-territorial reform and coordinated with the local authority government of relevant level;
- treasury servicing of all the cash flows of the newly established CEB and recording of all its operations within the state budget of Ukraine; and
- a balanced budget requirement for the CEB and requirement to create a minimum level of reserve funds to manage risk of annual variation in demand for health care within the benefit package.⁵

Law 2168 incorporates most of these key design features, establishing the NHSU as a CEB, keeping its finances on budget and managing its cash flows in the treasury system.

However, rather than establishing the Supervisory Board for the NHSU, Law 2168 provides for the CEB to be subordinate and accountable to the Cabinet of Ministers. This means that supervision is to be carried out by the system of Cabinet committees, on which ministers from the relevant state ministries are represented, including the Ministry of Health, Ministry of Finance and Ministry of Regional Development, Construction, Housing and Communal Services. Law 2168 also provides for the Public Control Council (PCC), with membership selected by open transparent competition and provisions to avoid conflict of interest of Council members. The PCC has the functions of monitoring activities and performance of the NHSU, reviewing reports from the NHSU and approving conclusions regarding them. More details on its establishment, functions, procedures, and the performance information and reports that the NHSU will provide to the Council are to be specified in a regulation (Article 7).

2.2.2 Setting objectives and providing coherent, stable policy and strategic direction for the NHSU

In line with recommendations on good governance practice,⁶ Article 5 of Law 2168 sets out a balanced set of objectives (called "Principles") for the NHSU. These include universal coverage, equity, restoration and preservation of population health, openness,

⁵ The description of design features is drawn from a July 2016 working paper of the Ministry of Health-led working group on health financing.

⁶ Governance for strategic purchasing: an analytical framework to guide country assessment. Health financing guidance No 4. Geneva: World Health Organization; forthcoming.

transparency, accountability, competition and non-discriminatory treatment of patients and providers. Article 7 balances this list by requiring the NHSU to ensure targeted and efficient use of its funds. The Law also sets out broad policy parameters for the benefit package design. It also provides for the NHSU to use evidence and technical methodologies as a basis for coherent proposals to the Ministry of Health, Ministry of Finance and government on the benefits package, tariffs and targeted use of its funds, consistent with balancing this set of principles.

While the Law provides a strong framework, whether this is translated in practice into coherent and stable policy and strategy depends on the realism and consistency over time of the decisions of the Ministry of Health, Ministry of Finance and government on a number of the regulations made under the Law, and on the priorities and targets in the government's performance agreement with the NHSU's chief executive officer.

For good governance, it is important for the government to work with and through these transparent formal instruments, avoiding frequent informal interventions into the everyday managerial and operational responsibilities of the NHSU. For example, a strategic health plan for a five-year period indicating the main health priorities based on evidence could be an important instrument for the Ministry of Health to steer priorities in NHSU funding allocations and contracting. Similarly, medium-term expenditure frameworks can provide a clear vision of the fiscal space in which the NHSU can plan to operate in the medium term. These vision-setting documents provide important directions and boundaries for the NHSU to exercise its operational autonomy while demonstrating policy coherence with health and fiscal policies. These documents can be reflected in accountability agreements between the government and the NHSU. Periodic reviews of alignment are helpful to adjust course.

2.2.3 Clear assignment of decision-making authority

Law 2168 makes it very clear that the NHSU's role is to implement policy – with the Ministry of Health, Ministry of Finance and government being the policy decision-makers. The Law also gives the NHSU the function of providing technical advice and input to formulate health financing policy proposals on the PMG. This makes good sense, because the NHSU will be the main repository of expertise and data on health financing within the structures of the government.

Some countries give their single purchasers more freedom to innovate in health financing and make a broader range of purchasing decisions than Law 2168 gives to the NHSU. An example is the provision in Article 8 of the Law that requires the NHSU to offer a contract to all (licensed) providers who apply to be contracted, which reduces the NHSU's leverage as a purchaser to obtain good value for money. This provision in the Law was promoted and adopted by parliament to prevent any risk that the NHSU would discriminate unfairly between providers – although the Law already has a requirement for the NHSU to ensure non-discrimination and competition (in Article 5). As a result of the Article 8 restriction, a greater onus is placed on the Ministry of Health to develop an objective basis for determining how to optimize service providers (e.g. through a hospital master plan and more detailed regulatory standards), which the NHSU can use as a basis for deciding which providers to contract (see Chapter 5). Bringing about the much-needed hospital rationalization is therefore not something the NHSU can achieve alone. It will need support from the Ministry of Health and local governments to reform the use of other policy levers (master planning, regulation, targeted capital investment, interventions by facilities owners to merge or close uneconomic and redundant facilities) to bring about optimization.

In line with recommended good practice, Law 2168 specifies clearly the respective roles of the NHSU, Ministry of Health, Ministry of Finance, the government (and parliament) in the stages of formulating, reviewing and approving key health financing policies and purchasing processes of the single purchaser. Even so, it is usually necessary for the Ministry of Health and single purchaser to work out at a practical detailed level how they work together on some of the issues that involve both organizations. For example, defining and measuring health care safety and quality indicators (used in contracts by the NHSU but a key component of the Ministry of Health's quality improvement and assurance functions) is an important area for coordination and cooperation between the two agencies. The Ministry of Health–NHSU agreement to establish a process to develop and approve a common set of indicators and shared use of the same data and reports from providers is desirable, to avoid duplicative or conflicting quality measures and minimize reporting burdens on providers.

2.2.4 NHSU institutional development: skilled human resources, data and information systems

In the first year after the NHSU was established, it has exceeded expectations in the speed with which it built up a critical mass of professional staff in its central office, and put in place information systems sufficient to implement basic PHC contracting and payment operations. This enabled the NHSU to meet political demands for rapid delivery of benefits to the population and reform opportunities to PHC providers. The next phase of implementation of the PMG – taking on purchasing of secondary and tertiary health care (along with emergency medical care, palliative care and rehabilitation) – entails a big step in institutional development. The staff, data, information systems and risk management involved are much more complex. The NHSU will need to implement the envisaged network of regional branch offices in order to contract these services, and monitor, control and audit claims for payment effectively. In the short term, the NHSU will be constrained by lack of cost, activity and quality data from providers, which currently stands in the way of development of more sophisticated contract specifications, case-payment systems and pay-for-performance initiatives.

2.2.5 Firm and credible fiscal constraint

A firm budget constraint is important for giving the NHSU strong incentives to target and use its resources efficiently, and play its part in the government's overall expenditure strategy by effective control of health care expenditure risks. If the NHSU is to be held accountable for achieving its objectives – providing the benefits package guaranteed in the Law – the budget constraint also needs to be realistic – based on reasonable expectations about the volume of services and prices, which the NHSU can afford to purchase within the budget. The Law sets out the process for approving both the NHSU budget and the benefits package and tariff annually, so as to provide the opportunity for the government (and finally parliament) to ensure the approved benefits package and tariff is achievable within the approved annual budget (Article 10). As discussed elsewhere in this report, development of a stable, predictable – and credible – medium-term budget ceiling for the NHSU is a critical success factor for the reforms, but under current fiscal conditions, moving towards a budget level for the NHSU that matches a properly costed benefits package will take a period of years (see Chapter 5). From a governance standpoint, it is important that the difficult

trade-offs and compromises involved in living within the NHSU's limited budget – such as services optimization and other efficiency measures – are fully owned and supported by the government. There are examples internationally of the single purchaser being blamed for failing to deliver the impossible in the face of a mismatch between the budget and the guaranteed benefits package, leading to a cycle of unstable management and governance arrangements.

The NHSU does have responsibility to introduce mechanisms of expenditure control, but will need political backing for the measures necessary to do this. Expenditure control is typically not a big issue in PHC because capitation budgets can be planned for once the initial enrolment period stabilizes. For volume-related payments for specialists and hospitals, volume ceilings, declining tariffs (for volume above plan) and floating base rates can achieve mechanistic expenditure control. Chapter 5 describes the expenditure control features of the NHSU's pilot in Poltava region for purchasing hospital inpatient and outpatient care. The most challenging issue is control of expenditure on the reimbursement of outpatient medicines. A variety of techniques can be used, for example, giving local networks of providers responsibility for managing the budget for local primary care prescriptions and for providing evidence-based feedback to prescribers. Other techniques are discussed briefly in Chapter 4.

2.2.6 Holding the NHSU accountable for performance

Law 2168 puts in place a strong legislative basis for external accountability of the NHSU. The Law gives the NHSU two separate major lines of accountability: to the Cabinet of Ministers and the PCC. Ukraine now has a well-organized system of Cabinet Committee oversight and decision-making for supervising CEBs including the NHSU. The NHSU is subject to independent external audit by the Council of Auditors, which has already been demonstrated in action. When a single purchaser is established for the first time, it can be important to provide orientation and training to the oversight committee and the external auditor, to support a shift to results-oriented external governance (rather than prescriptive external control of inputs and processes), alongside strengthening of the NHSU's internal systems of control and internal audit function.

Because the NHSU is still in a transition phase to full implementation of the PMG in 2020, the PCC has not yet been established. It is understandable that this has not yet been implemented, while priority has been given to establishing NHSU management, staffing and operating systems. In 2020, the PCC needs to be established, its members inducted and trained, and standard processes for NHSU reporting and PCC review developed.

Alignment and consistency between the different lines of accountability is a critical success factor for effective governance of a single purchaser. This could be fostered by developing some coordination process between PCC recommendations and conclusions and the oversight process of the Cabinet of Ministers. At the very least, biannual or quarterly PCC meetings could be scheduled before corresponding Cabinet Committee meetings at which NHSU reports and proposals are considered, so that the PCC meeting report can be placed on the Cabinet Committee agenda. External accountability will be enhanced by NHSU commitment to publish all its policies, strategy, budget plans and reports on its website. External accountability can also be enhanced by development of processes for direct consultation by the NHSU and the PCC with patients and the public.

Alongside these external accountability arrangements, development of systems of internal control within the NHSU is important. Every health purchaser has to manage substantial risks of error, fraud and waste in patient and provider claims for payment. The NHSU is committed to making use of big data analysis to identify potential fraud and target claims audit efficiently. As e-health systems are developed to include electronic patient records, the NHSU's capacity to use data analysis to identify error and fraud will increase. These same systems will also enable the NHSU to use data to monitor quality of care and promote evidence-based practice by contracted providers. Investing in these systems and in capacity for targeted sample audit of provider (and other) data to validate claims becomes even more vital once the NHSU takes on the complex task of contracting hospitals and specialist providers. This function should not be allowed to fall victim to excessively stringent controls on administrative expenditure. Development of the NHSU's internal audit function needs to be given priority in 2020.

2.2.7 Reform process, interagency relationships and communication

The policy development and decision-making process for designing the NHSU as an institution and the governance arrangements for the NHSU have been evidence-based, systematic and thorough – an exemplary design process. The Ukraine authorities took full advantage of the opportunity to learn lessons from the past 20 years of experience with design of single purchasers in the WHO European Region and beyond. Law 2168 largely follows the recommended design and provides a strong basis for the government to set policy and strategic direction for the NHSU, give the organization room to do its job with reasonable managerial autonomy on operational matters, and then hold it accountable both for use of financial resources and for performance in line with the principles or objectives set out in the Law.

Active expert engagement by the Ministry of Finance and Ministry of Health in this design process and early phase of implementation has also been exemplary during the past three years. Constructive, open working relationships between the Minister and Deputy Ministers of Health and the leadership of the single purchaser are a critical success factor for implementation – and continuing use of strategic purchasing as a key lever to support the government's strategy for the health sector. Some tensions between the NHSU, Ministry of Health, Ministry of Finance and other external accountability actors during implementation are inevitable and indeed are the natural result of the distinct responsibilities of each agency to ensure checks and balances within the machinery of government. The political priorities of the Ministry of Health for health spending can differ from the technical analysis of priorities for the benefits package, for example. The NHSU is inevitably caught between the aspirations of providers for higher prices and volumes of care, and the Ministry of Finance's focus on efficiency and overall expenditure control. Clear regulatory or administrative acts (detailing who does what), documented standard operating procedures, and more formalized bilateral and multiagency decision-making meetings will become more important during implementation and can mitigate risks in government transitions.

The Ministry of Health and the NHSU have cooperated closely in stakeholder consultation and communication during the reform implementation process so far. Over the coming years, as the NHSU takes on responsibility for purchasing secondary and tertiary services during a period of fiscal constraint, the health system will face major challenges of communication and management of public expectations about health reform that cannot

be treated as the responsibility of the NHSU alone. The governance actors – the Ministry of Health, Ministry of Finance and government as a whole – who set the budget constraint and policies for the PMG need to support the NHSU in explaining and defending to the public and health care workers the need for some difficult decisions, such as the necessity for major efficiency measures. The government as a whole needs to own these difficult decisions and communicate the need for realism and patience in tackling pervasive health sector issues in a phased manner, consistent with available fiscal resources.

2.3 | Alignment with other areas of health system strengthening and public sector reforms

2.3.1 Alignment with other areas of the health system

Law 2168 gives new roles to the Ministry of Health and Ministry of Finance as well as the NHSU in reviewing and approving health financing policies. These require new staff roles/job descriptions and new skills. The Law also creates new governance responsibilities for the members of the relevant Cabinet Committees (including the Ministers of Health, Finance and Regional Development, Construction, Housing and Communal Services among others) in the oversight of the NHSU. The staff work needed in these Ministries to support this Cabinet Committee oversight also requires new staff roles/job descriptions and skills and new standard operating procedures.

There will be a need for deepening of coordination over time between the NHSU's strategic purchasing development and development by the Ministry of Health of wider health strategy – in particular, its strategies for reform and optimization of service delivery, its medicines policy and its quality improvement and assurance strategy. Chapter 5 describes the very major challenge Ukraine faces with excessive and outdated hospital capacity. Section 2.2 above noted that Law 2168 constrains the NHSU's ability to use selective competitive contracting techniques and as a result, optimization of health service delivery and development of new services will be difficult unless the Ministry of Health and local governments support it using their policy levers of facilities planning, licensing, targeted capital investment (potentially including public–private partnerships) and interventions by facilities owners to merge or close uneconomic and redundant facilities. For example, the Ministry of Health's licensing function for health facilities may need to be developed to support optimization by clearer criteria for minimum requirements for secondary care hospitals, criteria for different types of licenses for particular specialist services and different levels of care. NHSU contracting can then use these clearer regulatory criteria as the basis for contracting various services.

2.3.2 Alignment with public financial management

Ukraine has so far been able to avoid the problems of misalignment of public financial management rules with health financing reform that many middle-income countries have encountered; this is due to the public financial management reforms already put in place and through close collaboration with the Ministry of Finance during reform design. The state budget, approved by parliament, provides a single programme line for PHC services

(2308020)⁷ under the NHSU. This permits payment to providers for outputs rather than inputs – a critical design feature, to enable the NHSU to pay autonomous and private providers of health services using methods that allocate resources equitably, and create incentives for provider efficiency and performance improvement. The NHSU budget structure separates appropriation for its own administrative costs, thus providing transparent accountability for efficient and economical operations. The state treasury management system is able to service the NHSU with sufficient flexibility and timeliness, providing aggregate control and detailed accounting and reporting of use of resources – but, importantly, it avoids prior controls over detailed input mix or over allocation to detailed subprogrammes.

2.3.3 Alignment with local government policies

Chapter 3 discusses the relationship between local government financing for health and health financing through the NHSU for the PMG and explains why it is vitally important to define clear, non-overlapping but complementary roles for the NHSU and local governments in health financing. The complementary nature of local government health spending – notably on capital investment and development of local health facilities – creates a need for governance arrangements to coordinate NHSU purchasing and local government health investment strategy. Without alignment of local government and NHSU decisions, the NHSU cannot achieve its objectives for ensuring access to health services or for increasing efficiency and quality of health care. Similarly, local government responsibility for local public health spending – on disease prevention and health promotion – needs to be aligned with NHSU spending, particularly at primary care level, where local government prevention activities at the community and population levels on high-priority health concerns (such as noncommunicable diseases (NCDs)) need to be coordinated with NHSU-funded screening, diagnosis and treatment services in order to have maximum impact on priority diseases – such as high-burden NCDs and mother and child health.

Coordination with local governments is one of the key functions of regional branches for a single purchaser in a country of the size of Ukraine, in which local governments own and manage most of the health care infrastructure. One of the key reasons why the NHSU needs regional branches is to lead and operationalize this coordination. The functions and processes of engagement with local governments usually include: joint participation in strategic planning for the local health system, consultation of the NHSU by local governments in health investment planning and human resource development, sharing of data and coordinated activities in monitoring health care provider performance: NHSU contract monitoring can either take over or utilize some of the current functions of local government health departments, shared public/customer interface functions and processes for handling complaints about local health care, and joint planning and preparation for emergencies with a health/health care dimension.

Additionally, during the next 1–3 years of the NHSU's start-up phase as it takes on responsibility for the health subvention for secondary and tertiary health care, there will be additional transition and change management tasks requiring coordination with local governments.

Many countries have formalized local coordination between their single purchaser and local governments through joint boards/councils, joint planning processes

⁷ Law on State Budget of Ukraine for 2018. (<https://zakon.rada.gov.ua/laws/show/2246-19/page>, accessed 1 August 2019, in Ukrainian).

and establishment of some shared services. Alongside development of NHSU regional branches, consideration could be given to establishing this type of formal arrangement.

2.4 | Emerging impact of policies on reform objectives

The NHSU is currently in its start-up phase. It has not yet had a full financial year of operation, and so the full annual cycle of governance-related accounts and reports are not yet available. The NHSU will only take on full responsibility for the whole PMG in 2020, and the PCC element of the governance arrangements envisaged in Law 2168 will only then be implemented. It is therefore too early to have evidence of the impact of governance arrangements, although some of the checks and balances created under Law 2168 are already visibly in operation, as envisaged.

The impact of governance arrangements on the ultimate outcomes health financing reform aims to achieve – such as improved financial protection, access, efficiency and quality of health care – is indirect, and inherently difficult to evaluate. Qualitative methods are usually used. Assessment or review can usually only be conducted over longer time frames, in order to assess whether the annual cycle of governance processes results in effective remedial action on issues identified, which requires assessment over a 3–5 years period. The kind of methods and indicators of good governance for a health purchaser proposed in international guidance and used in some countries include, for example:

- public expenditure and fiduciary assessment methods of the NHSU and wider public health expenditure management;
- process indicators such as timely and transparent publication of strategic and operational plans, budgets, financial and performance reports;
- publication of reports and recommendations of key governance bodies including PCC and external audit reports; and
- public and stakeholder perceptions surveys to provide indication of public awareness and institutional reputation.

2.5 | Anticipated challenges

2.5.1 Setting realistic objectives and a credible fiscal constraint

Realistic, achievable objectives for the NHSU and a firm, credible fiscal constraint are critical prerequisites for holding the NHSU accountable for performance. This will be very challenging to achieve in the Ukraine context because of the substantial existing gap between the fiscal resources available for the PMG, on the one hand, and high public and health worker expectations of a comprehensive benefit package of free services, improved quality of care and higher pay for health care workers, on the other. The key challenge for governance is that of avoiding the pitfalls of blaming the NHSU for slow progress in tackling these very longstanding challenges when the NHSU does not have power or authority to change these constraints. This challenge can only be tackled through joint ownership and aligned communication by all voices in the government and the NHSU of the long-term

nature of the task, and of the very difficult decisions required to close the gap. This will require a major focus on efficiency gains through optimization of health facilities. Fostering a continuing close and constructive relationship between the NHSU and Ministry of Health leadership through changes of administration is a critical success factor not only to health financing but to wider health sector strategy.

2.5.2 Developing mature governance oversight bodies for the NHSU

Developing a mature style of governance oversight bodies for the NHSU can be challenging in former Soviet Union countries where there has been an institutional history of detailed prior control of public institutions, and punitive responses to performance shortfalls. Results-oriented ex-post accountability requires governance bodies to have membership with depth of knowledge of the sector in order to set realistic, but challenging expectations and make reasonable judgements; make good judgements about the risk register and risk mitigation strategies of the purchaser; and assess performance based on a sophisticated understanding of the risks and trade-offs faced by the purchaser. Tapping individuals with governance experience from the private sector or international experience, along with training and coaching in governance has been helpful in other country examples. The external auditor also needs to develop this kind of knowledge of the sector and capacity to assess trade-offs and results – through some combination of training and hiring or contracting of relevant expertise.

2.5.3 Developing coordination mechanisms between the NHSU and Ministry of Health and local governments

Over the next 5–10 years, the health system will need to undertake two interrelated types of transition process for developing formalized coordination between the NHSU and the Ministry of Health at central level, and the NHSU and local governments at local level.

- One is the transition from historic levels of hospital budgets spending based on inputs in each health facility to hospital budgets largely derived from revenues from case payment and other payments for services from the NHSU. This transition will mean that some hospitals will need to reduce costs to avoid incurring fiscal deficits once NHSU payment methods are implemented, or – where feasible – expand service delivery to earn more revenue. Some hospitals may prove not to be financially sustainable. To manage this transition for hospitals, there will need to be coordination between the hospital owner and the NHSU, and agreed policies on financing from NHSU and owner sources.
- Another is the process of optimizing the hospitals network by concentrating more specialized services and closing, downsizing or re-profiling redundant facilities. This process will need leadership by the Ministry of Health and close local government involvement, but with NHSU input, and coordination over related changes to the services the NHSU purchases from different providers.

The success of transformation at provider level in response to the combination of new NHSU payment methods and facilities autonomy will be slow if management capacities in public providers remain weak. Provider autonomy brings increased financial risk of budget overruns, and will call for strengthened oversight and support by local governments as owners.

2.6 | Policy recommendations

Identify managerial and staff responsibility in the Ministry of Health and Ministry of Finance to support the formal governance oversight role of the NHSU by the Cabinet Committee system and build their capacity for governance of the single purchaser.

Build knowledge, capacity and experience in the Ukrainian public sector (wider government) for a wider set of accountability arrangements and considerations towards the health purchaser to ensure that the NHSU purchasing contributes to social objectives including equity and social justice, purchased services reflect value for money, and processes for internal controls and internal audits are in place and function.


Develop standard operating procedures and templates for a model annual governance cycle of NHSU papers and reports to the Cabinet Committee overseeing the NHSU and the PCC, and identify cycle of governance and accountability documents, which should be published on the Internet.

Establish the PCC according to the provisions of Law 2168 during 2020, to begin its work in 2021, after the NHSU has completed the transition to full responsibility for all of the PMG, and design mechanisms to ensure conclusions and findings of the PCC feed into the Cabinet's oversight of the NHSU.

Establish regional branch offices for the NHSU during 2020, in view of the importance of regional presence for several critical functions, including:

- to enable the NHSU to put in place robust monitoring and control functions for claims validation;
- to have regional NHSU capacity to communicate and negotiate with providers constructively over needed improvements in services; and
- to coordinate with local governments over local strategic planning for health services, and develop efficient sharing of data and functions (such as customer information and complaints services) with local governments.





Chapter 3

EVOLUTION OF FISCAL SPACE, REVENUE COLLECTION AND POOLING ARRANGEMENTS

3.1 | Introduction

Revenue collection and pooling are critical elements of health financing. To ensure fiscal sustainability of the health financing reform, it is important to raise sufficient and sustainable revenues in an efficient and equitable manner to cover individuals with a basic package of services and provide financial protection. Investments in health are important from an economic perspective: in developing human capital and for increasing individual and national productivity, as well as preventing higher/deeper levels of impoverishment resulting from dependence on OOP financing for health. Public financing – especially general government revenue financing – is key for making progress towards universal health coverage. Global experience has shown that countries closest to universal health coverage objectives spend upwards of 80% of total resources for health from public sources. Globally, there is a strong inverse relationship between the public spending share of gross domestic product (GDP) and OOP share of total health spending. The success of Ukraine's reforms will depend in part on the ability of the health financing system to replace OOP financing with public financing for health. In addition to the level of public financing, pooling arrangements are also important for financial protection and efficiency-enhancing service delivery reforms. Fragmentation constitutes a barrier to redistribution from a given level of prepaid funds, and is therefore problematic for risk pooling. Fragmentation can also be a cause of health system inefficiency.

Ukraine has chosen to rely primarily on general tax revenues with a single pool to finance the benefits package provided by the NHSU. This chapter evaluates reforms in revenue mobilization and pooling and assesses the fiscal space for health based on the broader macroeconomic trends. The mission team reviewed key documents and legislation related to the health financing reform, focusing on resource mobilization and fiscal space based on Ukraine's macroeconomic outlook. Data sources included central and local government budgets, International Monetary Fund projections and published reports.

3.2 | Overview of key policies

The Health Financing Reform Concept⁸ clearly articulates policy directions in revenue collection and pooling in order to improve efficient use of scarce resources and enhance the equity of allocations. In October 2017, parliament adopted the new health financing Law on “Government Financial Guarantees of Health Care Services”⁹ (Law 2168) and a package of related by-laws. This set of documents created a strong legal and political framework to implement new health financing arrangements. On 1 April 2018, the Government of Ukraine established a new single purchasing agency, the NHSU, and approved the regulations required for the functioning of the agency.

The Concept and Law 2168 retain general government revenue as the main public revenue source for financing health services in Ukraine. Historically, other alternatives had also been considered including the introduction of a payroll tax. However, this option was rejected from a macroeconomic policy perspective for its potentially negative impact on the labour market and on efforts to formalize economic activity. Unemployment and informality are relatively high in Ukraine. One tenth of the labour force is unemployed, while almost 24% of the employed population (or 4 million) worked in the informal sector in 2016.¹⁰ The government has taken substantial steps to incentivize individuals and businesses to formalize, and recent government data suggest that informal employment is declining.¹¹ In the first nine months of 2018, the shadow economy was estimated at 32% of GDP – almost three percentage points lower than during the same period in 2017. Given the labour market and overall macroeconomic conditions, the decision to retain general tax revenues as the source of public funding for health is the most efficient solution from a public finance perspective and creates the greatest opportunities for equalization and redistribution.

Law 2168 is transforming the pooling function. Since 2015, the government has been allocating funds for health to administrative units using a subvention mechanism.¹² Prior to the establishment of the NHSU, the general medical subventions covered prevention, primary care, outpatient and inpatient services. The size of the medical subvention was calculated as a proportion of the national budget and allocated to each administrative unit based on a capitation formula, using population size and differences in service provision (with a higher coefficient for mountainous areas). Approximately one third of the subvention was transferred to regional budgets, while the remaining two thirds were allocated to hromadas,¹³ rayons or cities. In 2018, there were 1288 administrative units (e.g. rayons, municipalities, regions and hromadas) each of which constituted an administratively decentralized and territorially overlapping budget-funded pool. This resulted in duplication of services and inefficient use of resources. The central government funded the bulk of health services via subventions,

⁸ Cabinet of Ministers Decree of 30 November 2016 No. 1013-p on Approval of the Health Financing Reform Concept (<https://www.kmu.gov.ua/ua/npas/249626689>, accessed 22 August 2019, in Ukrainian).

⁹ The Law of Ukraine on Government Financial Guarantees of Public Medical Services No. 2168-VIII (<https://zakon.rada.gov.ua/laws/show/2168-19>, accessed 22 August 2019, in Ukrainian).

¹⁰ Undeclared Work in Ukraine: Nature, Scope and Measures to Tackle It. Geneva: International Labour Organization; 2018 (https://www.ilo.org/wcmsp5/groups/public/---ed_dialogue/---lab_admin/documents/projectdocumentation/wcms_630068.pdf, accessed 26 August 2019).

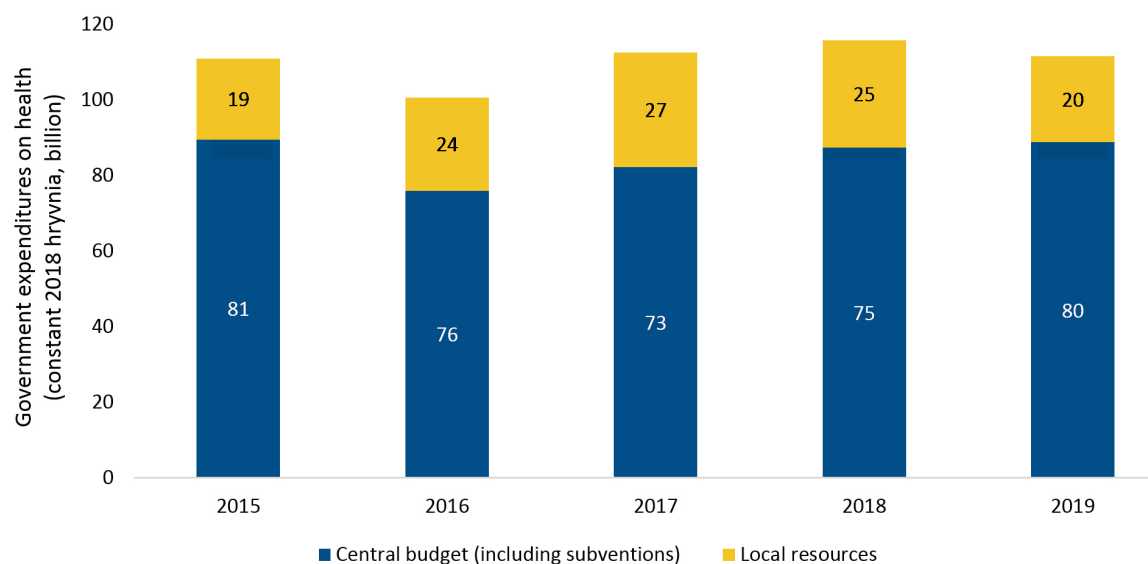
¹¹ ILO helps Ukraine to reduce undeclared work. In: International Labour Organization [website]. Geneva: International Labour Organization; 2019 (https://www.ilo.org/budapest/whats-new/WCMS_672587/lang--en/index.htm, accessed 26 August 2019).

¹² The two types of subventions are general medical subventions and subventions for specific medical programmes (e.g. diabetes).

¹³ Hromadas are local self-government units that range from cities to villages and rural hamlets in Ukraine, below the district level.

which between 2015 and 2019 represented on average 77% of government health spending. Local governments funded the remaining share from their own resources (Fig. 3.1).

Fig. 3.1. Government health expenditures, 2015–2019



Source of data: Ministry of Finance of Ukraine. Annual Treasury Reports.

Implementation of the new pooling and purchasing policies has begun with successful roll out to PHC, and plans are underway for roll out to hospital care. In the first stage of reforms, in July 2018 the Ministry of Finance transferred part of the medical subventions for PHC to the NHSU, which has contracted public and private providers on a capitation basis. Starting from 2020, the same principle will be used for all services covered under the benefits package, including hospital services, which will be paid using diagnosis-related groups (DRGs) and global budgets, thus channelling the former medical subvention through the NHSU. Pooling funds for health services in the NHSU ends previously experienced fragmentation and duplication, and provides the opportunity to develop a rational service delivery network that matches population needs. The reform aims to create a single national pool with a set of guaranteed entitlements and responsibilities for the whole population, regardless of the place of residence.

The health financing reform is also underpinned by broader public financial management reforms, and the government has made concerted efforts to strengthen public financial management. This includes the adoption of a medium-term budget framework (MTBF) for 2020–2022 to reinforce fiscal discipline and provide predictability in budget planning and execution. In addition, as part of the MTBF, the government plans to introduce binding budget ceilings for key spending units in the annual budget declaration. As autonomous legal entities, health facilities no longer have to follow the civil servant salary scales. At the same time, as stipulated in the Law on “Government Financial Guarantees of Health Care Services” (Law 2168), the tariffs calculated by the NHSU should incorporate the cost of labour using as the basis at least 250% of the average national wage in July of the preceding year.

¹⁴ Budget Code of Ukraine. Verdicts of the Parliament of Ukraine, 2010, No. 50–51 (<https://zakon.rada.gov.ua/laws/show/2456-17#n573>, accessed 26 August 2019, in Ukrainian).

The current Budget Code of Ukraine¹⁴ expands significantly the power of local governments to raise their own resources, reducing redistribution of revenue across local government units. Fiscal decentralization has set new rules for the allocation of taxes to local budgets. A total of 60% of personal income tax, 100% of state duty and 100% of the fees for administrative services are now paid into local budgets. In what is described as a radical change, local administrations have gained the right to levy a local property tax and a local excise tax on alcohol, tobacco and fuel.¹⁵ They are also allowed to borrow larger sums than before from the central government and banks to finance their spending projects. This is partly offset through a system of direct fiscal transfers between the central government and regional administrations through a transparent formula for the allocation of intragovernmental transfers, including medical and educational subventions, equalization grants and additional grants for maintenance of educational and health facilities.

Roles and responsibilities of each level of the government and types of expenditures to be financed by state and local budgets respectively are described in detail in Articles 87 and 89 of the Budget Code. The PMG must be financed from the state budget. However, local government bodies are responsible for utility costs and maintenance of facilities.¹⁶ Importantly, they can provide services beyond the PMG. The core public health services are within the responsibility of the central government, which is in line with general international recommendations. However, local governments can also have their own local public health programmes. The amendment to the Budget Code requiring local governments to finance utilities costs was done as a measure to mitigate the problem of insufficient fiscal space at central government level after devolution of increased revenue to local governments, although many local governments do not also have sufficient fiscal capacity to meet these obligations. This is an unusual regulation – not one that is generally recommended because normally utilities and maintenance are treated as part of the recurrent costs of service delivery and included in prices paid by the purchaser. While it was an understandable and necessary fiscal coping strategy, it may need to be revisited in the future.

Article 3 of Law 2168 also provides a brief description of the respective roles and responsibilities of state and local governments in financing health care in Ukraine. According to the Law, state medical guarantees are funded by the central government (*державний бюджет*). In addition, public health programmes and measures to combat epidemics and other programmes for health protection are funded by the state budget according to the list, approved by the Cabinet of Ministers of Ukraine. Within the limits of their competence, local self-government bodies may (*можуть*) finance local development and support programmes for health care institutions, in particular, for upgrading the material and technical base, capital repairs, rehabilitation, salary increases for health workers (local incentive programmes), local community health services, local public health programmes and other health care programmes.

¹⁵ Jarabik B, Yesmukhanova Y. Ukraine's Slow Struggle for Decentralization. Washington (DC): Carnegie Endowment for International Peace; 2017 (<https://carnegieendowment.org/2017/03/08/ukraine-s-slow-struggle-for-decentralization-pub-68219>, accessed 26 August 2019).

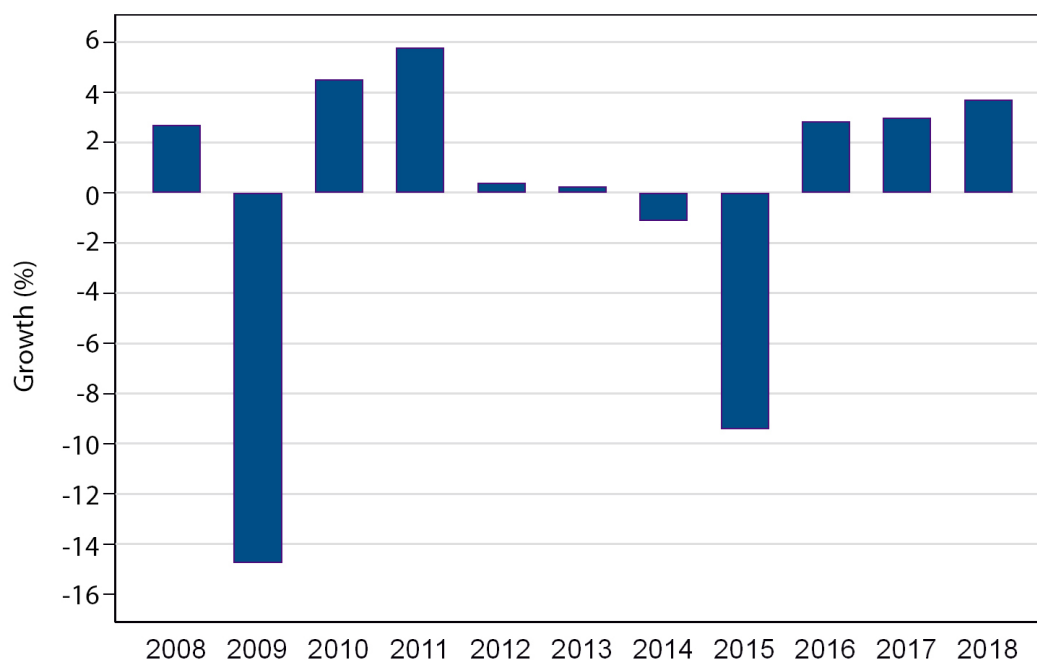
¹⁶ In 2017, the Budget Code was amended to mandate local governments to pay utility bills of locally owned health (and education) facilities, and this provision will be maintained at least in the short-to-medium term..

3.3 | Alignment with other areas of health system strengthening and public sector reforms

Health financing policies and health spending need to be considered within the overall economic and macro-fiscal environment of a country. Ukraine's health financing policies are well aligned with the macro-fiscal environment. There is a clear understanding that increasing fiscal space for health will remain limited in the long run, and efficiency gains will have to be sought as a major source of revenues for improving services.

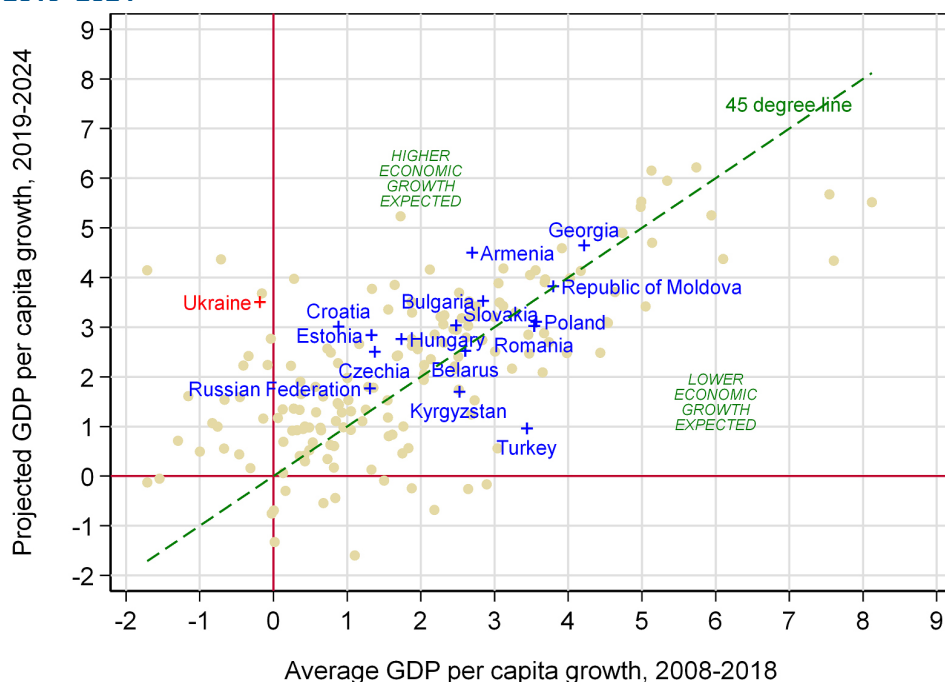
The health reforms are being implemented in a tight macro-fiscal environment. The overall size of the economy has remained largely unchanged in per capita terms over the past decade (2008–2018) with economic growth rates being highly variable over this same period. The average economic growth rate was –0.2% in per capita terms, with two notably severe declines: first due to the 2009 global financial crisis and again in 2014–2015 due to political events (Fig. 3.2). Ukraine's economic performance over the past decade stands in sharp contrast with that of comparator countries. Growth is expected to rebound in the near term, albeit to modest projected increases of 3–4% per year over 2019–2024 (Fig. 3.3).

Fig.3.2. Per capita economic growth, 2008–2018



Source of data: International Monetary Fund

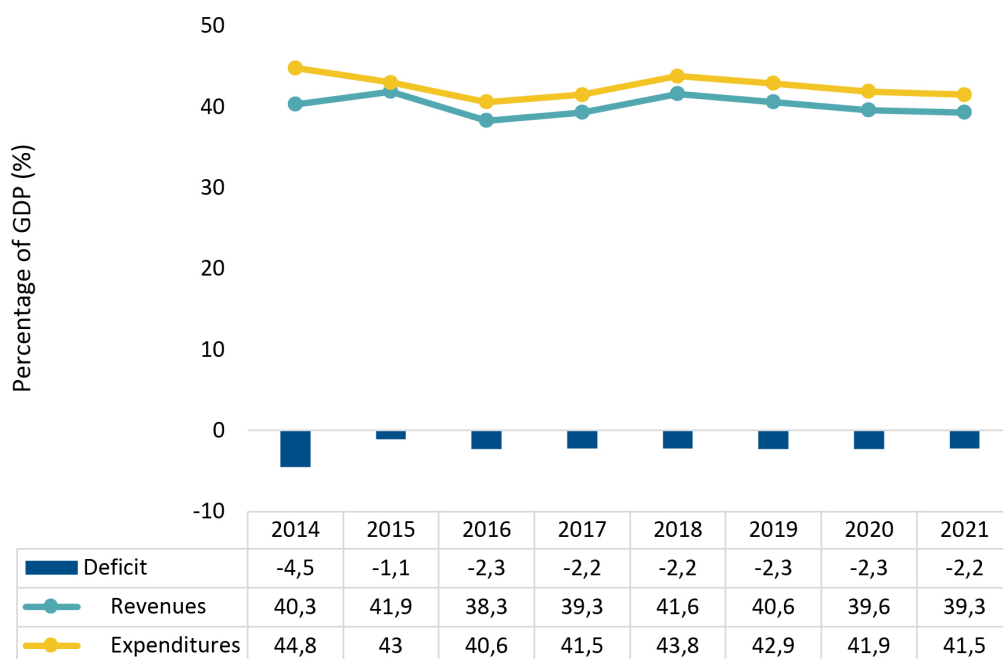
Fig. 3.3. Average GDP per capita growth 2008–2018 compared to projected GDP per capita growth 2019–2024



Source of data: International Monetary Fund

The government will continue to maintain a deficit of approximately 2% of GDP by 2021 (Fig. 3.4). Fiscal discipline worsened slightly in 2018 after the approval of supplementary budget and pension legislation that included large wage and pension increases. The budget deficit target is set at 2.3% of GDP in 2019¹⁷ and is likely to be met largely due to curtailing capital spending.

Fig. 3.4. Government revenues and expenditures as a share of GDP, 2014–2021



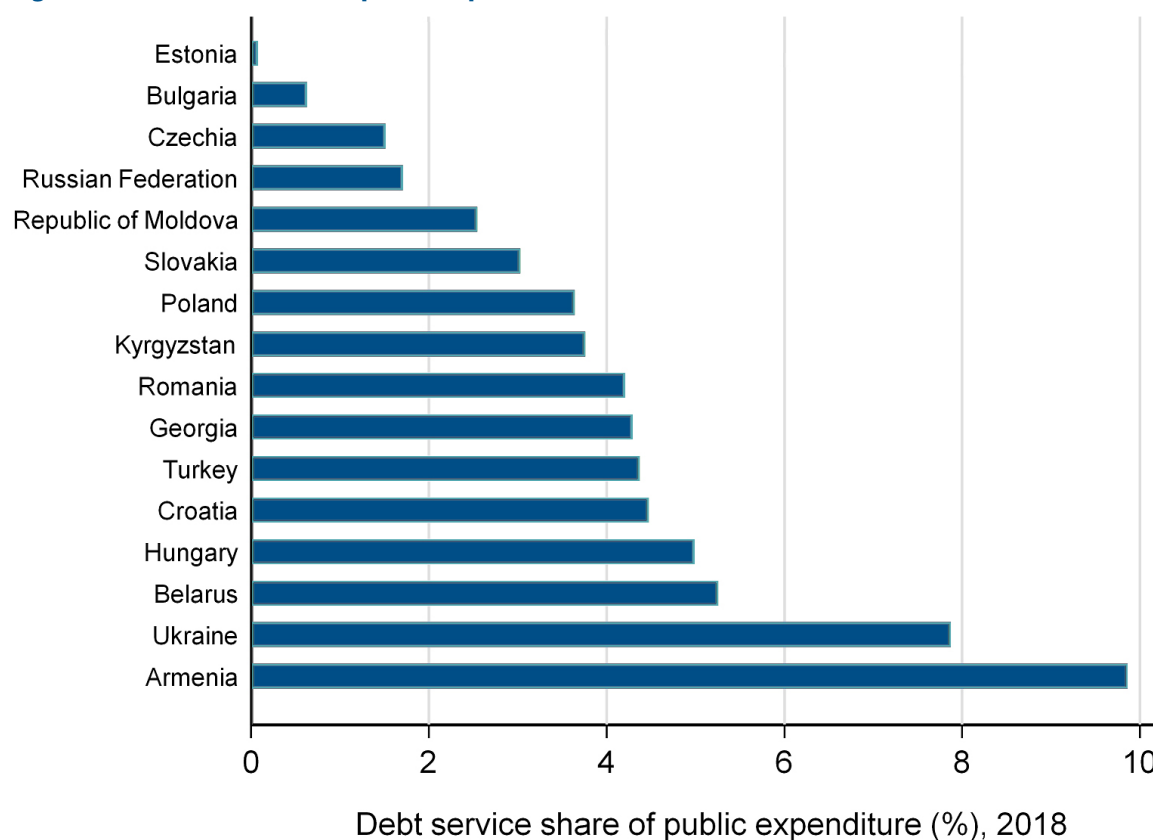
Source of data: International Monetary Fund

Note: 2014–2018 are actual revenues and expenditures; 2019–2021 are projections.

¹⁷ In 2018, the budget deficit target was set at 2.4% of GDP.

Fiscal space, or the ability of Ukraine to realize extra budgetary room to increase public financing in a sustainable manner, is also tight due to debt and security-related challenges in the country. Although public expenditures are a relatively high share of GDP – due to a relatively high (more than 40%) share of public revenues in GDP – a large share (approximately 8%) goes towards servicing debt, one of the highest shares among comparator countries; and a similar share accounts for security-related public expenditures (Fig. 3.5). After peaking at 16.5% in September 2017 due to large wage and pension increases and food price shocks, inflation reached 10% by the end of 2018. Tight monetary policies and slowing domestic demand will help to gradually bring inflation back to just under 7% by the end of 2019 and within the National Bank of Ukraine’s target range of 5±1% in early 2020.

Fig. 3.5. Debt service share of public expenditure (%), 2018

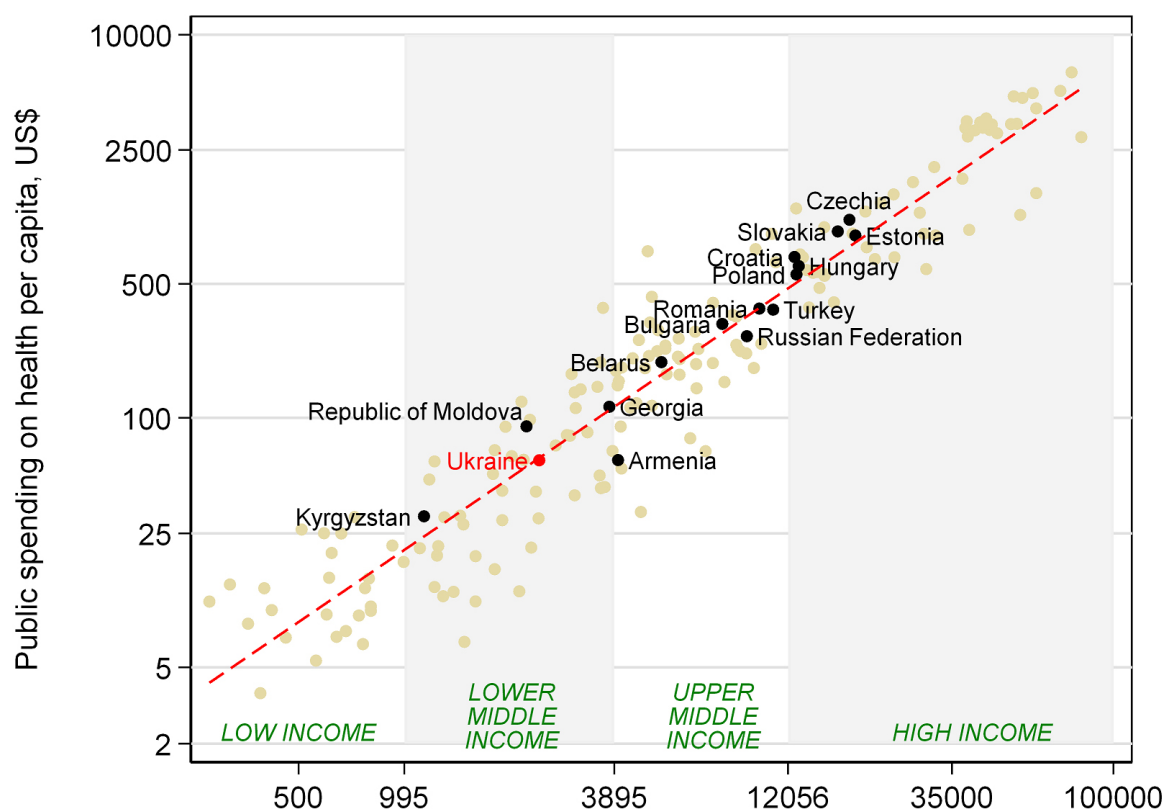


Source of data: International Monetary Fund

Pre-reform estimates indicate per capita health spending rates of approximately US\$ 150, with the largest share (54%) coming from OOP sources. In 2016, roughly 40% of health expenditures were from public sources. Public financing for health was approximately US\$ 87 (constant 2018) (or 3.2% of GDP), roughly as expected for Ukraine’s income level but lower than almost all comparator countries other than Kyrgyzstan (Fig. 3.6). OOP payments were substantially higher than in other countries with comparable income levels. Between 2010 and 2015, the incidence of impoverishing OOP payments rose from 7.6% of households to 9.0%, while the incidence of catastrophic OOP payments rose from 11.5% to 14.5%. Medicines and inpatient care were the largest drivers of OOP spending.¹⁸

¹⁸ Goroshko A, Shapoval N, Lai T. Can people afford to pay for health care? New evidence on financial protection in Ukraine. Copenhagen: WHO Regional Office for Europe; 2018 (<http://www.euro.who.int/en/countries/ukraine/publications/can-people-afford-to-pay-for-health-care-new-evidence-on-financial-protection-in-ukraine-2018>, accessed 26 August 2019).

Fig. 3.6. Public spending on health per capita vs gross national income per capita (US\$), 2016



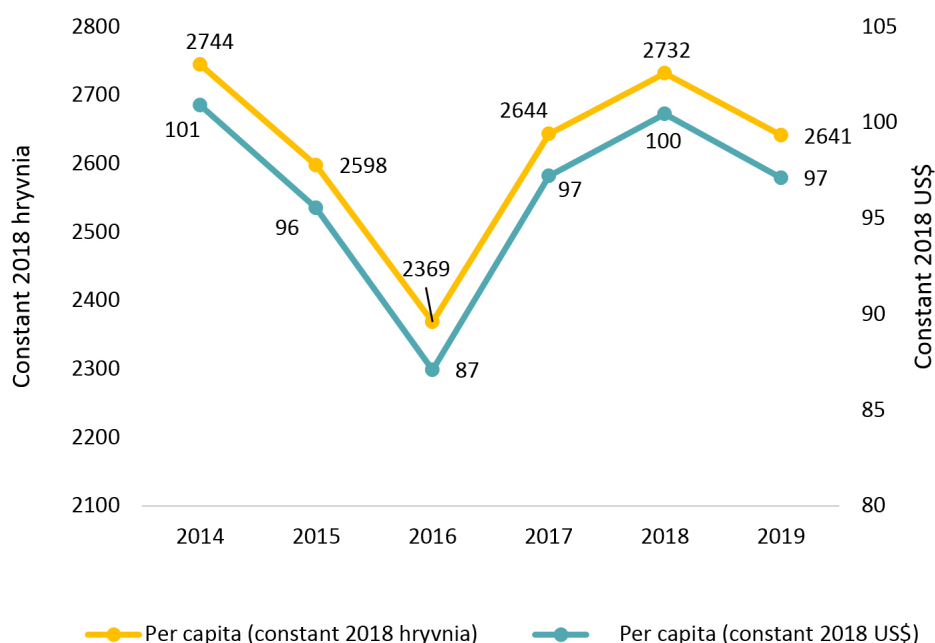
GNI: gross national income

Source of data: International Monetary Fund and World Development Indicators, 2019.

Public spending on health has remained roughly the same in real per capita terms since the initiation of reforms and has bounced back to the level observed in 2014.

In 2015–2016, the government was forced to significantly reduce expenditures on health (from US\$ 101 in 2014 to US\$ 87 in 2016 in constant 2018 US dollars) to reduce the general government deficit and restore macro-fiscal stability (Fig. 3.7). A tax reform introduced in 2015 significantly reduced the tax contributions to social security funds, thereby increasing the pension fund’s deficit to 5% of GDP. Higher gas tariffs led to the introduction of a fuel, housing and utility subsidy to offer social protection to the poor and vulnerable populations. As a result, social protection spending increased from 8.4% of GDP in 2015 to 10.3% in 2016, while spending in all other sectors was cut substantially.

Fig. 3.7. Government health spending in real 2018 hryvnia and US\$, 2014–2019



Source of data: Ministry of Finance of Ukraine. Annual Treasury Reports.

It is important to position the health financing reforms in the context of the decentralization reform approved in 2014. Given current policies on own revenue assignment and significant scope for determining local spending priorities, the role of local financing in total provider revenue appears to vary greatly between and within regions.¹⁹ Fiscal decentralization reforms have cut central subsidies to some areas and may widen inequities between and within regions. GDP growth in Ukraine is highly concentrated (i.e. meaning that some regions are growing very fast while others are not growing at all or experiencing even a negative growth), and the degree of concentration is well above the Organisation for Economic Co-operation and Development (OECD) average.²⁰ In this context, pooling of resources, including medical subventions, by the purchasing agency at central level will play a critical role in reducing the interregional disparities in entitlements and access to health services.

3.4 | Emerging impact policies on reform objectives

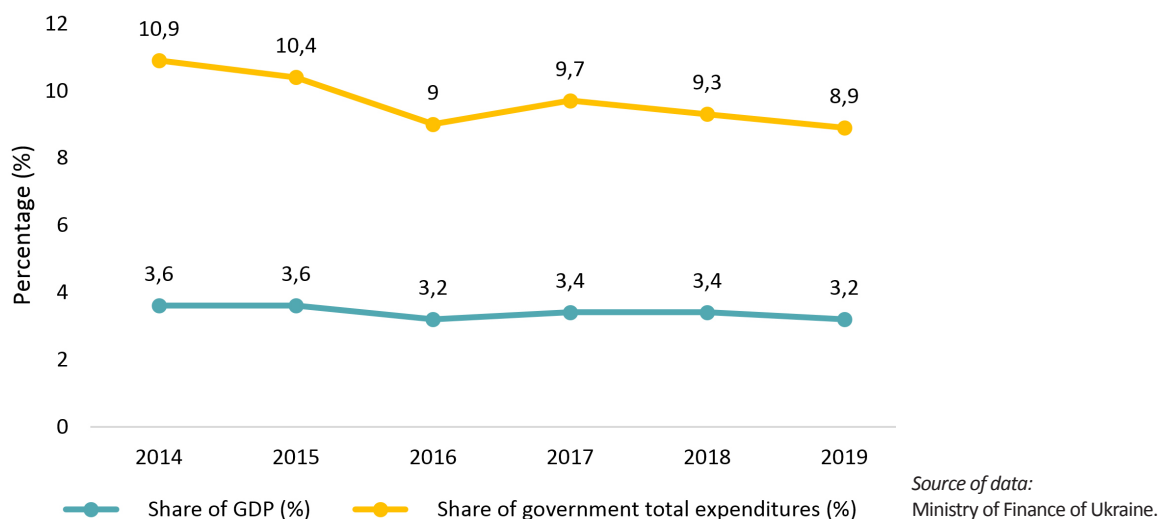
The share of health in government expenditures has been declining since 2014. The decline in the share of government funding is important because it is indicative of priority setting within the health budget. While decline in priority to health during the 2014–2019 period is understandable due to the above described pressures (debt service, subsidies and pension spending) and the ongoing conflict, the consistent year-on-year decline raises some concerns about the future sustainability of the reforms. Notably, health spending as a share of GDP at 3.2% is well below the 5% mandated by Law 2168 (Fig. 3.8). Ensuring

¹⁹ For example, the average share of local financing in hospital revenues is 20% in Zhytomyr region, 28% in Vinnytsia region; the average is 59% in Lviv region and 56% in Poltava region. While these data are self-reported by facilities that due to how funds are pooled at regional level are not always able to distinguish between local and central budget financing, it is clear that the extent to which local authorities finance providers varies significantly depending on their revenue-raising capacity and local priorities.

²⁰ Maintaining the Momentum of Decentralisation in Ukraine. Paris: OECD Publishing; 2018 (OECD Multi-level Governance Studies).

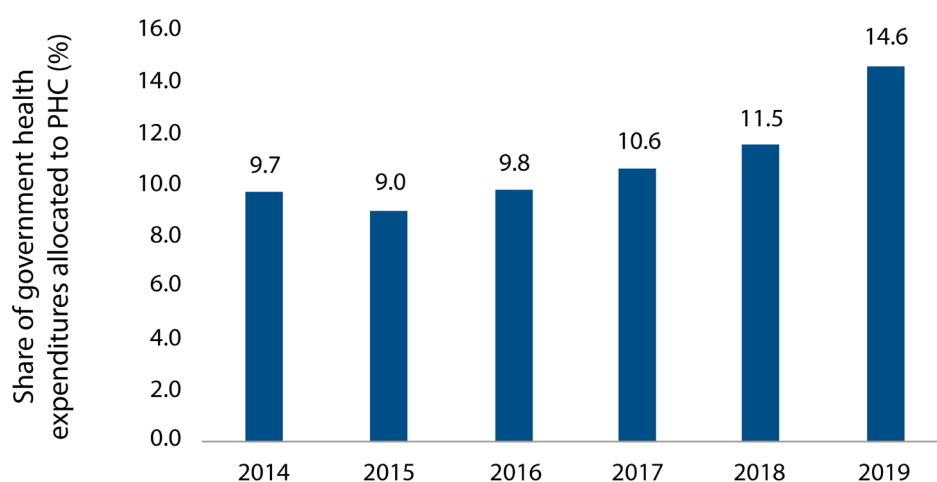
overall stability of the health budget envelope will be key for continued implementation of health system reforms to safeguard resources from efficiency gains and to translate them into better quality coverage and services.

Fig. 3.8. Government health spending as a share of GDP and total government expenditures, 2014–2019



On the positive side, spending on PHC has increased substantially reflecting efforts to strengthen frontline services (see Chapter 4 on purchasing primary care services for more details). PHC represented 10.6% of government health spending in 2017 compared to 11.5% in 2018 (Fig. 3.9). In 2019, the share of PHC in the approved budget is increased further, reaching 14.6% of total government spending on health. Increasing the balance of spending favouring PHC is an important indicator of within-sector priority setting. The observed prioritization of PHC supports the government’s focus on improving frontline services. It will be important to maintain this as secondary and tertiary care reforms are rolled out. Adequate budget planning, however, is critical to ensure fiscal discipline and sustainability of the reforms. Due to PHC enrolment exceeding the target population included in the 2019 budget calculations, the government is already running a deficit. While intermediate steps

Fig. 3.9. Share of government health expenditures allocated to PHC



Notes: PHC includes feldsher–midwife points of contact (budget code 0725) and PHC centres (budget code 0726). For 2018 and 2019, NHSU spending on PHC is also included (programme 2308020 on the “Provision of primary medical care”).

Source: Consolidated budget expenditures based on functional classification from the State Treasury Service of Ukraine website and programme expenditures for 2018 and 2019.

were taken to cover the deficit,²¹ moving forward it will be important to plan and allocate sufficient resources during the budget-setting process.

One of the objectives of the health reform is to improve financial protection, yet data on household OOP health spending are not available to measure this. It is important to measure the extent to which improvements in pooling and purchasing have resulted in lower OOP spending on health. While some sociological surveys and polls are being conducted, annual household expenditure surveys can provide a much more granular understanding of the drivers of and changes in OOP spending as reforms progress.

3.5 | Anticipated challenges

Ukraine's macroeconomic situation limits the fiscal space needed to increase public expenditure on health. As such, efficiency gains will be a critical source of fiscal space. Efficiency gains and optimization will be necessary as increasing public financing for an inefficient system will not yield desired outcomes. The focus should not be on cutting costs alone, but on buying more and better health from what is spent. It is vital to enhance the performance of health service delivery to achieve better health outcomes using the same amount of resources while protecting individuals from catastrophic health expenditures. Financing reforms that are not accompanied by hospital reforms are likely to be ineffective. Without implementation of efficiency gains and optimization in the hospital sector, there are risks that OOP spending rates will remain high, provider-level arrears/deficits will increase and inefficiencies will continue to constrain attainment of improvements in health system outcomes.

One of the key challenges of Ukraine's health financing reform is to streamline intergovernmental financing of the system. By pooling funds under the NHSU, the government aims to reduce fragmentation in resource allocation. Due to limited ability to substantially increase resources at central level, the reform will still rely on local governments to improve service delivery.

Without close monitoring and timely corrective measures, current fiscal decentralization policies expanding significantly the taxing power and autonomy of local governments may inadvertently lead to less equitable and efficient health spending across the country. Firstly, as described above, some local governments will choose and will be able to afford spending on health that exceeds the PMG, developing their own incentive programmes for health workers, providing additional equipment, etc. Not all such spending may be in line with national health priorities. Secondly, there is a concern regarding consequences of these arrangements for geographical equity if other mechanisms are not developed to ensure that areas with less revenue-raising capacity are able to maintain facilities in their ownership and cover utility costs, which are not insignificant in Ukraine, particularly during the cold season. As the OECD study shows,²² for many local authorities

²¹ In June 2019, the Cabinet of Ministers issued a resolution to transfer 1 billion hryvnia from the specialist outpatient care pilot to РНС. Уряд направив додатково 1 млрд грн на медзаклади, в яких працюють сімейні лікарі, терапевти і педіатри [The Government has sent an additional 1 billion Ukrainian hryvnia to medical institutions where family doctors, therapists and paediatricians work]. Kyiv: Ministry of Health of Ukraine; 12 June 2019 (<http://moz.gov.ua/article/reform-plan/urjad-napraviv-dodatkov-1-mlrd-grn-na-medzakladi-v-jakih-pracjujut-simejni-likari-terapevti-i-pediatri>, accessed 26 August 2019, in Ukrainian).

²² OECD. 2018. Maintaining the Momentum of Decentralisation in Ukraine. OECD Multi-level Governance Studies. OECD Publishing: Paris.

the weight of current expenditures on local budgets is high, limiting significantly their fiscal capacity to invest. In addition, variation in the amount health workers are paid, and variation in availability of drugs, supplies and equipment will continue and may even widen and cause disenchantment with reforms.

The central government, however, does not have a comprehensive overview of the total resources allocated for health in each region as it is not involved in the local budget-setting processes. Local budgets consist of the region, rayon and local self-governing authorities. Each local government votes on the respective budgets in the beginning of the year, and the individual budgets are available on each administrative unit's website. Consolidated expenditures, including central and local resources, are only available from the State Treasury Service of Ukraine website.²³ This limits the ability of the Ministry of Health and NHSU to adequately plan budgetary expenditures.

There are some early signs that health spending from local governments' own revenues is reduced due to unclear responsibility and accountability for health expenditure and service delivery at local government level. Although data on local spending on health are notoriously difficult to obtain by region, some raised concern that as budgets for next year are being prepared, local governments are allocating fewer resources to health from their own revenues. For example, in Poltava region, which is a pilot region for implementation of new hospital payment reforms, in the financing plans for hospitals, it appears that local authorities at district level already reduced funding for 2019 compared to 2018.

3.6 | Policy recommendations

The government should continue with the current model of revenue generation and pooling, with a general tax-financed revenue base for the health sector pooled in the NHSU, the single purchaser of health services in the benefit package from both public and private providers, to maximize the impact of public funds. This approach is well aligned with the existing economic and labour market conditions in Ukraine. The government should continue implementing funds pooling and creating a stable budget framework. The most urgent priority is to complete the roll out of contracting in 2020–2021 for secondary care. Having parliament pass the 2020 budget law with the list of state-guaranteed health services for secondary and tertiary care will enable uninterrupted continuation of the reforms.

Adequate budget planning is critical to ensure fiscal discipline and sustainability of the reforms. Actuarial projections of the cost of the benefits package are needed to ensure fiscal sustainability of the reform and enable the government to align the benefits package with the broader medium-term macroeconomic outlook of the country. Relatively high inflation rates will erode the purchasing power of outlays. The Ministry of Finance should ensure that per capita expenditures in real terms are maintained to enable predictability of financing and facilitate realizing improvements in efficiency. Maintaining and further increasing priority to PHC within the health budget envelope will enable further strengthening of frontline services. Any achieved efficiency gains should be reinvested within the health

²³ The budget-setting process at central level is as follows. The Ministry of Health submits the proposed budget to the Ministry of Finance, which then submits it for parliamentary approval as part of the budget-setting process. The PMG is approved by parliament as part of the Law on the State Budget of Ukraine, in which Annex 3 provides detailed budgetary allocations for each sector.

sector to support priority activities, while additional budgetary allocations for health should be correlated with economic growth and fiscal conditions.

It is important to align local financing with national priorities and reform processes.

The Ministry of Health and the NHSU should engage with local governments on budget planning processes early to ensure that local resources can be leveraged to fill gaps in service delivery and to improve quality of care. It is important to build capacity at local level for health service planning and to enable the provision of a supplemental benefits package depending on the region's needs and resources. Local governments have an important role to play as facility owners and financing agents, but further policy dialogue is needed on how to clarify and align decentralized roles and national health policy priorities. To do this, there are three broad options for Ukraine, but a combination of these is also possible. In all cases, a transition plan should be put in place to gradually pull up regions with low fiscal capacity and low spending on health from their own revenues without alienating richer areas, which are spending their own revenues on health, including for providing services beyond the PMG and financing incentive programmes to health workers.

Option 1.

The country could centralize the local government health spending from its own revenue and pool the funds at the NHSU. In most countries, however, it is politically very difficult to re-centralize revenue assignment to local government units, particularly in periods of flat overall revenue/expenditure. Although this option leads to the clearest assignment of responsibility, it lacks the potential benefit of the local knowledge and citizen engagement of local government in health service delivery. This option would also require the government to revisit the broader decentralization debate and would involve policies that go beyond the health sector (and are outside the scope of this report).

Option 2.

Clarify spending responsibility of local government units mandating them to continue to spend their additional own revenues on health in specified non-overlapping areas of spending (e.g. capital investment, local public health services, services beyond the PMG). This is already partly there but it requires strengthening the current arrangements. Ideally under this option, there should be cooperative joint planning/agreement between the Ministry of Health (and the NHSU) and local government units on spending priorities and plans. *This is the option recommended in this report, and this is also in line with the OECD 2018 review of fiscal decentralization in Ukraine.*

Option 3.

Introduce incentives for local governments to continue financing health and to align their spending priorities with national policy objectives. In this option, some countries introduced conditionality or performance-based features into central government transfers to local government units to create incentives for them to continue to allocate adequate funds to health and to align priorities with national government strategies (e.g. percentage cost sharing for some defined areas of health spending, or conditionality around coverage by local governments of some public health/population health interventions, or around defined upgrading of health facilities to meet new standards).

Regardless of the option chosen, it will be important for local governments to monitor spending from their own revenues as reforms move forward. As discussed earlier, lack of centralized data on local government budgets hinders the ability to align the objectives and reform efforts of national and local stakeholders.

The government should continue developing capacities and mechanisms to foster a shared understanding of priority objectives, approaches and solutions, and define roles and responsibilities between the Ministry of Health, NHSU, Ministry of Finance and local governments to attain high-performance in health financing. Close collaboration between the Ministry of Health and Ministry of Finance was a key success driver in the reform process from the beginning. The working group created in 2016 to draft the Health Financing Reform Concept comprised experts from the health and finance ministries with expertise in economics, medicine and finance. The shared understanding and vision of the Concept enabled the government to move quickly with implementing the reform. Good interagency relations are critical for the success of the reform.



4

INTRODUCING STRATEGIC PURCHASING OF PHC AND CATALYSING SERVICE DELIVERY TRANSFORMATION

4.1 | Introduction

This chapter reviews the PHC purchasing model in Ukraine. The review aimed to assess the existing policies, instruments and processes that support the introduction of strategic purchasing and catalyse the transformation of service delivery in PHC. With this purpose, the assessment team organized technical discussions with key national counterparts and international partners, collected legal documents, available data and PHC-related studies. The team conducted a rapid assessment of the PHC payment mechanism design and its implementation arrangements, seeking to find evidence of a transitional impact of the new PHC purchasing policy on access and quality of PHC. The team documented key accomplishments in the PHC purchasing reforms, identified future challenges and refinements needed, and provided policy recommendations.

4.2 | Overview of key policies

The NHSU began its operations as a single purchaser of health services with a focus on PHC, making tremendous progress in a short period of time. The first contracts with a PHC provider were signed in June 2018. For the first time, residents were legally given the right to choose a PHC physician; public and private PHC providers were given equal opportunities to deliver services under the PMG; public financing of PHC is prioritized; and the principle “money follows the patient” was implemented. There were several key accomplishments.

- From April 2018 to May 2019, 27.6 million (more than 65%) of Ukrainian residents signed declarations (enrolled) with primary care physicians.
- From June 2018 to May 2019, the NHSU contracted 1276 PHC organizations including 1024 public and 131 private organizations and 121 individuals (family doctors) to provide a guaranteed package of PHC services to the enrolled population.
- In all, 1024 public PHC providers became independent legal organizations with managerial and financial autonomy, which according to the NHSU is 97% of all PHC municipal medical organizations in the country.
- The PHC service package and payment formula are clearly defined; the unified rates/tariffs are set at an appropriate level, and new incentives for PHC providers are introduced through a capitation payment mechanism.
- From 1 April 2019, the NHSU has administered the government’s Affordable Medicines Programme. Since the Programme’s introduction, the NHSU has contracted 1000 pharmacies including 573 private ones; PHC doctors issued more than 2.3 million

prescriptions, of which 1.7 million were dispensed by pharmacies and supplied to patients.

- The NHSU is building the capacity needed to become a strategic health purchaser, developing its core functions and systems. These include digital processing systems such as e-contracting, e-registration of patients/declarations, e-prescription, and information and live management dashboards at the NHSU website.²⁴

Coverage and enrolment rules are defined in the Law 2168. According to it, all residents have the right to access PHC services within the PMG. Moreover, they have a right to choose a physician regardless of their registered place of residence. Residents are required to confirm their choice by formal registration by signing the “Declaration on the choice of a physician who provides primary health care”. According to Ministry of Health Order No. 503 in 2018, an individual has a right to change a PHC physician at any time but is required to sign a new declaration and terminate the initial one. Simultaneous enrolment with two or more physicians is not allowed.

Patients who have not chosen a doctor and are in an urgent situation are entitled to receive PHC free of charge in public health care facilities. They should also be informed about the free choice policy and advised to choose a PHC physician. The total number of enrollees with a PHC physician should be within the recommended optimal number of patients per PHC specialty (family doctor, paediatrician and therapist).²⁵

PHC services included in the PMG are defined by the Ministry of Health Order No. 504²⁶ as a mix of 17 types of PHC consultations and interventions, and eight types of laboratory and diagnostic examinations. These services include diagnostics and treatment of common and chronic conditions, preventive screening and vaccination, pregnancy and childcare, as well as certain types of emergency and palliative care. The laboratory and instrumental diagnostic examinations include general blood analysis with leukocyte counts; general urine test; blood glucose; total cholesterol; blood pressure measurement; electrocardiogram; measurement of weight, height and waist; and express tests for pregnancy, troponins (for diagnosing heart attacks), HIV and viral hepatitis.

The NHSU also administers the government’s Affordable Medicines Programme. This Programme was introduced in 2017 to reduce the financial burden and increase the availability of outpatient medicines for patients living with cardiovascular diseases, bronchial asthma and type 2 diabetes. The list of outpatient drugs includes 258 medicines, 64 of which can be obtained free of charge, others with a small co-payment. The Government or Ministry of Health Order No. 180²⁷ defines the procedures for the prescription, provision and reimbursement of these medicines. Outpatient medicines for other conditions are not included in the guaranteed benefit package and are fully chargeable to patients. PHC doctors are authorized to prescribe medicines for enrolled patients.

²⁴ Electronic card. In: National Health Service of Ukraine [website]. Kyiv: National Health Service of Ukraine; 2019 (<https://nszu.gov.ua/gromadyanam/elektronna-karta-misc-nadannya-pmd>, accessed 27 August 2019, in Ukrainian).

²⁵ Ministry of Health of Ukraine Order No. 503 of 19 March 2018 on open enrolment to PHC doctors and procedures of signing declarations (<http://moz.gov.ua/article/ministry-mandates/nakaz-moz-ukraini-vid-19032018--503-pro-zatverdzhennja-porjadku-viboru-likarja-jakij-nadae-pervinnu-medichnu-dopomogu-ta-formi-deklaracii-pro-vibir-likarja-jakij-nadae-pervinnu-medichnu-dopomogu?preview=1>, accessed 27 August 2019, in Ukrainian).

²⁶ Ministry of Health of Ukraine Order No. 504 of 19 March 2018 on PHC provision. (<http://moz.gov.ua/article/ministry-mandates/nakaz-moz-ukraini-vid-19032018--504-pro-zatverdzhennja-porjadku-nadannja-pervinnoi-medichnoi-dopomogi>, accessed 27 August 2019, in Ukrainian).

²⁷ Ministry of Health Order No. 180 of 16 March 2017 on the Affordable Medicines Programme, document 180-2017-p Table 1. (<https://zakon.rada.gov.ua/laws/show/180-2017-%D0%BF>, accessed 27 August 2019, in Ukrainian).

The NHSU contracted 1000 pharmacies (including 573 private ones), which provide medicines to patients and receive reimbursement from the NHSU. During the first two months, PHC doctors issued more than 2.3 million prescriptions; 1.7 million of them were dispensed by pharmacies and supplied to patients. In total, the NHSU reimbursed pharmacies 79 million hryvnia for medicines. A special module in the e-health system (e-prescription) was introduced to support the prescription, provision and reimbursement of medicines.

PHC quality standards are not specifically defined. The Ministry of Health supports some initiatives, which aim to improve the quality of PHC services. These include collaboration with the Finnish Medical Society *Duodecim* and adaptation of its key clinical guidelines for PHC services, and collaboration with the USAID Health Reform Support Project in the development of 15 PHC facilities as centres of excellence.²⁸

The NHSU's functions in quality assurance are not specified. Development of a medical audit framework is in process. Currently, the NHSU monitors the enrolment and e-prescription database for potential fraud and gaming; no on-site internal audit of PHC provider data or quality of care monitoring is yet done, because the NHSU has not yet built up sufficient staff or established regional branches (as discussed in Chapter 2 on governance).

PHC providers eligible for contracting with the NHSU are defined as public and private health organizations or individuals (entrepreneurs licensed for medical practice). However, they must meet basic equipment and computerization requirements and provide PHC service for the enrolled population. PHC specialties include family doctors, therapists and paediatricians.

The main task for PHC providers is to provide integrated services of comprehensive, continuous and patient-oriented PHC. PHC provider must meet the needs of the population in recovering and preserving health, preventing diseases, reducing the need for hospitalization and improving the quality of life.

The process of transforming public health care facilities into municipal medical organizations began in 2018. Public PHC providers changed their legal status to become independent medical organizations with managerial and financial autonomy. In total, by May 2019, the NHSU had contracted these 1024 public facilities, plus 131 private PHC centres and 121 individual family medicine doctors.²⁹ Currently, PHC is delivered through 22 020 physicians, including 14 516 family medicine doctors, 4241 paediatricians and 3308 therapists, who work in 6320 PHC centres/points under 1276 PHC organizations contracted by the NHSU.³⁰ The average enrolment is 4372 patients per practice and 1255 patients per PHC physician.

Formally, PHC physicians should act as gatekeepers. However, at this stage of reforms, referrals for secondary outpatient and inpatient care are not always required in practice. Gatekeeping, however, should be enforced, particularly as the hospital reform gets underway.

²⁸ Concept for the Development of the Primary Health Centers – Municipal Non-Profit Enterprises as Centers of Excellence, USAID Health Reform Support Project, 2018.

²⁹ Electronic card. In: National Health Service of Ukraine [website]. Kyiv: National Health Service of Ukraine; 2019 (<https://nszu.gov.ua/gromadyanam/elektronna-karta-misc-nadannya-pmd>, accessed 27 August 2019, in Ukrainian).

³⁰ Electronic card. In: National Health Service of Ukraine [website]. Kyiv: National Health Service of Ukraine; 2019 (<https://nszu.gov.ua/gromadyanam/elektronna-karta-misc-nadannya-pmd>, accessed 27 August 2019, in Ukrainian).

PHC providers contracted by the NHSU receive a capitation budget. The capitation formula is clearly defined and is based on active enrolment, a unified capitation rate, and a set of age and geographic adjustment coefficients. The capitation budget is intended to cover cost items such as personnel, medicines, supplies and administrative costs. Utilities and capital costs are not included in the capitation rate. According to the Budget Code, utilities costs must be covered through local budgets but the sources of the capital costs are not specified. PHC providers receive the capitation budget in their bank accounts monthly and have the flexibility to manage funds according to their needs.

The PHC enrolment policy became effective in April 2018 and was implemented during a transition period with parallel contracting methods. During 2018, the NHSU contracted and financed PHC providers based on active enrolment (“Green lists”), and the Ministry of Health continued to finance other PHC providers through a national subvention for the population administratively assigned to PHC providers (“Red lists”). From 1 April 2019, the national subvention for PHC was abolished, and the NHSU became the sole purchaser (see Table 4.1).

Table 4.1. PHC financing model in Ukraine 2018–2019

Year	National budget – NHSU	National budget – Ministry of Finance/ Ministry of Health	Local budgets
2018 transition model	Capitation payment based on active enrolment (Green list), unified base rate (370 hryvnia) and age coefficients (0–5, 6–17, 18–39, 40–64, 65+ years) and high/low land adjustments	Subvention from national budget based on the non-adjusted capitation rate of 270 hryvnia and the number of the population historically/ administratively enrolled to PHC facility (Red list)	Utility cost – mandatory by the Budget Code; additional funding up to the local government
2019	Capitation payment based on active enrolment, unified base rate (370 hryvnia), age coefficients (0–5, 6–17, 18–39, 40–64, 65+ years) and high/low land adjustments; final payment could be reduced by 20–80% according to the enrolment thresholds (110–150% of maximum capacity/recommended number of the enrolled population)	N/A	Utility cost – mandatory by the Budget Code; additional funding up to the local government

The capitation formula was designed purposefully to be clear and simple. The capitation payment formula is:

$$\text{PHC facility budget} = \text{base rate} * \# \text{ of enrolled population} * \text{adjustments}$$

The *base rate* or unified capitated rate was set to 370 hryvnia in 2018 and remains the same in 2019.

The *# of enrolled population* is the total number of population enrolled at the PHC facility defined as the sum of the number of enrollees with each PHC physician at the PHC facility. The number is calculated automatically at the NHSU level based on signed e-declarations. No paper-based lists are applied in the payment system.

The *adjustment coefficients* are the base rate adjusted by five age groups and the place of residence coefficient (Table 4.2).

Table 4.2. Age and geographic coefficients for capitation formula

Age group (years)	Place of residence	Base rate (hryvnia)	Age coefficient	Place of residence coefficient	Capitation rate (hryvnia)
0–5	Lowland	370	4	1	1480
	Mountain			1.25	1850
6–17	Lowland		2.2	1	814
	Mountain			1.25	1017.5
18–39	Lowland		1	1	370
	Mountain			1.25	462.5
40–64	Lowland		1.2	1	444
	Mountain			1.25	555
65+	Lowland		2	1	740
	Mountain				925

Source: NHSU.

In 2019, the NHSU applied additional adjustments to final payments to account for the recommended number of enrolled population by PHC specialties – the enrolment thresholds (Table 4.3). The recommended PHC physician’s full capacity is 1800 enrollees per family doctor, 2000 adults per therapist and 900 children per paediatrician. Providers are paid a lower capitation rate for patients beyond 110% of the recommended level, which is considered as full physician capacity. Providers are not paid for patients beyond 150% capacity.

Table 4.3. Enrolment thresholds for capitation payment adjustment

Enrolment thresholds	Coefficient applied to the base rate
Over 100% up to 110% of the recommended level of enrollees	1.0
Over 110% up to 120%	0.8
Over 120% up to 130%	0.6
Over 130% up to 140%	0.4
Over 140% up to 150%	0.2
Up to 150%	0.0

The NHSU is in the process of building an integrated health information system for general management, service delivery, provider monitoring and quality assurance.

It is envisioned that a national e-health system will support the NHSU in performing its purchasing functions, such as contracting, financing, quality control and monitoring provider performance. All PHC providers contracted by the NHSU are obliged to have information technology capacity (computers and reliable Internet services) and use a computer network to facilitate management tasks, including e-enrolment, e-contracting and e-prescription.

The e-health system – the Ministry of Health’s project – is currently under development.

The first stage of its development envisages the establishment of electronic systems to support PHC purchasing. Currently, the system serves primarily for financial and payment purposes rather than an e-health system complete with electronic health records. E-health includes specific modules that allow the NHSU to contract providers (e-contracting with PHC providers and pharmacies), register a population with PHC doctors (e-declaration) and reimburse drugs within the Affordable Medicines Programme (e-prescription).

The enrolment database is linked with the database on health providers contracted by the NHSU.

It is differentiated and disaggregated by patient age/sex, enrolment facility/doctor/specialty, administrative territories (region/city/district/village). The database on health providers contains provider identification/type/ownership, doctor’s specialty/name/sex/identification/contact details. Currently, the enrolment database includes information about the 27.6 million people registered with 22 032 PHC doctors, 1276 PHC providers and 1000 pharmacies contracted by the NHSU, and 2.3 million drug prescriptions.

In 2019, the NHSU conducted a verification of enrolment data (declarations) in the e-health system, which raised a significant issue with the PHC registration.

The NHSU identified more than 500 000 duplications, 283 000 cases of deceased enrollees and 61 000 people who do not exist. In total, the NHSU suspended 825 000 declarations (3% of total enrolment) and revised the budget of PHC providers accordingly.

The NHSU is posting data analytics and live management dashboards for public and health providers on its website.³¹

Beginning in July 2019, providers will enter detailed information for each consultation using the International Classification of Primary Care, second edition.

The newly introduced e-prescription module allows collection of personalized information on prescription, provision and reimbursement of medicines within the Affordable Medicines Programme.

The database connects information on prescribed medicines with the patient, health provider and pharmacy and should allow the introduction of the prescription and budget control systems.

The NHSU initiated changes in the Cabinet of Ministers Order No. 411 on the functioning of the electronic health system (25 April 2018).

The changes approved by the Cabinet of Ministers Order³² in June 2019 aim to improve the standards and implementation of the e-health system at all levels and, particularly, specify the NHSU’s role and functions in the e-health process, including data audit and verification.

³¹ Electronic card. In: National Health Service of Ukraine [website]. Kyiv: National Health Service of Ukraine; 2019 (<https://nszu.gov.ua/gromadyanam/elektronna-karta-misc-nadannya-pmd>, accessed 27 August 2019, in Ukrainian).

³² Cabinet of Ministers Resolution on Electronic Health System of 25 April 2018 № 411. (<https://zakon.rada.gov.ua/laws/show/411-2018-%D0%BF#n247>, accessed 27 August 2019, in Ukrainian).

4.3 | Alignment with other areas of health system strengthening and public sector reforms

In this early stage, there has been good alignment between PHC contracting and setting standards for a core or minimum basket of PHC services (MOH Order No. 504 on PHC provision). This Order establishes the first stage of implementing a vision of PHC based on a group of doctors working with a multidisciplinary team to provide care for a defined registered population.

In order to further align contracting with the service delivery vision, the capitation payment system will need to evolve to encourage early detection and management of complex NCDs, and more integrated care. This will involve gradual development of the PHC multidisciplinary team and expansion of the scope of services provided by PHC. The capitation payment system will also need to evolve to cover the link between the benefit package and its future expansion to include a broader range of services such as management of complex NCDs, tuberculosis, and mental health and some social services.

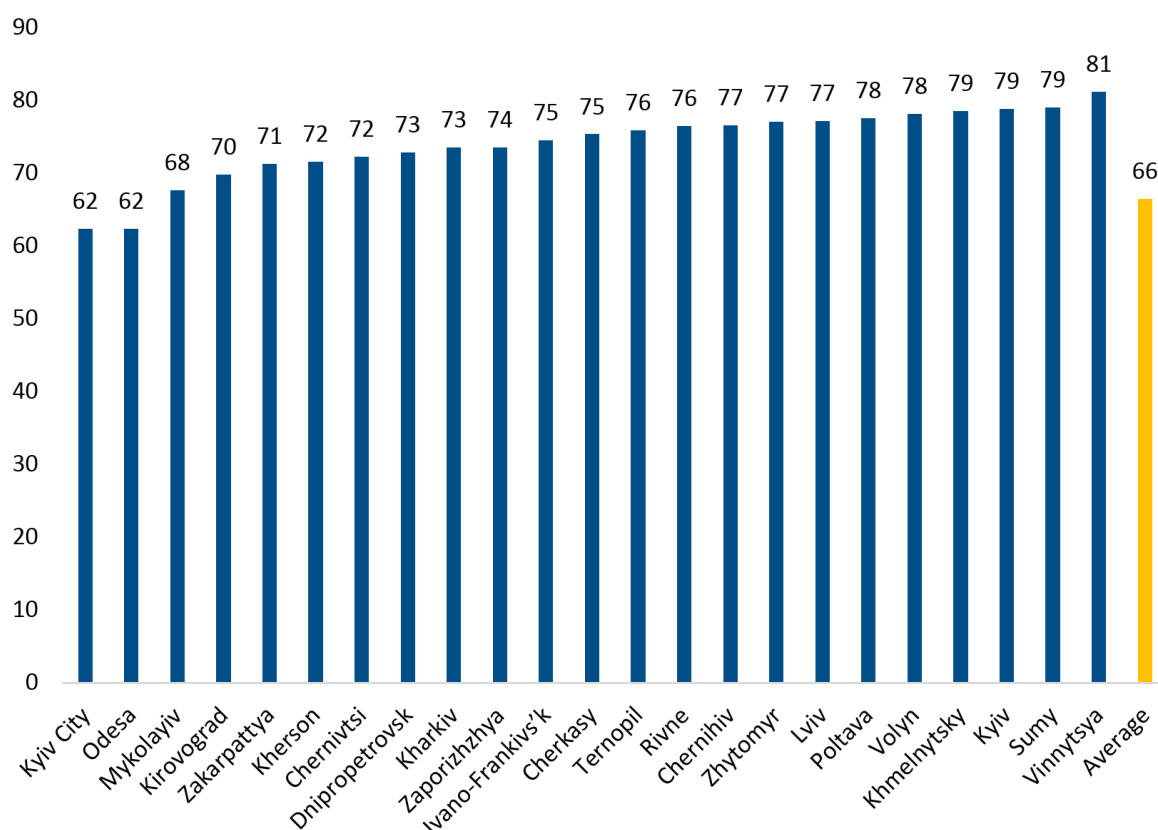
4.4 | Emerging impact policies on reform objectives

It is essential to invest in formal impact evaluation framework. A formal monitoring and evaluation framework is not yet in place to assess the impact of the overall health financing reform and specifically the impact of the implementation of PHC reforms. In addition, the health information system does not yet generate data to yield useful impact assessment indicators.

Available data from surveys and the NHSU information system, can provide some initial signals about the changes brought about through the PHC reform implementation regarding access to PHC services, patient satisfaction and informal payments.

- Spending on PHC has increased substantially reflecting efforts to strengthen frontline services (see Chapter 3): in 2017, PHC represented 10.6% of government health spending compared to 14.6% in 2019.
- “Free choice of PHC doctor” works successfully: almost 27.6 million residents (66% of the population) chose their PHC physician since the introduction of the free-choice policy in April 2018. Fig. 4.1 shows the active enrolment to PHC providers by regions of Ukraine.
- The “money follows the patient” principle and an explicit and simple capitation formula brought more transparency and equity in budget allocation among PHC providers and created a strong incentive for rapid transformation of public PHC facilities into autonomous organizations. As mentioned above, 1024 or 97% of all public PHC facilities (NHSU data) have been converted to municipal organizations and contracted by the NHSU since July 2018.

Fig. 4.1. Percentage of residents who signed declarations with PHC providers, by region

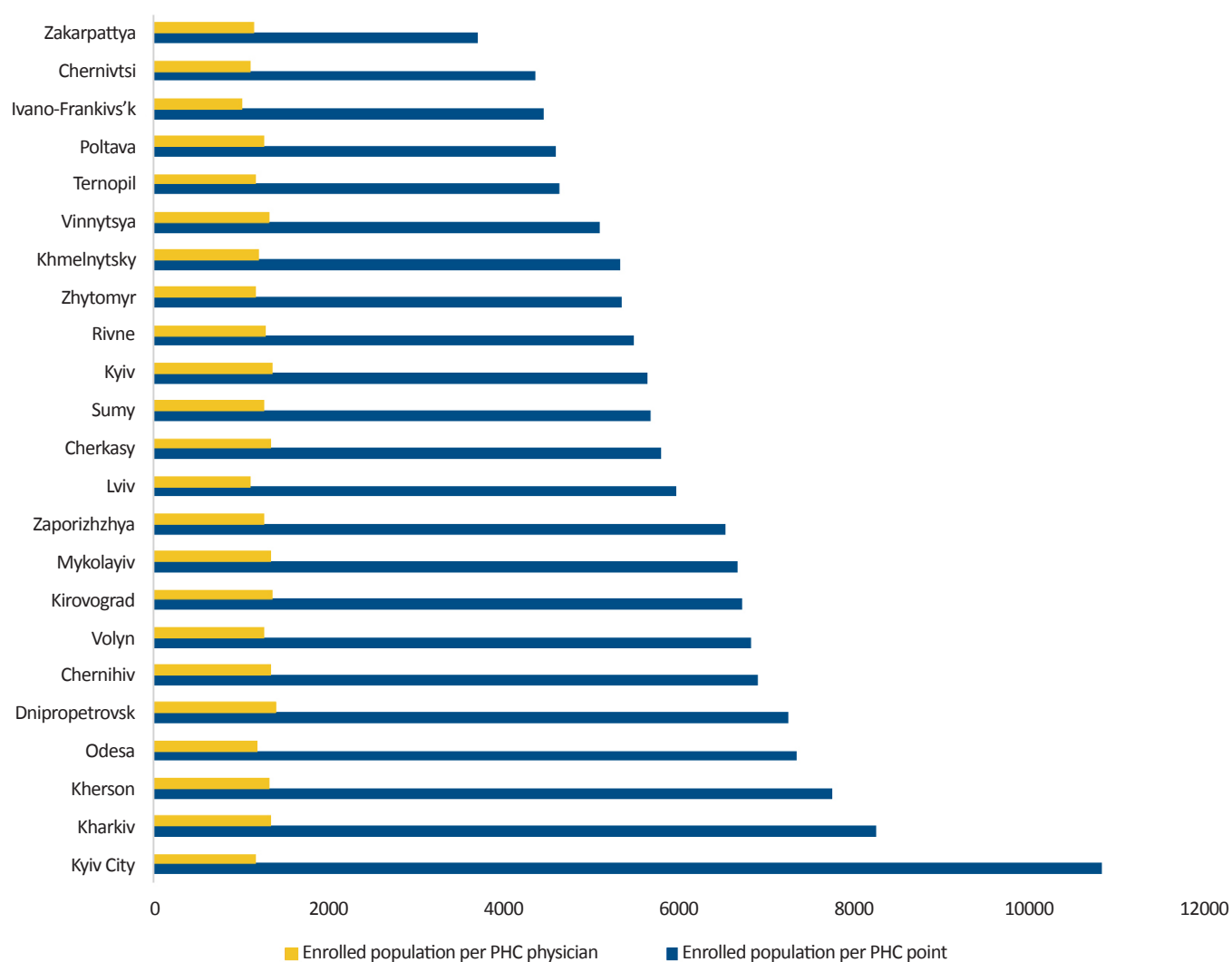


Note: this figure does not include Donetsk and Luhansk regions or the Autonomous Republic of Crimea.

Source: NHSU, July 2019.

The new PHC purchasing arrangements support access to PHC services. There is no significant geographic limitation in access to PHC services. PHC is delivered by 1276 PHC organizations that include 6323 practices/points of contact in rural (4072) and urban (2251) areas. On average, 4372 patients are enrolled per PHC practice and 1255 patients per PHC physician. Fig. 4.2 shows the average size of the enrolled population to PHC practices/points of contact and PHC physicians by region.

Fig. 4.2. Average enrolment per PHC physician and PHC point of contact, by region



Note: this figure does not include Donetsk and Luhansk regions or the Autonomous Republic of Crimea.
 Source: NHSU, July 2019.

In addition to these administrative data, a set of recent studies of the health sector could serve as a baseline for the PHC purchasing reform. These include: “Health Index. Ukraine” surveys (2016–2017) conducted by the International Renaissance Foundation; “Tracking Health Resources in Ukraine” by the World Bank (2018); “Can people afford to pay for health care?” by WHO (2018); “2018 Informal Payments Survey in Ukraine” by USAID; and “Patient’s Satisfaction Survey in 15 PHC Centers” (2019).

The majority of people are satisfied with their visit to a PHC doctor. According to a patient satisfaction survey,³³ conducted in 15 PHC centres by the USAID Health Reform Support Project, 95% of respondents were “satisfied” or “rather satisfied” with their visit to a PHC doctor. The highest impacts on patient satisfaction during a visit to a family doctor were due to such factors as the doctor’s respect, attentive listening and understandable explanation of medical information. The positive changes in service are perceived as a wow effect by the evaluators, influencing overall satisfaction. As this is a one-off effect, continued qualitative improvements are needed to sustain satisfaction.

³³ 15 PHC Centers Patient Satisfaction Survey, USAID Health Reform Support Project, April 2019.

Access to essential medicines for people with chronic conditions has improved.

According to the WHO *Evaluation of the Affordable Medicines Programme in Ukraine*³⁴ more than 6.6 million Ukrainian residents have benefited from the Programme. They account for approximately half of patients with a chronic condition.

The reform has brought increased transparency to benefit entitlements, which can crowd out informal payments.

According to the 2018 Informal Payments Survey in Ukraine³⁵ conducted by the USAID HIV Reform in Action Project, 56% of 4000 patients in Ukraine made at least one informal payment within the last 12 months, and 48% of patients made an informal payment for receiving PHC services. Since most of the recall period covered the period before introduction of the new contracting mechanisms in PHC, this figure serves as a baseline to track the impact of clarity in entitlements, free choice of PHC and increased allocations on informal payments. The average informal payment per service was 13.6 hryvnia in PHC (20.3 hryvnia for all services). On a yearly basis, the average informal payment was 55.9 hryvnia per patient for PHC services (126.1 hryvnia for all services). Among PHC services, informal payments were most frequent in nursing services. The primary reason for making an informal payment, stated by the patients, was to feel a better *attitude from the health staff* (24%), followed by to receive *better quality of care or range of services* (16%). With the significant increase in information, to both medical staff and patients, about benefit entitlements in PHC, these widespread informal payments should decrease, but continuous attention to the problem, and monitoring, is required.

4.5 | Anticipated challenges

The successful launch of the PHC purchasing reform in 2018–2019 should be accompanied by further development of the strategic health purchasing functions at the NHSU level and changes in medical practice.

A wider range of regulatory mechanisms and systems are needed beyond financing. Serious challenges in the medium term could be anticipated in the following areas.

Finalizing the vision and implementation arrangements to improve PHC organizational and clinical capacities is an urgent priority, and strategic purchasing will need to be adjusted to support its operationalization.

The priority role of PHC is declared in key regulations, but specific objectives for PHC's development, role and interaction with other levels of care need more clarity. The Ministry of Health is in the process of developing a white paper on a long-term service delivery vision, which is essential to move forward. The white paper suggests that PHC would take a greater role in the prevention and management of NCDs (including mental health) and infectious diseases (e.g. tuberculosis).

The current structure of the PHC network is mostly driven by the NHSU contracts, which could bring potential risks and limitations for access to PHC services.

A mechanism should be in place to monitor the structure, capacities and organization of the PHC service delivery system including the health provider network, number and distribution of providers by geographic area, and variation in the ability of providers to deliver services (urban/rural, by regions, by type).

³⁴ Evaluation of the Affordable Medicines Programme in Ukraine. Copenhagen: WHO Regional Office for Europe; 2019 (<http://www.euro.who.int/en/publications/abstracts/evaluation-of-the-affordable-medicines-programme-in-ukraine-2019>, accessed 27 August 2019).

³⁵ 2018 Informal Payments Survey in Ukraine. Kyiv: USAID HIV Reform in Action Project; 2018.

Mixed payments should be considered to align better financial incentives with desired changes in PHC as the reforms move forward. New actions, including a fine-tune of the model of care and financing mechanism, will be needed to further strengthen PHC for earlier detection and better management of NCDs representing the majority of the burden of disease in Ukraine. International experience suggests that a pure capitation system is insufficient to reorient PHC providers to a more proactive role in NCDs.

The Ministry of Health regulates general processes of quality assurance, but key areas, including clinical guidelines, continuing education and clinical audit, need more attention. With the establishment of the NHSU, the roles, relationships and distribution of main functions in quality control and quality improvement between the Ministry of Health, the NHSU, providers and professional associations should be revisited and clearly defined. Also, the contracting of private providers for PMG provision might require regulatory changes to unify clinical management systems and standards for private and public providers contracted by the NHSU.

The e-health system, while overall effectively performing its function of registering the population and contracting health providers, has issues that need to be addressed in the near future. The e-health information system, aimed to support health reforms, was designed and introduced in extremely tight timeframes to match the rapid pace of the ongoing reforms. Patients are identified by their declaration code generated from the patient's personal data (last name, first name, etc.). This makes duplicates inevitable. Misprints and different spellings of names are also possible. The register being created is not integrated with other national registers and does not provide prompt updating of data, including mortality, birth and other data. In this regard, the existing register already contains inaccurate data, which can cause problems on the part of inspection bodies and discredit the payment system. The formats of directories and databases are not standardized, hindering the connection of third-party management information systems to e-health. Standard requirements, which enable semantic and technical operability, are needed. The cancelled statistical forms were not adequately replaced by other reporting forms, which has led to the risk of losing large amounts of historical data, even if they were of poor quality.

The rapid development of e-health and strengthening NHSU capacities in digital operating systems are vital for further implementation of strategic health purchasing and step up NHSU's capacity to detect fraud and waste. Currently, the NHSU's key functions in general and clinical management, including medical records, performance and quality monitoring, are not computerized. The NHSU does not have digital mechanisms to track service provision and referrals, monitor provider performance and ensure that the PHC package is delivered to the population with adequate quality. Also, unintended consequences and negative incentives of the capitation system could cause risks in changing provider behaviour if not monitored (reduced productivity and quality, underprovision of services, over-referral and avoidance to enrol sicker or high-cost populations).

Demand for prescriptions at outpatient level is expected to continue to rise and will need to be effectively managed. The results of the Affordable Medicine Programme assessment³⁶ conducted by WHO and recent NHSU data demonstrate a huge demand and a sharp increase in medicines prescriptions. This is an often-seen trend in countries where coverage is rapidly expanded and the de facto prices of medicines or services faced by patients decline sharply.

³⁶ Evaluation of the Affordable Medicines Programme in Ukraine. Copenhagen: WHO Regional Office for Europe; 2019 (<http://www.euro.who.int/en/publications/abstracts/evaluation-of-the-affordable-medicines-programme-in-ukraine-2019>, accessed 27 August 2019).

4.6 | Policy recommendations

The overall design of the capitation payment system is working well and should be maintained. In general, the system is in line with international approaches of effective payment systems such as transparency, consistent incentives and appropriate rate setting. In the medium term a number of refinements can be considered.

- Some design details could be refined over time. The NHSU should consider revising the age, sex and geographic coefficients, as they are not necessarily correlating with the socioeconomic situation and medical needs. The basis for population estimates to plan the capitation budget and calculate the capitation rate also needs continuous revision. An effective process of internal audit and data validation should be established at the NHSU to minimize/eliminate fraud in the PHC registration.
- To support the introduction of more proactive mechanisms for early detection and management of chronic diseases representing the majority of the burden of disease in Ukraine, the NHSU should consider moving to a mixed payment model for PHC providers. It should align with the PHC service delivery model, the evolution of the PHC service basket and improvements in e-health.
- The “enrolment thresholds” policy and associated payment penalties introduced in 2019 could, in the short term, reduce provider incentives to enrol populations beyond the recommended full capacity norms. However, this policy could affect access to PHC services, particularly in rural areas, which have a shortage of PHC doctors. Adjustments in policy and payment arrangements will be required based on experience of the 2019 implementation.

The Affordable Medicine Programme provides coverage against a major source of catastrophic patient expenditures and enhances the effectiveness of PHC. However, it needs effective purchasing arrangements to avoid escalation in volume and funding.

National clinical guidelines should be developed for all the covered diseases. Further improvements in the financing model are needed, including the basis for budget planning (estimated number of patients and needs by disease category, especially for cardiovascular disease conditions) and caps in volume (based on the structure of the enrolled population). A more sophisticated routine monitoring system needs to be developed as a priority. This needs to be based on developing the e-health system to link patient data, to monitor prescribing behaviour (to ensure it is in accordance with clinical guidelines) and use algorithms to look for patterns of overprescribing and potential fraud by prescribers, patients or pharmacies. There is also a need to monitor and analyse trends in the reimbursement prices for AMP medicines, to look for any inappropriate price escalation, for example due to anticompetitive behaviour in the market. Further improvements in the provider payment model are desirable to avoid possible budget escalation. The NHSU could use analysis of local population needs of patients with chronic illnesses to set local budgets for AMP on a more accurate basis. It could then consider contracting larger PHC organizations or groups of smaller PHC providers to take on responsibility for managing this AMP budget for a defined population, including responsibility for providing feedback to prescribers to manage the risk of excessive growth in prescriptions. On the other hand, once e-health includes patient records and when budgetary resources permit, it will be important for the NHSU to strengthen coverage of the population with necessary medicines to prevent and manage NCDs. For example, the NHSU could consider refinement of the PHC provider payment method in the future to incorporate some pay-for-quality component, to create incentives for PHC providers to increase the percentage of NCD patients maintained on medication to control their condition.

Strengthening the NHSU strategic purchasing functions requires rapid changes in the e-health system and the introduction of digital solutions to track service provision and referrals, detect and prevent fraud, and manage unintended consequences of the capitation payment system. The NHSU should have adequate capacities and systems in place to ensure that PHC providers are providing the required health services at an acceptable level of quality.

Further developments in e-health should consider the principle “from simple to more comprehensive” and be able to connect the existing local management information systems effectively. It is also important to introduce the “single data entry” principle, which will allow the use of data by different organizations and for different purposes and minimize duplications in the system. Also, it is important to define an institutional structure responsible for the standardization of coding systems, data formats and reporting forms to ensure data quality and interoperability.

Quality improvement requires specific arrangements at the provider and purchaser levels. Provider payment systems by themselves do not ensure high-quality care. Therefore, appropriate implementation arrangements should be in place to monitor and improve quality of care. The governance and quality assurance functions should be improved through refinements of regulatory mechanisms at the Ministry of Health level (licensing, accreditation, clinical guidelines, clinical audit, continuing education, etc.), strengthening the NHSU capacities and digital systems for provider performance monitoring, and investments in health management information systems (medical records), clinical management and training at provider level.

The white paper on service delivery reforms, including PHC development, is an urgent priority as is its implementation plan. The white paper will synthesize past experience of PHC reforms, lessons learned and current arrangements, and define desirable improvements in the structure, capacities and organization of the PHC service delivery system in Ukraine. Effective coordination and leverage of resources from national, local and international programmes will be necessary to support further improvements in PHC.

PHC provider management capacities need to be improved. PHC providers were given greater autonomy, but they need enough time to adopt the changes and develop adequate skills and processes in general, financial and clinical management. Investments in health management information system capacities at PHC level are critical to establishing automated processes for patient eligibility/verification, medical records, clinical management, accounting and financial management. Training and special arrangements such as clinical practice guidelines, electronic medical records, and continuous quality improvement instruments are critical to improving PHC clinical capacities. Management training for staff should be available to support financial and service planning, cost analysis and staff performance.

A monitoring and evaluation framework for reforms is needed. Taking into consideration the rapid start of the health financing reforms, the development of the monitoring and evaluation framework and establishment of mechanisms to review, evaluate and document the impact of implemented reforms are crucial. The Ministry of Health and the NHSU should have information and evidence of whether or not the reforms are going in the right direction, bringing results and having an expected impact on the health care system and health. A coordination mechanism at national level could improve the process, avoid duplication and leverage resources in implementing large-scale surveys and specific service coverage and health system studies.

GEARING UP FOR ROLLING OUT STRATEGIC PURCHASING BEYOND PHC

5.1 | Introduction

This chapter summarizes current developments in preparation of gearing up to strategic purchasing beyond primary care. The technical team assessed the preparations and the progress to date in the following pillars of service delivery: emergency care, outpatient specialized care and hospital care (including post-acute and long-term care). Although purchasing of hospital services is in its onset, piloting the new purchasing arrangements in just one region of Ukraine, the review aimed to assess the existing policies, instruments and processes that support the introduction of strategic purchasing and catalyse the transformation of service delivery beyond PHC.

With this purpose, the assessment team organized technical discussions with key national counterparts and international partners. The team visited two regions of Ukraine and collected legal documents, available data and relevant studies. The team conducted a rapid assessment of the hospital pilot in Poltava region and its implementation arrangements, and took stock of preparations to initiate strategic purchasing at the other levels of health care provision. The team worked to identify future actions needed for successful implementation of strategic purchasing beyond PHC based on international best practices and the country context and provided policy recommendations.

5.2 | Overview of key policies

With primary care contracting successfully underway, in 2019, the NHSU began to develop mechanisms to expand the purchasing function to cover hospital, specialized outpatient, emergency and other types of health services that will be included in the PMG. In 2019, preparations for purchasing hospital and specialized outpatient services have started with the implementation of a purchasing pilot in Poltava region.

5.2.1 Organization of hospital services in Ukraine

The hospital care system in Ukraine comprises monopile and general (multipile) hospitals providing care at the secondary and tertiary levels. Some key numbers illustrating the hospital network³⁷ and its performance is provided in Table 5.1. In addition to the hospital network, which reports to the Ministry of Health, hospital care providers

³⁷ The hospital network is used in this chapter to describe the entirety of providers of hospital care. Hospitals are not connected in any form of a network. Each hospital belongs to either a local community (rayon/city/region) or to the Ministry of Health (or other government bodies, e.g. the Ministry of Interior Affairs).

exist in parallel structures. These structures include service providers of the Ministry of Interior Affairs, State Security Service of Ukraine, separate clinic- and hospital-serving public officials and the National Academy of Sciences of Ukraine. Although the Ministry of Health regulates hospital standards (licensing, clinical guidelines, etc.), it does not directly control the planning and financing of these providers.

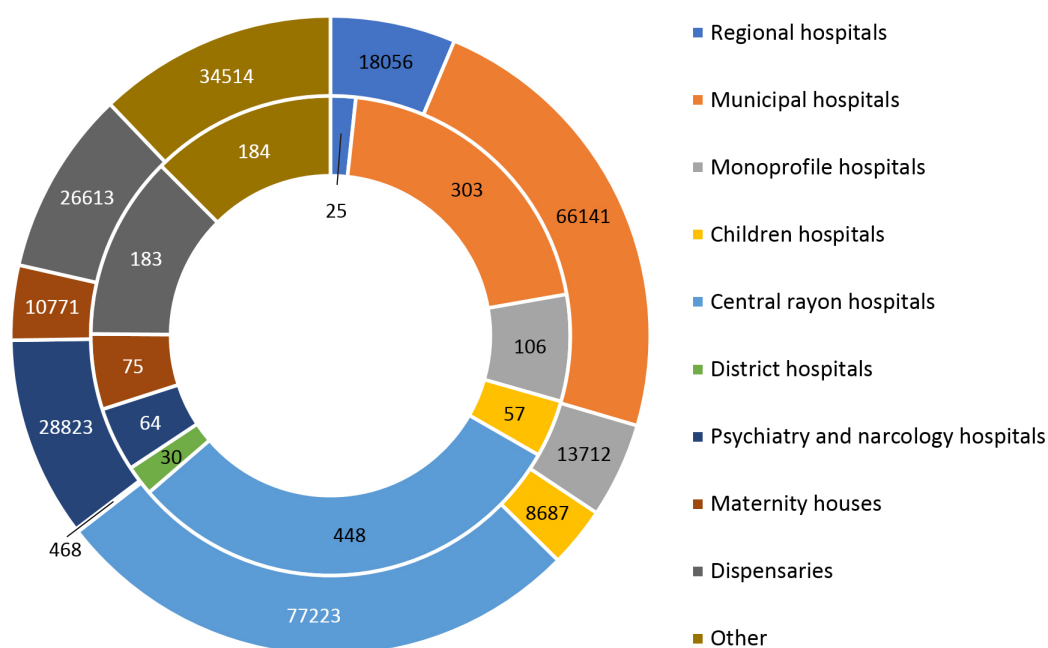
Table 5.1. Key hospital statistics

Indicator	Hospitals under the Ministry of Health subordination
Total number of hospital care provider organizations	1 475
Total number of beds	285 008
Beds per 100 000 population	675
Bed occupancy rate	88%
Average length of stay (number of days)	11.0
Hospitals admissions per 100 population	19.7

Source: NHSU data, 2018.

The hospital network usually represents a relatively closed system within the boundaries of each region. Hospital care providers at regional level provide tertiary care for residents of a specific region, frequently duplicating other secondary care capacities. These providers will usually include a regional multiprofile hospital, several monoprofile specialized hospitals (e.g. cardiac, cancer, endocrinology, etc.), a regional children’s hospital, psychiatry hospitals, tuberculosis and other monoprofile facilities. The secondary care network is represented by municipal hospitals, maternity hospitals and children’s hospitals located in larger cities of the country, and central rayon hospitals in each administrative district of the region that provide care for the population in its districts. The structure of the hospital care is presented in Fig. 5.1.

Fig. 5.1. Number of hospitals (inner circle) and bed capacity (outer circle) by type of hospital



Ukraine has an oversized hospital sector with almost twice as many hospitals than comparator countries of the WHO European Region (e.g. 4.2 hospitals per 100 000 population in Ukraine, 2.3 in Estonia, 2.8 in Poland and 2.9 in the United Kingdom). Many hospitals are obsolete with inadequate use of modern technologies and low capacities to provide acute care in emergency cases such as strokes and heart attacks. Also, of the total number of hospitals, about 7% are psychiatry/narcology monoprofile hospitals; 7% are recreational sanatoriums; and 6% are tuberculosis monoprofile hospitals. Such hospitals are almost non-existent in countries with more developed economies since many of their services can be provided in a PHC setting. These facilities consume a lot of resources in the hospital sector but provide services to a small number of patients, and these services could be provided in alternative settings.

Hospitals are often maintaining beds and staff that are not needed to provide care in inpatient settings. In Ukraine, the ratio of hospital beds and hospital staff per 100 000 population is at least 30% higher than in comparator countries.³⁸ Patients are hospitalized more frequently (18.9 admissions per 100 population in Ukraine compared to 15.6 admissions in Estonia, 12.9 in Sweden and 12.4 in the United Kingdom),³⁹ and for longer duration of inpatient stay (the average length of stay in hospital is 11.2 days in Ukraine versus 7.3 in Poland, 7.6 in Estonia and 7 days in the United Kingdom). At the same time, Ukrainian hospitals offered more low-intensity care. Official statistics showed that 24% of cases in Ukrainian hospitals involved surgery compared to 70% in other countries. At least 20% of all hospital cases could have been treated on an outpatient basis,⁴⁰ and 57% of hospital bed days could not be justified.⁴¹

Hospitals account for 60–65% of the total public spending on health care, which still makes service delivery hospital-centric. The estimated average cost of one case treated in hospital in 2017 was 4315 hryvnia (US\$ 170).⁴² According to a 2015 survey, semi-voluntary charity contributions of patients generate an additional 30% of hospital financing compared to the resources hospitals receive from public sources. Patients OOP payments for drugs, so-called charity contributions and gratuity fees all contribute towards their cost of care. The share of OOP payments is high and grew to 52.3% in 2016⁴³ with almost all households (93% of total) reporting paying out of pocket for health services in 2015.⁴⁴ Patient OOP spending on prescription medicine varies widely across different health facilities creating large inequalities in terms of affordability of care. Also, estimated OOP payments vary by types of hospitals: the study conducted in Poltava region found that patients are most frequently paying out of pocket if hospitalized in general hospitals, and they cover from 59% to 94% of the total cost of medicines associated with inpatient treatment.⁴⁵

³⁸ Ukraine has 4.4 doctors and 8.7 nurses per 100 000 population, compared to 2.3 and 5.2 in Poland, 3.4 and 6.0 in Estonia, and 2.8 and 7.9 in the United Kingdom, respectively.

³⁹ In Poland, the number of admissions per 100 population has increased to 18.2 in 2017 from 14.8 in 2008.

⁴⁰ Based on the results of monitoring hospital performance in three regions of Ukraine, conducted within USAID's Health Finance & Governance Project, up to 20% of all cases treated in hospitals could potentially be treated at outpatient level.

⁴¹ Zhao, Doroshenko, Lekhan, et. al. (in print) Assessment of appropriateness of hospitalizations in Ukraine: analytical framework, method, and findings. Washington, DC: World Bank.

⁴² Based on the analysis of hospital costs in three regions of Ukraine (Poltava, Odesa and Lviv regions)

⁴³ World Health Organization Global Health Expenditure database (<http://apps.who.int/nha/database/Select/Indicators/en>, accessed 2 September 2019, in Ukrainian).

⁴⁴ Goroshko A, Shapoval N, Lai T. Can people afford to pay for health care? New evidence on financial protection in Ukraine. Copenhagen: WHO Regional Office for Europe; 2018 (<http://www.euro.who.int/en/countries/ukraine/publications/can-people-afford-to-pay-for-health-care-new-evidence-on-financial-protection-in-ukraine-2018>, accessed 26 August 2019).

⁴⁵ Muratov S, Katsaga O, Zues O. Technical Report: Hospital Drug Expenditures – Estimating Budget Needs at the Regional Level in Ukraine. Rockville (MD): Health Finance & Governance Project, Abt Associates; 2018.

On average, hospital labour costs account for about 80% of total expenditures, and 5–10% of all expenditures are associated with medications and suppliers. However, in tertiary-level hospitals, the proportions are different with about 50% of all expenditures covering labour, and 20–30% of expenditures covering medications and suppliers. Despite the high share of labour expenditures in hospital spending, salaries of medical personnel are low – almost 35% below the reported salaries for the average Ukrainian worker. Such a low official compensation in the health sector encourages widespread OOP payments, lack of transparency and demotivates staff.⁴⁶ The Public Expenditure Tracking Survey reported that physicians consider their salaries at only 33% of the expected levels in the most moderate case.

Hospital restructuring is therefore one of the main priorities in the course of the health reform. The previous health financing arrangements were mainly a mechanism of allocating medical subvention between the facilities in the region according to the required inputs. The subvention was sent to all districts in the regions according to a population-based formula with the assumption that districts will be providing all primary, secondary and other medical services to its population. Such financing arrangements fragmented the resources available and did not create the enabling environment for restructuring. The new financing mechanisms imply that resources are pooled at national level and used for contracting of service providers within the existing budget envelope. The new provider payment mechanisms therefore create an opportunity to comprehensively approach the purchasing of hospital services and implement them along with the restructuring of the hospital network. Excess hospital infrastructure needs to be converted to other uses and offloaded from the available resources, which should create space to decrease hospital-related OOP payments and improve the financial protection of the population.

5.2.2 Pilot purchasing of hospital care

The pilot purchasing of hospital care was launched in April of 2019 and covered 48 hospitals in Poltava region. This region was selected based on its readiness to participate in the pilot and the availability of strong reporting systems at the level of service providers. Poltava region has been well prepared for the launch of the pilot: all hospitals in the region received the status of non-commercial enterprises (provider autonomy), populated the database with historical numbers of cases treated in hospitals and conducted the cost analysis of hospital care according to the methodology approved by the Cabinet of Ministers of Ukraine in 2017.

The pilot purchasing of hospital services in Poltava region covers a relatively small share (3.4%) of hospitals in Ukraine. It was rolled out to the entire region of 1 439 000 people (2015) and included multiprofile hospital care providers of all levels with few exceptions. Monoprofile hospitals such as tuberculosis, psychiatry and oncology and hospitals for war veterans were not included in the pilot. Contracts with hospitals cover both specialized inpatient and outpatient services.

Hospital services are contracted using a combination of the global budget and case-based payment mechanisms. The global budget share is 60%, and it is defined by the

⁴⁶ Ungerer C, Golovach A, Piontkivska I, Sondergaard L, Brandt K, Sohnesen P et al. Towards a More Effective and Fiscally Sustainable Public Sector for Ukraine: Second Public Finance Review. Washington (DC): World Bank Group; 2018 (<http://documents.worldbank.org/curated/en/186591544547101839/Towards-a-More-Effective-and-Fiscally-Sustainable-Public-Sector-for-Ukraine-Second-Public-Finance-Review>, accessed 2 September 2019).

historical hospital budget from the previous year. Case-based payment was developed for 50 groups; cases are assigned to each DRG based on the International Classification of Diseases, tenth edition (ICD-10) codes and the presence of coding in the case documentation of surgical procedures. For each provider, the expected case-mix complexity is defined. Reporting is done routinely, and data for each case treated in each facility are provided in excel format to the NHSU. Grouping is automatic, based on logic defined in the Ministry of Health order. Payments are made monthly, comprising 60% of the fixed agreed allocation and 40% of the variable share, which is defined by the actual number of cases treated and assigned coefficients to each group of cases. The base rate is 1421 hryvnia. Ceilings are agreed in contracts between the purchaser and provider for the fixed (global budget) and the variable (case-based payment) parts of monthly payments. Measures to control the risks of budget overruns are defined in the regulation for the pilot and are based on the “budget neutrality principle”, which includes the following: correction of the base rate, use of facility-level coefficients and volume controls.⁴⁷

The purpose of the pilot is to assess the preparedness of hospital providers to receive volume-based payments and to study the reaction of hospitals to the new payment methods. The pilot will also help to develop and test the operational procedures and document flow in the new payment system, lead to increased capacity of the NHSU in terms of conducting strategic purchases of inpatient care before the countrywide implementation, and create a system of monitoring and early response to the possible risks of providers’ overprovision of services. The pilot will help to understand the potential consequences for hospital care providers, such as under- or overprovision of services, expected rightsizing of hospital capacities, risks and benefits associated with new payment mechanisms from the perspectives of purchasers, providers and consumers of hospital care.

5.2.3 Preparations for the roll-out of purchasing of hospital care in 2020

The Ministry of Health and the NHSU are actively preparing for the launch of nationwide purchasing of hospital care. This year (2019) is critical to define the criteria for contracting hospital care providers. Depending on the finalized criteria, the NHSU may initiate purchasing from all hospital care providers that will comply with certain criteria identified in broad packages of care (e.g. therapy, adult and child surgery, paediatrics, acute myocardial infraction, stroke, labour assistance and neonatology). The Ministry of Health is working on the long-term vision of the service delivery model and master plan for hospital transformation.

Certain hospital services – for acute myocardial infraction, stroke, assistance at birth and neonatal care – are selected for priority implementation and modernization. Hospital-based treatment of priority conditions will be appropriately financed, and additional investments are envisioned for the modernization of care delivery and capacity building of medical personnel involved in the provision of such services.

The government plans to switch to case-based payments, gradually decreasing the share of the global budget in hospital provider payments. Fully fledged DRGs, which will be developed for Ukraine based on the Australian model, will be the basis for hospital

⁴⁷ Underprovision of care for 10% or more of the agreed volume of cases in each group during three consecutive months is defined as a reason for contract adjustment by proportionally reducing the monthly payments for the remaining months of the contract. See contracts for hospital between the NHSU and Poltava regional hospitals in NHSU website (<https://nszu.gov.ua/ukladeni-dogovori/dlya-medichnih-zakladiv> accessed in 1 July 2019 in Ukrainian).

payments. Ukraine will follow the example of other countries implementing this model, such as Croatia, Ireland, North Macedonia, the Republic of Moldova, Romania, etc. To date, classifications required for the Australian-based grouping are translated and available in Ukrainian, trainings for staff from 103 hospitals on coding and the DRG system are completed, and the Ministry of Health and the NHSU are discussing the potential scale up of trainings to other hospitals. Contracting of specific diseases traditionally provided in monoprofile hospitals (e.g. HIV, tuberculosis or psychiatry care facilities) will be conducted on the basis of the global budget, and one contract will cover all facilities of the same specialty in one region.

The initial stages of contracting can be based on simplified DRGs. DRG-based financing will be based on the defined base rate, which will be standard for all hospitals in the country, defined weight coefficients for each DRG based on other country examples and customized calculations of costs acquired for three regions of the country. Payments are planned to be based on nationwide standard tariffs.

For the effective contracting of hospitals by the NHSU, all providers need to obtain the new status of non-commercial communal enterprises (hospital autonomy). As of February 2019, 324 hospitals or 27% of all hospital care providers have received the new status. Provider autonomy changes the rules of operation for providers: it requires that hospitals are working within the Economic Code of Ukraine⁴⁸ and using new financial rules (e.g. using changed approaches to financial planning) and sets new rules for contracting employees (e.g. requiring hospitals to agree to the terms for collective agreements with employees); it also gives more flexibility to address efficiency issues and improve service delivery.

To incentivize restructuring and modernization of hospital capacities, several approaches were implemented including defining hospital districts, defining minimum volume requirements for acute hospitals and increasing the admission requirements of students to medical universities. Hospital districts are suggesting larger population groups (120 000 or more people for level I acute hospitals and 200 000 or more people for level II acute hospitals) as a unit for the planning and organization of hospital care. The volume requirements for level I and level II hospitals are defining the expected scope of hospital care that should be provided in acute care hospitals, and indicative minimum volume of tomography-based diagnosed strokes of no less than 400 cases for level II acute care hospitals.

To regulate the numbers and quality of training of medical personnel, the Ministry of Health has set several regulations. Increased entry requirements for medical students are intended to improve the quality of graduates from medical schools and reduce uncontrolled inputs to the doctors' labour force in terms of medical specialists who study in medical universities on a contractual basis (two thirds of all students) and have free choice of specialty selection. The latter regulation already decreased the number of enrolled students to medical universities in 2018. The Ministry of Health is working to address the formal inefficiencies in postgraduate education.

The speedy implementation of new payment mechanisms for PHC and the increased salaries of medical personnel providing primary care have created the expectation for fast and effective implementation of hospital payment reforms. Providers are keen to

⁴⁸ Economic Code of Ukraine as of 16 January 2003 with amendments as of 17 January 2019 № 436-IV. Verdicts of the Parliament of Ukraine (VVR), 2003, № 18, № 19-20, № 21-22, (<https://zakon.rada.gov.ua/laws/show/436-15>, accessed 3 July 2019, in Ukrainian).

learn details of the new payment approaches and enter into contractual relations with the NHSU. The expected outcomes of the new payment mechanisms are the increased revenues of hospitals, based on volume and complexity of care provided, and consequently increases in the salaries of hospital staff.

5.2.4 Purchasing of outpatient secondary services

Outpatient secondary care is mainly organized as polyclinics within hospital structures (1085), as standalone polyclinics (459 facilities, often located in larger cities) or as monoprofile dispensaries (423 facilities, including 179 dental clinics). More than half of all doctors (55%) are employed in outpatient units of hospitals, in polyclinics or outpatient dispensaries. Doctors of almost all specialties provide outpatient care with some exemptions (e.g. heart and thoracic surgeons, neurosurgeons, anaesthesiologists, radiologists, neonatologists and forensic doctors are primarily employed by hospitals).

Patients can refer themselves directly to see doctors at secondary level. Such arrangement undermines the capacities and scope of care delivery at primary care level. According to legislation, polyclinics have the right to charge fees for consultations provided to patients without referrals.

Despite the large availability of hospital infrastructure, the surgical activity of hospitals is low: on average in 2013, the number of surgical procedures per 100 000 population was 5408 in Ukraine⁴⁹ compared to 9684 in Estonia and 10 759 in Spain⁵⁰. On average, there were 55 surgeries per doctor with a surgical specialty in Ukraine⁵¹ compared to 76 in Estonia and 99 in Spain⁵². Day care surgeries and procedures do not comprise the largest part of outpatient care. To date, procedures such as cataract surgery, tonsillectomy and hernia repair are mainly treated in inpatient settings.

The Ministry of Health was initiating fee-for-service payments for outpatient specialized care. The intention was to purchase a fee-free consultation or diagnostic procedure that would be guaranteed to all patients referred by their primary care physician. However, the list of these outpatient procedures was limited, which was creating the wrong incentive for providers of these procedures to concentrate only on the defined services and provide larger amounts of fee-based services looking for higher revenues. These risks and the insufficient allocation of resources for purchasing of specialized outpatient care were the main reasons to postpone the nationwide purchasing of such services in 2019. Plans for 2020 outline a specified set of procedures (hysteroscopy, colonoscopy, gastroscopy, bronchoscopy and cystoscopy) that will be reimbursed to providers on a fee-for-service basis to incentivize outpatient provision of these services.

⁴⁹ Hrechiskina N. Analysis of surgical care in Ukraine during the last decade (2003–2013). Visnyk of Vinnytsia Medical University, #2, t19; 2015 (http://www.irbis-nbuv.gov.ua/cgi-bin/irbis_nbuv/cgiirbis_64.exe?C21COM=2&I21DBN=UJRN&P21DBN=UJRN&IMAGE_FILE_DOWNLOAD=1&Image_file_name=PDF/vvnm_u_2015_19_2_57.pdf), accessed 2 September 2019, in Ukrainian).

⁵⁰ <https://data.worldbank.org/indicator/SH.SGR.PROC.P5>

⁵¹ Hrechiskina N. Analysis of surgical care in Ukraine during the last decade (2003–2013). Visnyk of Vinnytsia Medical University, #2, t19; 2015 (http://www.irbis-nbuv.gov.ua/cgi-bin/irbis_nbuv/cgiirbis_64.exe?C21COM=2&I21DBN=UJRN&P21DBN=UJRN&IMAGE_FILE_DOWNLOAD=1&Image_file_name=PDF/vvnm_u_2015_19_2_57.pdf), accessed 2 September 2019, in Ukrainian).

⁵² Specialist surgical workforce (per 100 000 population). In: World Bank [website]. Washington (DC): World Bank Group; 2019 (<https://data.worldbank.org/indicator/SH.MED.SAOP.P5?view=chart>, accessed 2 September 2019).

In the pilot in Poltava region, contracts with hospitals also cover outpatient specialized care. The payment mechanism was defined based on the global budget estimated using historical costs of aggregated services for the period of April–December 2019, with equalized monthly payments. Per capita payments are not age- or sex-adjusted but are higher than the per capita premiums paid for PHC.

5.2.5 Purchasing of the emergency care

Emergency medicine centres are in each region of Ukraine and have a network of stations with permanent and temporary substations, located conveniently to reach the population within each region. Regional emergency medicine centres have centralized or decentralized dispatcher units that manage ambulances and address emergency calls from their catchment area. The decentralized model leads to fragmentation of resources and duplication of services and the centralized model is being gradually implemented. The actual number of ambulances employed by emergency medical services (EMS) is 3118 ambulances (0.7 per 10 000 population versus the normative of 1 per 10 000 population), but further clarification of EMS algorithms and pathways may decrease the actual need for ambulances.

Currently, EMS is mainly financed through the medical subvention, which is allocated from the central budget (5 billion hryvnia in 2018) and an additional 20% of funds are allocated to finance EMS from local budgets. EMS dispatch centres in Ukraine annually receive 9 465 137 calls (2232 per 10 000 population) and deploy ambulance visits for 8 400 770 calls (1981 per 10 000 population).⁵³ The numbers of calls received in Ukraine is twice that in Scandinavian countries, and the number of visits is 4–5 times higher than in comparator countries. At the same time, only 24% of calls received by EMS require transportation to a hospital versus about 60% in comparator countries. The EMS system in Ukraine uses a “treat and release” approach, which is common in post-Soviet countries and may also indicate that the EMS provide some primary care services that are otherwise not accessible. The outcomes of those patients treated by EMS and left at home are unknown. The ongoing reform of EMS should concentrate on provision of care to actual emergencies rather than offering other types of care for non-life-threatening conditions.

In 2019, the Ministry of Health has initiated the transformation of EMS and has allocated almost 1 billion hryvnia of additional funding to implement the EMS reforms. Six regions were identified for piloting the EMS reforms (Donetsk, Odesa, Poltava, Ternopil and Vinnytsya regions and Kyiv City). These regions will purchase new ambulances and equipment. They will upgrade the emergency dispatch system to include prioritization protocols to decrease the burden of non-urgent calls and optimize the response to urgent calls. These dispatch centres will be able to submit computerized real-time data on their performance, which will allow for better monitoring and future planning of EMS in pilot regions. Significant additional effort will be invested to improve capacities and train or retrain the EMS staff, both dispatchers and first aid responders. The considered reorganization of EMS teams to include paramedics with appropriate training may improve the use of resources and reduce the call-to-hospital interval. Purchasing of emergency services in 2020 is planned to be implemented on a capitation basis through direct contracts between the NHSU and emergency medicine centres in each region.

⁵³ Haazen, Gaiyevskiy, Danyliuk. (in print) Emergency System in Ukraine: policy brief. Washington, DC: World Bank.

5.3 | Alignment with other areas of health system strengthening and public sector reforms

The reviewed purchasing of health services beyond PHC is well aligned with the priorities of the health care financing reform as well as with other areas of transformation of the health system. Law 2168 defined the principles and timelines for the implementation of the new purchasing of services, and the Ministry of Health has been effectively following the provisions of the Law. For example, the following actions are directly linked to the purchasing of services beyond PHC.

- **Establishment of the NHSU in 2018 with broad functions for purchasing of health care.** The NHSU has been able to implement the pilot purchasing of hospital and outpatient specialized care in 2019 to prepare for the scale-up of purchasing of all health care services in 2020.
- **Implementation of new payments for PHC and reimbursement of drugs.** The early success of the PHC reform with declaration-based capitation payments coupled with the prescription of medicine for patients with hypertension, diabetes and asthma by PHC providers was a powerful signal to confirm the readiness and capacities to implement new provider payment mechanisms for other types of health care.
- **Definition of benefits included in state-guaranteed medical services.** This is an important element of health financing reform as it defines the boundaries of purchasing and serves as the basis for contracting between the NHSU and providers.
- **Development of e-health.** Law 2168 has defined the principles of functioning and requirements for electronic information exchange and storage. These are critical elements for purchasing and will require further development for the implementation of purchasing in the future.
- **Provision of remote technology support including basic telemedicine.** Such initiatives, if further strengthened, may help to expand specialized clinical care in settings outside hospitals and establish effective cross support within the hospital network. Remote health services offer many possibilities, including using mobile technologies and personal devices, as well as reading images and making diagnostic and treatment decisions remotely.

Other activities of health care transformation that impact purchasing include medical education reforms, development of specialized care (e.g. reperfusion centres) and the reform of centralized procurement of medicines and medical products. The medical graduate and postgraduate education reforms will help to improve the skills mix of medical personnel and, potentially, the purchase of advanced and better quality services; it may also help to improve the match between workforce demand and supply. The objective for developing priority specialized care services is to reduce amenable mortality from acute conditions. It started with the establishment of a network of reperfusion centres that provide access to heart stenting and will continue with the establishment of stroke centres. The reform of centralized procurement helped to improve access to essential drugs by increasing the volumes of procured medicines from the generated savings. In the coming period, centralized procurement will need to be properly coordinated with the procurement of hospital and outpatient centralized care to avoid mismatches in supplies of medication and the expected volumes of services purchased from providers.

Health reform is one of the most welcomed (second priority after the anticorruption reform⁵⁴) and widely recognized reforms in the population. Broader public sector reforms include public service, decentralization and anticorruption reforms. Public service reform has been the core lever for the transformation of the Ministry of Health structure and functions. It can also help to develop the NHSU and its regional branches by specifying the requirements and the hiring process for public servants, as well as for increased payment scales. The decentralization reform created ambiguity in terms of providing more resources and powers to local communities but pooled health funds and direct purchasing of health services from the national level. It has, however, helped to create the idea of inter-rayon territories, which will be served by higher-capacity hospitals within the hospital district concept. The anticorruption and health financing reforms pursue the same objectives of introducing transparent systems of interactions between communal enterprises and the state, and reducing informal transactions in health care.

5.4 | Emerging impact of policies on reform objectives

During preparation of this chapter, purchasing beyond PHC had been in implementation for just about three months and covered only hospital care and outpatient specialized care in one region of Ukraine. At this stage, evaluating the impact of the implemented approach is difficult. However, implementation of direct purchasing was planned to help to improve the efficiency of service delivery at provider level by providing less control of inputs used for treatment of each case and offering space for internal regulation of the needed use of human and material resources.

Depending on the share of the global budget and case-based treatment at hospital level, one may expect that some providers will benefit more from the proposed approach, while others may not be able to generate sufficient revenues to keep the same level of input as before. Therefore, the decision on how to split the global budget and case-based payments for hospitals is critical: using a larger share of the global budget may increase the chances for hospitals to avoid bankruptcy, especially in the initiation of new payment methods, while an increase of case-based payments will incentivize larger service providers as they may receive more income from the principle “money follows the patient”.

Considering the measurements set in place to control for the overprovision of services – the reduction of the base rate and monthly ceilings – it is unlikely that hospitals will react to the proposed per case payment mechanisms with a significant expansion of service provision. The same expectation is applicable to contracts for the provision of outpatient specialized services – the global budget will likely not significantly change the outputs of polyclinics but may influence the use of resources in polyclinics needed for the organization of outpatient care.

⁵⁴ What top-priority reforms do citizens expect. Kyiv: Democratic Initiatives Foundation & Sociological Services of Razumkov Center; 2019. (<https://dif.org.ua/article/na-yaki-pershochergovi-reformi-chekayut-gromadyani>, accessed 2 September 2019, in Ukrainian).

The first positive change already observed in the pilot is the improvement in data reporting. The time to enter patient discharge data in an electronic system notably reduced from 8 days in January 2019 to 1.5 days in May 2019. A more comprehensive evaluation is planned in Poltava region based on recorded changes at the provider, patient and purchaser levels. At provider level, the following characteristics will be tracked and assessed: the number of cases treated by case groups; changes in the characteristics of hospitalizations, such as length of stay and admission of patients with conditions that can be treated at the outpatient care level; and internal reorganizations of hospital care providers (if any). At patient level, the assessment will cover the changes in preferences and patient pathways (e.g. which hospitals will be selected by patients for the treatment of non-acute conditions), readmissions of patients to hospitals and levels of patient satisfaction, which can be captured within the “Health Index. Ukraine” survey of 2019 or other surveys. For the purchaser, the main targets are to assess the needed capacities to manage contracts with hospitals, the need for business intelligence modules that will help to digitalize billing and payments to providers, and to prepare for the roll-out of purchasing in 2020.

5.5 | Anticipated challenges

Roll out of the pilot nationwide is a significant implementation effort, which needs political backing. The launch of strategic purchasing, contracting and new financial incentives has been implemented well but needs to step up a gear; however, to achieve changes in clinical practices on the ground, a wider range of instruments beyond financing, such as institutionalized mechanisms to expand benefits and improve quality, are needed. The implementation of purchasing of hospital, specialized outpatient and emergency care is more complex than purchasing of primary care, especially in a situation of financial constraints. The next steps would need support from all stakeholders, and building a coalition for successful implementation can be the first challenge to address.

The biggest challenge ahead is the needed restructuring of the provider network. The new financial incentives and provider payment mechanisms are necessary but not sufficient conditions to achieve the effective right-sizing of the hospital provider network. The white paper on service delivery produced by the WHO team with the Ministry of Health and hospital master planning conducted by the World Bank in cooperation with two regional teams clearly suggest the need to reshape and divest hospital infrastructure concentrating on fewer locations that will provide a full cycle of acute hospital services to the population and develop post-acute and palliative capacities in some settings, which will not be selected as main acute care providers. Such interventions will be essential to ensure sustainability of the financing reform. In particular, efficiency gains via hospital restructuring will be essential and will require political support and stamina.

Purchasing from care providers would need to better regulate the standards for quality of care and ensure adherence to such standards. Contracts with providers will need to include concrete expectations to the quality of care provided to customers. Presently, the NHSU is fairly limited to act upon quality issues, as the only effective instrument it has is

termination of contracts with providers. The NHSU may need to hire an independent quality supervision agency or develop the capacity inside the organization to properly monitor quality and have regulations to address the quality issues routinely. This major change in the licensing and delicensing process is needed as its current procedure is mainly formal and does not help to ensure quality.

Implementation of the DRG-based payment will require significant strengthening of audit functions. The current plan is to start purchasing of hospital services using a simplified version of DRG-based payments. After 3–5 years of implementation (or sooner), the more developed DRG system may be needed to serve as a basis for payments to better capture hospital activities and use of resources for hospital treatments. The adoption of the DRG specificity will be based on resources availability and readiness of the NHSU. To assure the quality coding and its continuous improvement, the clinical coding audit system needs to be implemented as soon as there will be enough resources (human, information technology) and capacity for this. The auditing function can be located within the NHSU or outsourced to medical associations or providers. Either way, potential auditors need training, tools (e.g. audit software programs) for conducting the audits, methodology, etc.

The development of hospital care may increasingly rely on the use of day surgeries. Purchasing of hospital services would need to incentivize more efficient types of acute and elective care. The development of day care surgery has very rapidly become the major share of all surgical activities in outpatient settings within or outside hospitals in the more developed neighbour countries. Over the last 25 years, day surgery is a frequent solution for the following types of medical interventions: hernia repair, cataract surgery, tonsillectomy and cholecystectomy. In Ukraine, all these interventions are mainly hospital-based with an average length of inpatient treatment of 6–8 days, and this trend should be changed by putting the right incentives in purchasing arrangements.

The increased sophistication of the hospital care purchasing may lead to the need to implement additional payment regulations to purchase emergency care. To date, purchasing of emergency services is planned to be organized on the per capita principle. This may not be enough to create the needed changes in the patterns of EMS delivery. Rationing mechanisms need to be developed, such as an effective triage system. Payments for emergency care may also need to include incentives for the reduction of call-to-emergency room time for acute conditions; appropriate transportation of patients according to defined clinical pathways and reference points for strokes, heart attacks (cardiovascular conditions), maternal care, neonatal care and all other emergencies; infectious diseases, mental health, metabolic-related diseases and cancers. This may lead to the inclusion of results-based mechanisms for the purchasing of EMS.

The next phases of the purchasing would need to appropriately estimate and develop mitigation strategies for the following risks.

- 1. There may be resistance to reforms from the medical community and well-paid specialists** (from informal payments) to the new transparent mechanisms of purchasing, which will tackle informal revenues of hospitals. The strong communication campaign may help to build the buy-in from the proponents of the reform and explain the new ways of the contracting providers. It may also provide more clarity on the changes to patients and increase credibility of reforms.

- 2. The skills of managers of providers may be inadequate to perform appropriately in the new environment.** The new regulation that requires hospitals to have a non-clinical manager with training in management or business administration needs resources and a process to materialize. To encourage development, hospitals may need to get a matrix of performance indicators to compete and benchmark against each other, and leading hospitals need to receive rewards.
- 3. A synchronized development of e-health will put purchasing at risk.** Further e-health development is important to better understand the volumes and complexities of care, connect patients at all levels of care and better execute strategic purchasing decisions. A unique national identifier will be necessary to make sure that information for one episode of care can be fully linked to all other episodes in all other facilities. This area will require enough investments and attention for steady growth.
- 4. Case-based and fee-for-service payments may incentivize overproduction of services or upcoding of patients to higher cost DRGs.** The careful collection of baselines for each service provider and accurate tracking of the changes in the volumes of care provided should help effectively react to the unexpected variations in service outputs. Appropriate measures should also be in place to help to eliminate wasteful spending such as unnecessary hospitalizations and inefficient prescriptions. The next phase of implementation will require further strengthening of capacities of the NHSU at central level and territorial purchasers.
- 5. Purchasing of services and centralized supplies of medicines and medical goods may put at risk implementation of contracts based on the volumes of care provided if not appropriately coordinated.** The decisions on what goods will continue to be purchased centrally and the delivery schedules should be available before contracts are fixed or contracts should allow some flexibility to adjust for the changes.
- 6. Direct purchasing of health services through the NHSU may further reduce the involvement of local governments in financing health service providers.** At the same time, providers will need additional resources and investments for strategic development of capacities. In the implementation of purchasing, clarity should be provided regarding financing the capital expenditures of providers and the role for local governments in covering expenditures and proposing solutions for covering the expenditures of providers that will not be included in purchasing through the NHSU, including a divestment programme for non-strategic facilities.
- 7. OOP payments may not be easily eliminated, especially in the fiscally constrained financing of health services and existing inefficiencies at all levels of care delivery.** The proposed approach to focus on incentives for priority conditions and more efficient providers is reasonable, but it may not be enough to meet the expenditures of patients for improved financial protection in all cases of health care use. The government should carefully explain that the implementation will be phased, and the system will undergo a gradual long-lasting transformation.

5.6 | Policy recommendations

Full-scale implementation of purchasing of health services needs to be continued to achieve the tangible results and improvements at all levels of care. The next phase of purchasing will require a lot of concerted effort from all players – parliament and government to support enabling legislation, the Ministry of Health and the NHSU for design of the purchasing mechanisms and their implementation, and the active participation from the providers' side. The roadmap with clear expectations for actions and timelines should be readily available for all actors to be on board and contribute as necessary.

Managing provider transformation needs to be supported by policy dialogue with local authorities and owners of providers. Local governments have an important role to play as facility owners and financing agents, but further policy dialogue is needed on how to align decentralized roles and national health policy priorities. There is variation in the implementation of the functions of local governments in practice, and variation in local government financing of health.⁵⁵ Lack of coherence between national and local policies can lead to both inequities (e.g. forcing electricity cuts, dilapidation in infrastructure in poorer regions) and inefficiencies (e.g. purchasing extra equipment for facilities that may not be of priority). Agreeing on non-overlapping responsibilities in financing across the Ministry of Health, the NHSU and local governments is an important discussion to have. The government may need to consider how to create national leverage over the role of local governments in financing capital expenditures and quality improvement measures in their facilities to ensure coherence with national plans and policies (e.g. facility master plan and service priorities).

Shifting the focus from hospital-centred care delivery would require coordinated development of other layers of care. Care needs to be patient-centred to lead the patient smoothly from health promotion activities to treatment and disease management to rehabilitation and end-of-life care repeating the phases depending on patient needs and circumstances. This would require further strengthening of primary care by adding capacity, implementing patient-targeting strategies and encouraging outpatient-based management for the majority of health care conditions. Further expansion of the reimbursement of outpatient drugs will help patients to stay in touch with their primary care provider for more types of care.

Strengthening quality regulation, monitoring and assurance should be a critical element of the reform. The hospital reform should be driven by considerations of patient safety and quality of care for better health outcomes and patient satisfaction. Higher volumes of hospital care per facility and per practicing doctor associate with better outcomes. Many countries consider cut-off minimum volume thresholds (e.g. minimum number of specific procedures executed in one hospital per year or per one specialist doctor per year) for safety and quality reasons. Such cut-offs can be developed for Ukraine's specific context. The cut-off points can be effective for contracting of hospitals, but for licensing lower thresholds can be used to create space for development of the necessary volumes at the expense of private or providers' own resources.

⁵⁵ Zhao F, Vakhitova H, Doroshenko O, Sologoub I, Obrizan M, Iavorskiy P et al. Tracking the health resources in Ukraine. Washington (DC): World Bank Group; 2018.

Implementation of DRGs is a very important development milestone in the health system. It will serve many purposes and will help to better manage hospital service delivery. Case-based payment with acceptable weighting coefficients can serve as a reasonable approach to incentivize development of critical hospital services in the preselected hospitals. The development and explanation of the DRG-based payment principles are critical. The government needs to develop a transparent process of the establishment of the payment formula and refinement of DRGs. The implementation arrangements and supporting systems will need to be in place such as information systems, the process for the revision of the national coding and classification systems, and hospital performance monitoring systems. Adjustment to the new payment mechanisms may need time and capacity-building support.



6. DESIGNING TRANSPARENT AND FAIR BENEFITS

6.1 | Introduction

A purposely designed system for benefit entitlements is an important tool to prioritize scarce resources in the health sector. Well-defined and understandable entitlements to services selected based on criteria like medical evidence, cost-effectiveness, population needs and national priorities, support an efficient and equitable use of public resources. In addition, benefit design is also an essential part of forming a country's social contract, as it links obligations and benefit entitlements for the population and the health sector.

Ukraine has a challenging fiscal situation and a publicly funded health system, which has historically not been able to meet its stated obligations and the population's need of medical services, as indicated by unmet need and large OOP payments for a wide range of medical services and goods. As part of a comprehensive health system reform, Ukraine has enacted Law 2168 on the PMG, which guides the benefit entitlements, and gives the newly established purchasing organization, the NHSU, responsibility for implementing delivery of these entitlements. This chapter reviews the current state of development of benefit design and its potential for supporting a rational use of resources and equitable distribution of medical services.

6.2 | Overview of key policies

Historically, Ukraine's legislation was an obstacle to reform, particularly with respect to formally shaping realistic benefit entitlements. In the Ukrainian Constitution, Article 49 gives all citizens of Ukraine entitlement to free health care in all government facilities. The publicly financed benefit package, however, was not defined explicitly even in an aggregate manner. This focus on the legal form of the provider, in combination with an implicit benefit design and extensive public provider network, has made it difficult to ration services. In the past 20 years, the fiscal context made it very difficult to fund this commitment, leading to a range of implicit rationing mechanisms including the growth of unofficial payments, access barriers, service dilution and deterioration of quality. The constitutional guarantee and the 2002 Constitutional Court decision made it difficult to introduce reforms of explicit rationing in the Ukrainian health system. The presence of implicit rationing mechanisms for 20 years, however, eroded the trust of the population in their entitlement and in the health system as a whole.

The Law on “Government Financial Guarantees of Health Care Services” enacted in 2017 established a new framework for health benefit entitlements. Article 5 of Law 2168 lays down important principles for defining the benefit package that signal the needed transformative approach:

1. equal state guarantees to patients independent of a patient’s age, race, complexion, political, religious and other beliefs, sex, ethnicity and origin, property status, registered place of residence, language or other characteristics;
2. ensuring preservation and restoration of health and the quality of medical services and medicines;
3. universal coverage and equity of access to needed health services and medicines within the PMG;
4. predictability and planning of the amount of coverage of the cost of medical services and medicines; and
5. openness, transparency and accountability of governmental authorities and local governments and their officials in the field of government financial guarantees for health care.

Law 2168 has been a game changer and transformed the legal foundation for benefit design and rationing. The entire population (all citizens and residents) is now entitled to health services explicitly specified in the publicly funded state-guaranteed programme. This shifts entitlement from the provider network perspective of where the service is sought to a set of services, which are publicly funded regardless whether they are provided in a public or private facility. Services included under the publicly funded PMG can legally not be provided under any cost-sharing arrangement. This implies that user charges can only be introduced for services outside the publicly guaranteed benefit package, and therefore, those services must be based on 100% user charges.

Law 2168 on financial guarantees outlines a two-level process for how the benefit entitlements shall be formed and developed over time. According to the Law, the introduction of defined benefits is done at two levels: the general approach to benefit design (principles, institutional dimensions, scope) is defined in the Law itself while further details are elaborated through an annually updated government decree (the PMG). The decree will define the services and medicines to be covered by public funds and gives the NHSU the responsibility to implement the programme.⁵⁶ This responsibility incorporates several important functions, such as drafting the proposed benefits package and reimbursement tariffs, contracting providers and monitoring quality and outcomes.

An important implication of the clause on user charges is that the principle dimension of rationing that the government can use to match resources and entitlements is service coverage. To make this rationing effective, a more explicit and more detailed definition of the services was proposed. The Law stipulates that the benefits package will cover provision of emergency, primary, secondary, tertiary and palliative, rehabilitation, child, pregnancy and childbirth health care and associated medicines with further details defined in the PMG. To operationalize rationing, the PMG will use a combination of general descriptions of services that are fully covered and more detailed lists of services that will be subject to explicit

⁵⁶ Law 2168 gives responsibility to an authorized body to implement the PMG. The authorized body is responsible for drafting the PMG – that is for developing the proposed benefits package and the tariffs to be paid for services, for approval by the government. This authorized body is the NHSU.

rationing. It will use both positive lists of services covered and negative lists of chargeable services. This approach will depend on type of care. General descriptions will be used for PHC, emergency health care, child health care, health care for pregnancy and childbirth, and palliative care – accompanied by negative lists of chargeable services. The Ministry of Health proposes to use more detailed positive lists for non-urgent specialist health care, rehabilitation, prescription drugs, dental and optical health care, accompanied by clinical protocols and guidelines, and introduction of more formal waiting lists. The primary care benefits package has already been defined and the rest is currently taking shape.

A number of criteria have been established to guide rationing the decisions in establishing positive and negative lists. These criteria include the following.

- 1. Effectiveness** is the degree in which a service is scientifically proven to prevent, diagnose and treat disease. For instance, in the most advanced health systems, control of blood pressure is organized at outpatient level, without the need for hospitalization for most patients. This approach is known to be effective based on a large body of scientific evidence.
- 2. Health need** is the extent to which access to a service will save lives, prevent or treat diseases, affect patient functioning and quality of life – reducing death, disability and pain.
- 3. Cost-effectiveness of services** is the comparison between cost and attained results of different interventions for preventing, diagnosing or treating the same disease. Services are more cost-effective when one can get the same results for a lower amount of resources. Selecting services based on cost-effectiveness helps to ensure greater health benefits are achieved with the available public funds. Health benefits can be measured in prevented deaths, additional life years, or improved functioning and quality of life.
- 4. Protecting households from catastrophic expenditures for very high cost services** includes services that would result in significant costs to the household or even loss of assets or debt. These usually are services that have low frequency but very high cost. It is particularly an issue for emergency services, when the patient has no possibility to wait or save for health care, but services for chronic conditions, which require patients to take medication or undergo diagnostic tests on a regular basis, can also lead to accumulation of high costs over time. So selecting services to be included in the benefits package based on risk of catastrophic expenditures helps to ensure that people have equal access to health services despite economic status, and that the system is equitable.
- 5. Equity of access** means that all citizens have the same opportunity to use health care.
- 6. Population preferences** recognize that political and social acceptability of decisions on health priorities is important. The input of citizens and their political representatives is especially important in relation to equity issues.

To further operationalize the link between guaranteed services and available resources, costing will be introduced gradually. Initially the NHSU will adopt a top-down method for costing the benefits package based on the existing spending envelopes and volumes of service provided for broad categories of covered services (primary, emergency, hospital specialized, rehabilitation, and palliative health care), adjusted for projected changes in costs, including any approved salary increases, potential efficiency gains and for projected utilization of services. As fiscal resources permit, the Ministry of Health and the

NHSU will propose incremental increases in the scope of benefits, volume of rationed services and quality of care. Progressively as data improves over time, the NHSU will use bottom-up costing of services and improved analysis to refine the methodology for producing cost benefits package scenarios. There will be a continuing need to combine top-down and bottom-up methods in developing the benefits package and allocating the NHSU budget. The PMG included in the state budget document will present the NHSU budget in broad categories of services corresponding to different payment methods and seek approval for base price levels or tariffs of health services price levels rather than detailed lists of services tariffs.

Ukraine has commenced on this new system by implementing an explicit positive list of basic PHC services and pharmaceuticals, which have been clearly defined in contracts with providers and thoroughly communicated to the population. The current list of PHC services provided free of charge is defined by the Ministry of Health Order No. 504 (Table 1.1). It contains 17 basic PHC consultations and procedures, focusing on high-frequency and chronic conditions, preventive screening, vaccination, and maternal and child health care. It also includes eight types of laboratory and diagnostic examinations: general blood analysis with leukocyte counts; general urine test; blood glucose; total cholesterol; blood pressure measurement; electrocardiogram; measurement of weight, height and waist; and express tests for pregnancy, troponins, HIV and viral hepatitis. These services are largely what primary care facilities were already providing before this reform, and build on earlier reforms expanding the role of family medicine and increased focus on health promotion and disease prevention. The list of entitlements therefore mostly serves as a clarification of service benefits patients should expect to have at no cost when visiting a PHC clinic.

The foremost extension of benefit entitlements is a short but clear and carefully selected list of pharmaceuticals in the Affordable Medicines Programme, introduced in 2017 (Ministry of Health Order No. 180, Table 1.1). Until this point, there was no explicit entitlement to prescribed drugs, and the availability of publicly funded drugs was arbitrarily governed by the traditional budgeting and distribution system. This created, in combination with poor evidence-based prescribing, severe financial and access barriers, especially for low-income population groups. The current list provides public coverage for 64 outpatient medicines for patients diagnosed with cardiovascular diseases, type 2 diabetes and bronchial asthma. The new system prioritizes the government funding to essential medicines but also keeps the reimbursement level per prescription low by using a reference price mechanism with regulated markups for retail.

The Affordable Medicines Programme already has several important building blocks established for continuously developing a national essential pharmaceuticals list covered by the public budget. In February 2019, the Ministry of Health created the Health Technologies Assessment Department to carry out assessments of effectiveness, safety and economic feasibility of the medicines to be included in the essential medicines list, building on previous work by an expert committee established as an advisory body of the Ministry of Health. From April 2019 reimbursement for the Affordable Medicines Programme is managed by the NHSU, strengthening the opportunity for a comprehensive capacity to strategically purchase health services and goods.

6.3 | Alignment with other areas of health system strengthening and public sector reforms

In both the population and cost dimensions of coverage, Ukraine's legislation expresses a strong commitment for an inclusive health system with equitable access that goes beyond the ambitions of most other countries, particularly when compared with countries of similar economic development level. This approach also supports the transparency of entitlements to the population, and administrative efficiency for public administration, providers and patients.

However, the ambitious population and cost coverage legislation lead to a need for an elaborated strategy and application of other rationing mechanisms. Ukraine has so far focused on essential services, which global evidence shows are the most cost-effective and at the same time support an equitable consumption. Expanding the positive list in PHC, i.e. an explicit list of benefit entitlements provided free of charge and developing the service content in PHC by means of medical protocols and other guiding, will be essential. Several other policies will also be needed to shape benefits, linked to the strategic purchasing role of the NHSU. These include, for example, explicitly excluding publicly funded services in hospitals and using waiting time as a rationing mechanism.

Institutional roles for benefit design are formally well developed in legislation, but capacity building and practice are yet to be developed and institutionalized. In an annual process, the NHSU develops the set of benefits based on the principles set in the Law on financial guarantees (see above), and Ministry of Health priorities for the coming year. After approval by the Ministry of Health and subsequently the Ministry of Finance, it must be approved by the Cabinet of Ministries and finally taken by parliament as part of the annual law on the state budget. The level of detail in the PMG is evolving with the expansion of benefits and purchasing mechanisms. For example, with the hospital priority areas for 2020 (stroke, myocardial infarction, deliveries and neonatal care), explicit criteria on requirements for contracting, basic tariffs and scope of services are included in the PMG. Since the establishment of the NHSU, it has led the build-up of the benefit package, involving a broad set of stakeholders, including the Health Technologies Assessment Department of State expert Centre and the Committee for Selection of Medicines in selecting medicines. The work is largely dependent on external support from development partners and needs to be institutionalized with capacity building in national government agencies.

6.4 | Emerging impact policies on reform objectives

Law 2168 aims to link the benefit package with the available fiscal space to reduce unfunded mandates. Article 4 stipulates that it is necessary for the NHSU to fund a benefits package within the annual state budget provision for financial guarantees for health care. In Ukraine, as in other health systems that are financed from general taxation, the fiscal space for health is decided as part of the budget negotiation process. Parliament has adopted⁵⁷

⁵⁷ Draft Law on Amendments to Section VI, Final and Transitional Provisions of the Budget Code of Ukraine (for the introduction of medium-term budgetary planning as of 6 March 2017. (http://w1.c1.rada.gov.ua/pls/zweb2/webproc4_1?pf3511=61294, accessed 2 September 2019, in Ukrainian).

the procedure for a medium-term fiscal framework for planning the budget for three years in advance (2019–2021). In 2017, the Ministry of Health submitted to the Ministry of Finance the proposal on government health spending for 2018–2021. Introduction of this procedure will enable the NHSU to have a medium-term expenditure path, beginning in 2019–2021.⁵⁸ Article 4 of the Law also stipulates that the amount of state budget funds allocated to the PMG should be not less than 5% of GDP.

The benefit design in terms of actual services and their distribution is very much dependent on how service provision on the ground develops. Ukraine has very successfully built up benefit entitlements to health services and implemented them in a logical sequence, with a purposeful selection of guaranteed services and pharmaceuticals based on rational criteria guided by legislation. Yet, what creates value for patients from this implementation is how benefits materialize in the actual provision of services. This dependency on real service development is the case for all countries, but with fundamental reform in provider payments and service delivery still ahead, this is particularly true in Ukraine. The Ministry of Health is currently developing a service delivery transformation vision up to 2030, and it will be critical to align this vision with health financing and, in particular, benefit design. As the interaction with other parts of health and public sector reform is very complex, the following aspects are not exhaustive, but key to effective benefit design in Ukraine.

The main obstacle to monitor and evaluate the effectiveness of how benefit entitlements develop on the ground is the lack of objective information about which type of services are provided, to whom and at what volume. So far surveys have indicated high service quality satisfaction, but very little medical information that can describe service consumption and medical quality is available. The e-health plans are strategically very well developed and have the potential to mitigate this problem. However, the apparent lack of very basic diagnosis and service consumption data seems to be an effect of mistrust in the old paper-based system, which has been abandoned before anything new was in place. There is also a risk that implementation will be slowest in regions with the highest needs, as local budget resources affect investment opportunities (see below).

The contracting and payment mechanisms can be developed to expand services offered by PHC providers. With the new enrolment and capitation reform, doctors' incentives to how many and to whom they meet have changed fundamentally. This is purposefully developed to increase service quality and responsiveness. The incentives for developing and changing the provided medical content have changed much less. Performance elements in the payment model should support health promotion and disease preventive services. Contracts can also be developed to put more responsibilities on the PHC doctors.

The NHSU, and possibly other national government authorities, need to continue to expand the scope of PHC. PHC in its current form, predominantly based on general practitioners, is a relatively new form of service delivery in Ukraine. There have been a lot of efforts put into clinical protocol development as well as curriculum development and retraining. This will need to continue for a long time, as the task profile of PHC is still relatively narrow compared to countries with more sophisticated general practice. From a benefit definition perspective, the key services to strengthen in the primary care setting include:

⁵⁸ Note that the NHSU will begin purchasing the whole PMG only in 2020. In 2019 it will have the more limited role of purchasing PHC, while other government funding for health care continues to be funded through medical subvention to local authorities and through central Ministry budgets.

more proactive detection and management of chronic conditions, integration of community detection and management of tuberculosis, and integration and deinstitutionalization of mental health services and, finally, integration with social care.

Differences in local budget resources create differences in prerequisites between providers in affluent and non-affluent areas and need to be mitigated, especially as PHC should continue to take on responsibilities. The 370 hryvnia base capitation rate is intended to be used for running costs (predominantly salaries). Even though capitation revenue is at the facility management's disposal and nothing prevents them from using it for investments, many facilities still rely on local budgets for new equipment or needed modernization. These differences are probably exacerbated by the differences in starting points for the facilities, as the corporation of the clinics were conducted by handing the premises over to the new legal entity. This was a practical approach that minimized bureaucracy but also led to an unequal starting point. There is a risk the real service content under the PMG is affected by available resources and differences in local priorities. National investments in low-resource areas can be effective to mitigate these differences in the midterm.

6.5 | Anticipated challenges

In 2020, when the NHSU will start purchasing hospital services, priority setting and rationing will be more difficult than in the initial reform stages. It is in the hospital sector most of the resource rationing should take place over the coming years. Alongside a much-needed service provider master plan, Ukraine needs to become more selective in which hospital services it funds publicly (for details of hospital purchasing, see Chapter 5). The strategy to expand the PMG to priority conditions also for hospital services can be useful, but not effective enough. The PMG as a tool to define a positive list of benefit entitlements is much harder to practice for hospital services, and other tools have to be applied. With introducing an advanced DRG payment system for hospital care, Ukraine indirectly defines a very broad benefit package, a set of services that risk sustaining an oversized hospital sector, providing a large range of underfunded service. Volume caps per diagnosis are a means to tackle this problem (see recommendation on structured waiting times below) and can be applied to keep the overall budget, but it will not necessarily ration between different types of services.

A clear, well communicated and realistically funded benefit package is key to eliminate informal payments but in any case, this will take time. In Ukraine, as in most eastern European countries, informal payments are a common attribute of using health services. The average amount paid for a PHC service in Ukraine is estimated to be 26 hryvnia (approximately 50 euro cents), while specialist services typically generate higher payments (e.g. computer tomography is on average 261 hryvnia), but with a large variation with type of service and geographic area.⁵⁹ With the very transparent PHC entitlements, which are well advertised in PHC facilities and explicitly stated as free of charge, informal payments should decrease significantly over time. This should also be supported by the relatively well-funded capitation payment, as one commonly stated cause of informal payments is the low salary levels of health professionals. For several reasons, this will be more difficult in specialist care (and

⁵⁹ The 2018 Informal Payments Survey in Ukraine. Kyiv: USAID HIV Reform in Action Project; 2018.

in particular advanced hospital services), where informal payments are more frequent and the amounts are higher. Building transparency is more difficult, as formally paid services are common, and many services contain several actions and involved professionals. Narrowing down which specialist services will be included in the benefit entitlements, and providing these with enough efficiency, are key to ensure public funding is adequately available. In combination with transparent entitlements to ensure public awareness, informal payments also for specialist services can decrease over time.

PHC providers seem to very quickly have learned how the new system works, and the capitation rate and payment regulation will need adjustments to avoid cream skimming of patients, which can lead to worse access for less profitable patients.

Interviews with PHC staff and management indicate that clinics are aware how to maximize revenue when registering patients. A gender-based adjustment is in the planning and the age adjustment can be right, as there is no given level. The capitation rate is not yet adjusted for socioeconomic factors more than a mountain region coefficient, which is probably not an effective way of capturing need. A disease burden adjustment, which is common in more developed capitation systems (e.g. the Johns Hopkins Adjusted Clinical Groups®), will not be possible until the e-health system is well implemented and tested. In the meantime, single assessments of enrolment by socioeconomic groups and disease burden can be conducted to evaluate possible adverse selection effects.

There is a risk that fast responding PHC clinics implement patient fees for such services, which should be included in a broader PHC package. An intrinsic problem with capitation-funded services is that it can, depending on regulation, create incentives for not providing more than is explicitly stated in the contract. In Ukraine, PHC clinics are allowed to charge patient fees for anything outside the PMG. At the same time, the ambition must be to expand the PHC responsibilities in terms of scope of services, at the same level of capitation rate, without introducing additional incentives payments for this expansion.

The large enrolment with PHC doctors is a true success of the reform, but to keep and build credibility of the health system, the technical system needs to be fine-tuned.

The currently 27.6 million enrollees is a very high number, representing a large share of the resident population, but there seems to be a risk of double counting, as the database is not linked with any other population register. This does not only risk unnecessary high costs for the capitation-based PHC budget. It also causes a risk of mistrust in the system. Generally, population trust in the new reform is essential, including its ability to avoid fraud, and a robust registry of enrolment is therefore important.

6.6 | Policy recommendations

Development of clear benefit entitlements is a continuous effort and needs to move forward, hand in hand with the overall reform. Ukraine has established important and purposefully organized institutions in the NHSU. The Department of Health Technologies Assessment and the Committee for Selection of Medicines have traditionally been responsible for registration of medicines and the national essential medicines list respectively. These organizations hold important functions, which need substantial development also beyond

pharmaceuticals. Large efforts and financial resources must be invested in institutional capacity for the next wave of reform implementation. The new purchasing arrangements for secondary and tertiary care in 2020 is an important opportunity to reform hospital services, by selecting contracted services in line with the priorities stated in Law 2168.

Ukraine's health system needs more health care information to monitor the reform and develop strategic purchasing, to know if the population receives the intended benefit entitlements, and if the system improves in rationing its scarce resources. A solid structure and well thought-through processes cannot navigate in darkness. Based on the experience from just about all other countries, the e-health system will take longer to function well than is anticipated by the plan. This means the NHSU must plan for short- and midterm evaluations, which include strategic aspects of the reform. This can be outsourced to external partners to avoid shifting NHSU's strong focus on moving forward. The WHO *Evaluation of the Affordable Medicines Programme in Ukraine*⁶⁰ is an example of such evaluation, but some need to be more data driven.

Examples of PHC evaluations that are needed in the short run to assess the PMG, and can also be conducted without a sophisticated nationwide e-health system, are:

- development of referrals to specialist and hospital care, to understand if the scope of PHC services is broadening and gate-keeping is effective;
- measurement of traditional indicators of hospitalization for ambulatory care sensitive conditions, to understand if PHC effectiveness is improving; and
- analysis of enrolment from a socioeconomic or burden of illness perspective, to understand who benefits from the PHC system.

Health care information from PHC should be developed before performance-based elements are introduced as complement to the capitation payments. Performance-based payments are in the strategic purchasing plans, which is a possible way to further develop the payment mechanism. In the mission, the Lithuanian experience and practice were mentioned. Indeed, Lithuania has a balanced mix of incentives for PHC targeting both activities and outcomes. It has also had an elaborated process of selecting indicators, involving medical professions, policy-makers and international expertise, but implementing similar incentives is data demanding and would be very difficult to do in Ukraine in the near future. In addition, while outcome-based incentives have many advantages over activity-based incentives, the latter are difficult to introduce in a meaningful way when linked to individual doctors, which is the basis for the Ukraine capitation system.

The government prioritized a fast implementation of effective, frequently used, low-cost pharmaceuticals, which was an effective way to pick low-hanging fruit. For further, and continuous, development, priorities will be increasingly difficult. Developed health technologies assessment, with substantive use of evidence from other countries to keep the work load down, is essential. The essential medicines committee also need to develop its protocols for listing of new drugs, and communicate how decisions to add or remove new molecules are made. In addition, efforts to increase rational prescribing, responsible use and increased use of generics must continue.

⁶⁰ Evaluation of the Affordable Medicines Programme in Ukraine. Copenhagen: WHO Regional Office for Europe; 2019 (<http://www.euro.who.int/en/publications/abstracts/evaluation-of-the-affordable-medicines-programme-in-ukraine-2019>, accessed 27 August 2019).

Broadening the service package in PHC is a necessity to build a more efficient health system. Ministry of Health Order No. 504 on PHC provision (Table 1.1) has a comprehensive list of PHC service domains, but clinical reality must follow suit. Expanding the breath of services beyond what PHC clinics are currently doing needs to take various forms, of which some are dependent on physicians' knowledge and skills, other on patient expectations, yet other on the availability of technical equipment. An important tool is centres of excellence, which can be expanded with trainers of trainers and peer-to-peer education. Another concrete and, so far, underused tool is clinical protocols as a means to expand and direct service content. The adopted Finnish Medical Society *Duodecim* material can be a useful base, but a lot of work remains in the NHSU to contextualize the information and support clinics in implementation. In the longer run, increased residency training in family medicine should be considered, as two years is relatively short compared to most European countries.

In addition to the priority conditions in hospital services, more tools are needed to ration publicly funded hospital services. These can broadly be described in two groups.

1. First is **removing tariffs for public reimbursement of hospital services.** To achieve this, principles for which hospital services should not be contracted must be developed. This is a complex task involving a range of possible criteria, of which some are information and resource intense. However, the criteria can be developed relatively fast, and with their help services can be excluded in a 2–3 years perspective with relatively few negative consequences, for example: develop/review thresholds for medical evidence; implement tight requirements of medical indications for treatment; exclude low-cost, low frequency (for the individual patient) procedures (e.g. simpler elective surgeries); exclude procedures for which day cases can be provided, and others.
2. Second is **developing effective volume caps for treatment of non-life-threatening conditions.** This is a common rationing mechanism, which can lead to either waiting times or privately funded service provision. Most often these volume caps are created implicitly. Sometimes they are created explicitly from a pure budget perspective and consequences are not anticipated, but with careful selection and monitoring, negative consequences can be limited. The timeframe is an important tool; for example, volume ceilings can be set per month or per year, depending on type of service and need.

For any of these approaches, it is useful to keep maternal and child health as services and population groups with high priority, and instead view the priority work as an opportunity to strengthening these groups. It is also important that these policies are seen as complementary to a hospital structure reform targeting the excessive but low-quality hospital bed capacity.



7. SUMMARY OF KEY POLICY MESSAGES AND POLICY CONSIDERATIONS

Based on the analysis presented in the previous chapters, the joint review team of WHO and the World Bank have identified the following 11 summary policy messages regarding the implementation of the health financing strategy 2016–2019, future challenges and opportunities.

Message #1

The overall design of Ukraine's health financing reforms is in line with international good practices to improve access, quality and efficiency of health services.

WHO and the World Bank support the basic model introduced in Ukraine. The essence of this model is a single purchasing agency, the National Health System of Ukraine (NHSU), acting as a state insurer for an explicit benefit package, funded from general tax financing, making service contracts with public and private providers. To maximize value (health, financial protection, access, quality) for available resources, the NHSU uses a range of strategic purchasing, contracting and incentive mechanisms to influence provider behaviour. This is a complete break from the past of passive historical line item budgets focusing on inputs, such as building and staffing, and represents a new focus on people's needs and services. This new approach is expected to trigger reconfiguration of the service delivery network and service offering. As with any reform, it is normal to encounter challenges during implementation, and such challenges should not be mistaken for design flaws.

Policy consideration: Provide political support for continued implementation of the fundamental shift to the single payer system with strategic purchasing as per the Law on "Government Financial Guarantees of Health Care Services" (Law 2168) to demonstrate tangible benefits to the population in coming years. Emergent challenges are normal for such large-scale and comprehensive system transformation and need to be adjusted during implementation without compromising the basic design architecture of the reform.

Message
#2

Health financing reforms are well-aligned with Ukraine's overall development objectives and if implemented consistently should also yield dividends in terms of improved economic outcomes and ensuring fiscal discipline.

General government revenue financing under current reforms is good from an economic perspective considering Ukraine's overarching development goals of job creation and formalization of economic activity. In addition, such a financing system avoids fragmentation and ensures sustainability. Ukraine avoided the pitfalls of payroll tax-based financing, which increases labour costs and, thus, provides disincentives to formal employment. The separation of purchaser–provider functions, the establishment of the NHSU as a single purchaser, close-ended prioritized benefits and payment systems provide opportunities to enhance efficiency and accountability to maximize the impact of public funds. Due to the explicit definition of what is covered by the state, this design also allows for the development of voluntary health insurance and the growth of private sector participation in service delivery.

Policy consideration: Continue with the current model of revenue generation and pooling, with general tax-financed revenue base for the health sector pooled in the NHSU, the single purchaser of health services in the benefit package from both public and private providers to maximize the impact of public funds. This approach is well aligned with the existing economic and labour market conditions in Ukraine.

Message

#3

Implementation of health financing reforms has successfully moved forward and its continuation can begin to yield tangible benefits for the population in the coming years.

Getting health system reform off the ground and overcoming inertia has been a monumental challenge in many countries including in Ukraine. There are many examples of well sequenced and successfully implemented policies including high-level approval of the health financing concept, Law 2168 passed by parliament, the establishment, staffing and capacity development of the NHSU, conversion of primary health care (PHC) providers into autonomous entities, introduction of strategic purchasing and new incentives for PHC providers, development of the Affordable Medicines Programme and contracting of pharmacies, development of new payment mechanisms for hospitals, beginning the conversion of hospitals into autonomous state enterprises and gearing up for hospital contracting. This progress reflects significant investment and work over the past three years. Now that the reforms have begun to move forward, slowing down or changing course would reverse investments made in the past three years and would require substantial additional time before reform impact may materialize.

Policy consideration: Continue implementation to demonstrate tangible benefits to the population in terms of improved coverage and services. In particular, passing the 2020 budget law by parliament with the list of state-guaranteed health services, including secondary and tertiary health care services will enable uninterrupted continuation of the reforms.



Message

#4

One key reason for successful implementation of reforms to date has been a strong political commitment and good interagency relationships between the Cabinet of Ministers, Ministry of Health, NHSU and Ministry of Finance.

The Ministry of Health has played and will play a critical role in formulation of health financing policy, and it is essential to continue to develop capacities in the Ministry of Health in this area for policy coherence. In addition, contractual mechanisms alone have proven insufficient in most countries to change service delivery configuration and service quality. Thus, core Ministry of Health functions in the area of service delivery stewardship, regulation, provider performance monitoring and establishing a range of quality improvement processes will be essential. Similarly, the role of the Ministry of Finance has been exemplary in providing support to the health financing reforms, engaging in a productive dialogue about priority setting and pushing for continued efficiency gains. Joint leadership from the Ministry of Health, NHSU and Ministry of Finance is critical to attain high performance, and it is important to continue to develop and deploy health and finance expertise across the institutions.

Policy consideration: *Political commitment and good interagency relationship is the basic foundation of the future health system, and the close early working relationship between the agencies is a strength to preserve and further invest in. The government should continue to develop capacities and mechanisms to foster a shared understanding of priority objectives, approaches and solutions. This requires simultaneous investment into capacity and institution building for the Ministry of Health and the NHSU and joint approach to large-scale system issues such as reconfiguration of service delivery infrastructure, provider performance monitoring and introduction of quality improvement mechanisms. Similarly, it is important to strengthen the emerging priority-setting approach in the annual budget negotiation process by investing in capacities at the Ministry of Health, the NHSU and Ministry of Finance.*

Message
#5

The NHSU is now a critical change agent in the system, and continued institutional and capacity development will be necessary in order to enable it to play a key role in furthering Ukraine's health system transformation.

Law 2168 provides for relatively clear functions with Ministry of Health policy development, and the NHSU as executing agent. The NHSU has an appropriate organizational structure and began developing its core functions in strategic purchasing; a next generation challenge is the establishment of regional branches to build closer relationships with local governments, providers and patients. Basic provisions of external accountability in the health financing law are appropriate. The NHSU published its first annual report, and key indicators of performance are available online. This service and output orientation is a strength to be built upon. Further accountability instruments need to be put in place through operationalizing the envisioned Public Control Council once the NHSU purchasing role for the benefits package (i.e. the medical guarantees programme) is implemented in a coordinated manner with the Cabinet of Ministers oversight. Parallel to external accountability, another next generation challenge is to develop a system of internal controls at all levels of the system.

Policy consideration: Continue to invest in institution and capacity building for the NHSU through capacity building in strategic purchasing and contracting of health care providers, further development of its organizational structure with regional branches, continue implementing the envisioned external accountability instruments and develop a system of internal controls (e.g. integrity violations and quality control).

Message

#6

Ukraine's overall macro-fiscal environment remains challenging. As a result, efficiency gains will be key to demonstrate results from the reforms. Hospital restructuring is critical to the overall health reform and for the efficiency agenda in particular.

Tight fiscal space will characterize the coming years of reforms. To demonstrate tangible reform impact to the population, public funds need to be better used, and achieving efficiency gains is critical. The most significant source of efficiency gains is in restructuring the hospital sector. Ukraine cannot afford to maintain hospitals with low utilization rates and low performance. It is both safer and more efficient to concentrate resources in fewer but better hospitals and to strengthen PHC. Implementing hospital restructuring requires significant political consensus, support and implementation stamina. A range of instruments are required for this beyond changes in contracting and incentives: master planning, licensing instruments, explicit allocation of capital expenditures and local change management support. It is important for this to be an inclusive process from the design to the implementation phase led by the Ministry of Health with the participation of local governments, medical professionals and community representatives. In addition, it will be important to realize efficiency gains from other sources beyond hospital restructuring: e.g., from rational use of medicines, by reducing avoidable hospitalizations and ensuring that the right interventions (low cost, high impact) are done in the right way (without waste) in the right settings (at the most appropriate system level).

Policy consideration: Begin to implement policies triggering efficiency gains with particular attention to hospital restructuring. The Ministry of Finance and Ministry of Health should ensure that a range of efficiency enhancing policies are explicitly presented and deliberated during the annual budget process and government support is provided to their implementation. The Cabinet of Ministers and regional administrations' overarching support to the hospital reform will be essential to accomplish the required changes.

Message
#7

Ensuring overall stability of the health budget envelope will be key for continued implementation of health system reforms to safeguard resources from efficiency gains and translate them into better quality coverage and services.

As systemic reforms begin to generate savings, it is important that these are reinvested into the health sector through better services – for example greater availability of medicines, diagnostics, laboratories and service conditions. Visible improvement in services will help to build support for subsequent rounds of structural reforms and political support among the population. The precondition to achieve this virtuous cycle is a stable and non-declining budget envelope. If the budget envelope declines while efficiency enhancing structural reforms take place, these savings will de facto be taken outside the health sector. As a result, the same coverage levels, financial burden and service standards will continue as of today with diminished enthusiasm for further reforms and disillusioned population.

Policy consideration: *Relatively high inflation rates will erode the purchasing power of outlays. The Ministry of Finance should ensure that per capita expenditures in real terms are maintained to enable predictability of financing and facilitate realizing improvements in efficiency. Any achieved efficiency gains should be reinvested within the health sector to support priority activities. Additional budgetary allocations for health should be correlated with economic growth and fiscal conditions.*

Message

#8

Financing and prioritization for public health (health promotion and disease prevention) and PHC need to be protected within the budget envelope so that hospital reforms do not take the focus away from financing of frontline services.

Tight fiscal space will require more careful setting of priorities within the health sector budget reflecting policy priorities. Spending on PHC has increased substantially reflecting efforts to strengthen frontline services. Integration of hospital services should be phased in a manner commensurate with budget resources such that it does not jeopardize these priorities. The process of drafting and dialoguing around the annual budget law will provide an opportunity for explicit priority setting within the fiscal envelope. As required by Law 2168, a health benefit package (health services, medicines and medical goods) needs to be defined and included in the budget from 2020. The government has already defined priority conditions and services, including pregnancy and delivery services; noncommunicable diseases (asthma, chronic obstructive pulmonary disease, ischaemic heart disease, type 2 diabetes, and cancer); and communicable diseases (vaccine-preventable diseases; HIV, tuberculosis, and hepatitis B and C). This is based on detailed criteria (health need, cost-effectiveness and efficacy of services, protection from catastrophic expenditures, equity of access and population preferences). This package needs to be approved as part of the 2020 budget law and annually going forward, and will play an important role in improving the effectiveness of health care at affordable fiscal cost.

Policy consideration: Approve the 2020 budget law with the list of medical guarantees, including secondary and tertiary health care services. Ensure that the benefits package corresponds to the established criteria of health need, cost-effectiveness and efficacy of services, protection from catastrophic expenditures, equity of access and population preferences. A transparent process should be institutionalized for the definition and revision of the benefits package, supplemented with adequate monitoring and evaluation. Protect the share of public health and PHC in the health sector budget over the coming years, and explicitly set these as monitoring indicators to be assessed during the annual budget negotiation process and also during analysing budget execution.

Message
#9

Local governments have an important role to play as facility owners and financing agents, but further policy dialogue is needed on how to align decentralized roles and national health policy priorities.

The current Budget Code expands taxing power of local governments. Without close monitoring and timely corrective measures, current fiscal decentralization policies may inadvertently lead to less equitable (e.g. forcing electricity cuts, dilapidation in infrastructure in poorer regions) and less efficient health spending (e.g. purchasing extra equipment to facilities which may not be of priority) across the country. A range of instruments are available to ensure coherence with national plans and policies including formal regional dialogue platforms around health priorities, local master planning and service planning exercises, agreeing on non-overlapping roles in health financing and incentivizing local government action in health. In all cases, a transition plan should be put in place to gradually strengthen regions with low fiscal capacity and low spending on health from their own revenues without alienating richer areas, which are spending their own revenues on health, including for providing services beyond the medical guarantees programme and financing incentive programmes to health workers.

Policy consideration: Engage in policy dialogue on how to achieve policy coherence between national health policy priorities and local government action as owners and financiers. This will involve a dialogue over the desired end model of non-overlapping roles in health financing between the Ministry of Health, the NHSU and local governments as well as joint priority setting and planning exercises.



Message
#10

Strategic purchasing, contracting, and new financial incentives are well designed, and implementation is going well; however, to achieve changes in clinical practices on the ground a wider range of instruments beyond financing, such as institutionalized mechanisms to expand benefits and improve quality, are needed.

Purchasing PHC services was the first step in implementing a strategic purchasing function in Ukraine through the newly established NHSU. For the first time, residents are legally given the right to choose a PHC physician; PHC public and private providers are given equal opportunities to participate in the medical guarantees programme; public financing of PHC is prioritized; and the principle “money follows the patient” is implemented. In less than a year, 27 million or 65% of Ukrainians made a choice and signed declarations with primary care physicians. The NHSU developed transparent rules for PHC provider contracting and financing and contracted 1276 organizations to provide a guaranteed package of PHC services. Similarly, the NHSU is gearing up to introduce contractual mechanisms with providers of outpatient specialist services and hospitals based on a combination of global budgets and close-ended volume incentives. To demonstrate change in clinical practice on the ground, a wider range of instruments are needed beyond financing including definition of the vision of the model of care, quality improvement mechanisms, provider performance monitoring and benchmarking. Information systems and digital solutions will provide opportunities to achieve these, and implementation of the e-health system should proceed rapidly. This is a huge next generation challenge requiring close collaboration between the Ministry of Health and NHSU with involvement of providers and local governments.

Policy consideration: Continue strengthening the strategic purchasing model at all levels. Invest in provider service and performance monitoring. Strengthen the NHSU capacities and establishment of electronic systems to manage claims, track provider performance, priority services, referrals, detect gaming and fraud, manage unintended consequences of the capitation payment system and monitor the quality of care. At provider level, invest in health management information system capacities (medical records), clinical management and training. In the Ministry of Health, improve regulatory basis, governance and implementation of quality monitoring and assurance systems (licensing, accreditation, clinical guidelines, clinical audit, continuing education, etc.). Develop a vision for future service delivery model of care and transition path.

Message

#11

For sustainability, it is important to build distributed ownership for the reforms among key stakeholders including local governments, providers and the population.

The first stage of the reforms required political leadership and implementation effort at national level. The next stages of the reform, including hospital restructuring and improvement of quality of care, will require an increasingly participatory approach and joint effort of stakeholders at all levels. For the success of the reform, this requires expanding communication efforts to different audiences so that providers and the population are better informed and demand continued change.

Policy consideration: Stewardship of the reform will need to be inclusive. The reform implementers should seek agents of change at the levels of facility owners and their managers, clinical professionals and their associations, and invest in citizen engagement efforts.



The WHO Regional Office for Europe

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