Economics Education and Research Consortium

Working Paper Series

ISSN 1561-2422

No 07/07

The evaluation of health care system in Ukraine in the context of structural and quality-enhancing reforms

Oleksandra Betliy

Oksana Kuziakiv

Kateryna Onishchenko

This project (No. 04-009) was supported by the Economics Education and Research Consortium with funds provided by the Eurasia Foundation (with funding from the US Agency for International Development), the World Bank Institution, the Global Development Network and the Government of Sweden

Research area: **Public Economics**

JEL Classification: I18, H51, P36, H75, D78

BETLIY O.V., KUZIAKIV O.V., ONISHCHENKO K.V. The evaluation of health care system in Ukraine in the context of structural and quality-enhancing reforms. — Moscow: EERC, 2007.

The health care sector in Ukraine remains unreformed, keeping the substantial overcapacities inherited from the Soviet Union. The project describes the evidence on the health situation in Ukraine and reveals the weaknesses of the current health care system. Several methodological tools are used: data analysis, institutional study, quality approach and international experience study. The research shows that insufficient government financing promoted segregation of population by the level of income, place of residence, and, thus, contradicts to the constitutional guarantee of free health care provision to all. The revealed drawbacks of the system include insufficient financing, improper funds allocation, lack of incentives, low managerial autonomy and absence of competition between providers. The absence of motivation for health personnel leads to poor performance. As a result, the current health care system delivers poor results and lacks equity. The findings of the project are used for elaborating policy recommendation for equity and quality enhancing health care reforms.

Keywords. Ukraine, Public Health, Health care reform, Corruption, Emerging Economy.

Acknowledgements. Authors would like to express their gratitude to Eric Livny and Jim Leitzel for the guidance and useful comments along the work of the research. Also authors are thankful to Oleh Vynogradov for his help in receiving data and to Ivan Poltavets and Denis Poltavets for their help in organizing in-depth interviews. Authors are grateful to the GDN for providing financial support enabling the study.

Oleksandra Betliy
Institute for Economic Research and Policy Consulting
Leader of the Fiscal and Social Policy Group
8/5-A Reytarska Str., Kyiv 01034, Ukraine
Tel.: +38044 278 63 42
Fax: +38044 278 63 36
E-mail: betliy@ier.kiev.ua

Oksana Kuziakiv
Institute for Economic Research and Policy Consulting
Executive Director, Head of the Center for Contemporary Society Studies
8/5-A Reytarska Str., Kyiv 01034, Ukraine
Tel.: +38044 278 63 42
Fax: +38044 278 63 36
E-mail: kuziakiv@ier.kiev.ua

Kateryna Onishchenko
Cardiff Business School
PhD Student
Aberconway Building, Colum Drive, Cardiff, CF10 3EU, United Kingdom
Tel.: +44(0)29 2087 6013
Fax: +44 (0)29 2087 4419
E-mail: onishchenkok@cardiff.ac.uk

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GLOSSARY

AIDS — Acquired Immune Deficiency Syndrome

BYT — Block of Yulia Tymoshenko

CIS — Commonwealth of Independent States

EERC — Economics Education and Research Consortium

EU — European Union

GDP — Gross Domestic Product

GE — Government Expenditure

HCE — health care expenditures

HCP — health care providers

HIV — Human Immunodeficiency Virus

NGO — Non-Governmental Organization

PHI — private health insurance

OECD — Organization of Economic Cooperation and Development

TE — Total Expenditure

UAH — Ukrainian hryvnia

USD — United States Dollars

WDR — World Development Report

WHO — World Health Organization

NON-TECHNICAL SUMMARY

Health situation in Ukraine is not encouraging. According to the estimation of the World Health Organization healthy life expectancy at birth in Ukraine remains low comparing to other European countries. The real problem is faced by Ukraine in the form of tuberculosis epidemics. The poor health of Ukrainians might be attributed to several factors, among which are deficiencies of health care system. Basically, the Ukrainian health care sector was rather intact since the collapse of the Soviet Union, while neighboring countries were conducting various health care reforms. While according to the Constitution the health care is declared to be free of charge, the private payments both formal and informal are common in Ukraine. Insufficient government financing created the situation that promoted segregation of population by the level of income, place of residence, and, thus, contradicts to the constitutional guarantee of free health care provision to all. As a result, the current health care system is delivers poor results and lacks equity. Taking into account social and economic transition of the last decade, Ukrainian health care sector needs reforms and implementation of new type of relations both on the national and local levels.

Recent years have been marked by heated discussions related to the introduction of the compulsory state health insurance. However, numerous draft laws failed to be approved by the Parliament. The weakest point of those draft laws was treating this type of insurance as a mechanism of pouring more money into the current system. At the same time, as our Institutional analysis indicate, there are many structural deficiencies in the system, including improper funds allocation, lack of incentives, low managerial autonomy and absence of competition between providers. Therefore, in conformity with evidence from other countries it is imperative to correct these deficiencies along with the introduction of a more efficient funding allocation mechanism.

Our research has indicated that performance and quality should be the major subjects for health care reforms in Ukraine. While elaborating policy recommendations the restrictions on reforms should be taken into account. The major restriction in Ukraine is an existence of equilibrium in the sector, which is created and supported by informal payments.

The reforms should ensure better finance allocation, improved incentives, more efficient management, introduction of market elements, definition of role of key stakeholders, including government, health care providers (HCP), and patients. The policies should be aimed at creating regulated market of health care provision, which is characterized by competition and will meet the needs of the population. After deficiencies of the health care system are corrected and efficiency increased the government can consider the possibility to introduce compulsory health insurance, which will be provided by both public and private health insurance companies.

1. INTRODUCTION

Health is one of the major values of the people's life. For the country it is important as stimulates human capital accumulation and development. In Ukraine the health care system produces rather poor outcomes contributing to low life expectancy, high rates of sickness and tuberculoses epidemic. One of the causes of such situation is improper structure of health sector and inadequate and insufficient financing. The worsening of people health and demographic situation create a pressure for systematic changes in the health sector.

Ukraine inherited rather complex structure of the health sector from the Soviet Union, which was intact during years of Ukrainian independence, while neighboring countries were conducting health reforms. The health care is declared to be free of charge, but private payments both formal and informal are common in Ukraine. Such situation has endorsed segregation of population by the income level, place of residence, contradicting to the universal constitutional guarantee of free health care provision. At the same time, the possibility of making informal payments creates equilibrium in the system, though the outcome is not an efficient one.

Taking into account social and economic transition of last decade, Ukrainian health sector needs reforms. While it is widely accepted that budget financing is insufficient, not all politicians pay attention to the necessity to correct failures and structural problems of the system. The content of reforms remains unclear at the moment.

The objective of our research is to provide health-care decision makers with high-quality evidence to enable them to make informed choices about the measures they should undertake in order to improve equity and quality of health care sector in Ukraine. For this, we describe the health sector, revealing its weaknesses and failures. In order to obtain clear vision on how the sector operates we use focus groups and interviews. Besides, we study international experience on health care policies concentrating on competition enhancement and motivation of health personnel. The tools we use help us to reveal failures and deficiencies of the health care system in Ukraine. Even partial correction of the revealed failures will increase the equity of the health care sector. Following Whitehead (2000), we would like to stress that the aim of policy for equity and health is not to eliminate all health differences so that everyone has the same health level and quality, but rather to reduce or eliminate those that result from factors that are considered to be both avoidable and unfair.[1] Findings of our research are used for elaboration of policy recommendations aimed at improving quality and equity of the health care system.

The report is structured as follows. First, we describe health situation in Ukraine and provide description of methodological tools used in the research. In the next section, we analyze data and

[1] The equity in health care might be defined as equal access to available care for equal need, equal utilization for equal need, equal quality of care for all.

Ukrainian legislation and indicate the major characteristics and drawbacks of current health care system. Using the results of the qualitative part of the research we describe the real working of health care system. In the next chapter we present the political agenda of Ukraine and point of view of policy-makers on health reforms. In the last sections we summarize the major findings and provide policy recommendations.

2. OBJECTIVE OF THE STUDY AND METHODOLOGY USED

2.1. Health situation in Ukraine

Health situation in Ukraine is not encouraging. According to the estimation of the World Health Organization healthy life expectancy at birth in Ukraine remains rather low comparing to the members of the European Union at 62 years for man, and 73 for woman (see Appendix A1). Life expectancy at birth varies between regions of Ukraine (66.27 years in Odessa region and 71.35 in Kyiv City).

The poor health of Ukrainians might be attributed to several factors, including poverty, ecological environment, and deficiencies of health care system. Mass poverty (around 30% of households) contributed to the spread of the HIV/AIDS. The real problem is faced by Ukraine in the form of tuberculosis epidemics. Over the last decade the number of people with this illness substantially increased from 41.8 persons per 100 thous. of population in 1995 to 84.4 persons in 2005. One of the explanations of such trend might be a lack of efficient preventive health care measures.

The main causes of death are diseases of the circulatory system followed by injury, and respiratory diseases. The tobacco and alcohol consumption is rather high in Ukraine, also contributing to low life expectancy. Maternal mortality, though falling, remains about five times the EU average. Besides, Ukrainians have health problems due to Chornobyl nuclear accident. For instance, cancer incidence is more than three times higher than EU average.

While data reveals that health situation in Ukraine is not encouraging, the access to the health care services is poor. In 2005 around 13% of households reported that they were not able to receive necessary health care services, when needed.[2] From these households around 77% claimed that the reason for that were high costs of needed consultation of a doctor, 95% could not buy necessary medical devices, as they also were too expensive. Besides, there are significant regional differences in the access to the health care services. In order to improve the situation the government should conduct policies aimed at enhancing quality and equity of the health care system.

2.2. Objective

The objective of our research is to provide health-care decision makers with high-quality evidence to enable them to make informed choices about the measures they should undertake in order to improve equity and quality of health care sector in Ukraine.

[2] The State Statistical Office of Ukraine (2005).

2.3. Methodological tools

In order to reach the objective of our research we use several methodological tools (for data sources see Table 1). First, we start our research from *analyzing available data* on health situation in Ukraine. Such analysis shows weak outcomes of the health care system in Ukraine as well as points out at some failures of the system. Then the *institutional analysis* intends to reveal weaknesses of the health care system and provides us with the basis for policy recommendation on improving the structure of the health care system. For this we study Ukrainian legislation, rules of the game, *etc*.

Table 1. Data sources used in the research

Methodological tools:	Data sources
Analyzing available data	the The State Statistical Office of Ukraine the Ministry of Health the WHO
Institutional analysis	the Constitution of Ukraine the laws, resolution, orders of Ukrainian authorities
Study international experience	the papers on health economics reports of international organizations
Qualitative analysis	4 focus groups (3 with patients (age groups: 19–22, 25–35, 36–55) and 1 with doctors); in-depth interviews (10 with heads of health care establishments and 10 with patients); 45 standardized interviews with health personnel; 9 standardized interviews with representatives of political elite.

We also *study international experience* on the health care policy. The experience of other countries may be valuable for correcting deficiencies of the Ukrainian health care system.

However, studying data and legislation cannot serve for elaborating compelling case for reforms as they miss some important points of cooperation of individuals with health personnel and the real extent of some problems. Therefore, we also conduct *qualitative analysis* that comprises of case studies and focus groups discussions and provides us with illustration of inefficiencies existing in the health care system and insights into the mechanisms of relationships and activity within the sector, what gives us more solid basis for elaborating policy recommendations.

Qualitative research has become an invaluable research tool for the rapid collection of information by means of respondents' attitudes towards different issues of social reality and policy studies (Luntz, 1994). This tool was used in order to obtain information on rules of the game worked out by key stakeholders as well as reveal their perception of current problems.

The following qualitative methods have been applied: focus groups, in depth one-to-one interviews, standardized interviews with open-end questions (see Appendix A2). They have targeted three main

groups of audience: providers of health care (health personnel); consumers of heath care (patients); policy-makers (members of Parliament, representatives of executive bodies).

3. HEALTH CARE SECTOR IN UKRAINE: INDICATORS, REGULATIONS AND ACTUAL PICTURE

3.1. Current regulation of health care provision in Ukraine

The Constitution of Ukraine states health care as being free of charge and being ensured through state funding of the relevant socio-economic, medical and sanitary, health improvement and prophylactic programs. At the current level of health care expenditure, the government fails in providing adequate level of the health care, what makes 'free' health care be just a declared provision. According to the respective decision of the Constitutional Court, people cannot be forced to pay for health care provision and, thus, user charges were recognized as non-constitutional. Therefore, in case of introduction of the compulsory health insurance, the burden of contribution payments will be put on shoulders of employers. This might increase the share of shadow wage payments, as payroll taxes in Ukraine are already excessively high amounting to 38.16%–53.1% of the wage bill. At the same time, the Constitutional Court stipulated that health establishments could charge for some services, which 'go beyond the limit of health care'. The latter ruling has created hot debates in Ukraine directed at the definition of what should be the limit.

Besides, the Constitution contains a provision, according to which the number of state and municipal health care establishments cannot be reduced. This restricts the possibility of the government to use commercialization mechanisms in order to improve the situation in the health care system. Therefore, private sector is developing through creation of new private health establishments.

The only Law that provides basis for health policy was approved in 1992 and is named 'Principles of Legislation on Health Care in Ukraine'. It stipulates that national policy is defined by the Parliament and involves establishing policy goals, setting standards, allocating budgets and creating national health care programs. However, not all provisions of the law are fulfilled in real life. For instance, according to the law the national policy is complemented by regional policies reflecting specific health care needs of their population. However, in real life the standards are determined by the Ministry of Health, and usually do not really allow for taking into account the difference in health situation in different regions. The national and regional administrations own and finance the health care. The health care system is to be financed at the expense of central and local budgets. According to amendments to the Law made in 1998 health establishments can receive charitable donations for improving quality of services provided. While the Law foresees the possibility of developing health insurance, it does not foresee respective source of revenues of health establishments. It is also stated that each individual has a right to choose a doctor, while in practice a person should apply to the resident doctor or hospital in order to be served free of charge. Therefore, though the Law stipulates sound principles for regulating health care sector, its provisions are not always fulfilled in real life.

The Law also foresees the possibility of provision medicine subsidies. The respective legislation was developed. It defines certain groups of population that have a right to purchase medicine on prescription at discounted or zero prices in case of outpatient treatment. Groups of population eligible for receiving medicine at zero prices include:

1. war veterans, *etc*.;
2. people having recognized outstanding merits for the fatherland;
3. persons affected by the Chernobyl catastrophe;
4. certain pensioners receiving low pensions;
5. children up to 3 years old;
6. disabled children up to 16 years old.

Groups eligible for receiving medicine at prices discounted by 50% include disabled people of group 1 and 2 (who are disabled due to occupational or general sickness) and disabled from birth people, *etc*.

As in a situation with many other privileges and subsidies in Ukraine, medicine subsidies are provided not to poor people but to different categories of persons. Due to such principle, upper income households receive subsidized medicine more often than poor households, what is supported by the data from Household budget survey, conducted by the The State Statistical Office of Ukraine.

According to the Ukrainian legislation, the Ministry of Health is responsible for 1) setting standards of health care provisions; 2) defining rules for accreditation of public and private health establishments; 3) licensing health professionals and pharmaceutical producers and distributors; 4) determining the list of pharmaceuticals, which are allowed for being purchased by public health establishments. However, by now the clear standards of quality health services were not approved yet, what makes impossible to monitor the efficiency of work of health establishments.

In 2000 the President approved the "Concept of Health care development in Ukraine", which foresees the necessity to take into account the population needs while setting standards in the health care sector. In 2002 the first National Health Strategy was approved in the government program "Health of the Nation" for the period of 2002–2011. The program was developed according to the European WHO policy. However, by now no real reforms were accomplished.

3.2. Current situation of health care provision in Ukraine

In contradiction to experience of developed countries, in Ukraine the major part of care is provided not at a primary level, but on the most expensive level of health care provision — inpatient and specialized. Therefore, public-owned hospitals continue to be major health care providers (HCP). The structure of health care services provided in Ukraine does not correspond to the WHO standards (Fig. 1). Some illustration of such inverted pyramid is provided in the Appendix A1.[3] In comparison

[3] The Minister of Health communicated this message during the Collegium's meeting, held on the 26th of April, 2005.

to the EU countries, the number of hospitals per 100000 of population as well as number of in-patient care admissions is relatively higher in Ukraine. However, their amounts vary significantly across regions indicating imbalances in access to the health care services. At the same time, the ratio of primary health care units and number of general practitioners in Ukraine is lower than European average. In Ukraine people often refer to general practitioners only with the aim to receive sickness leave documents to be provided to employer. Thus, the role of the primary care is rather restricted and preventive care is not treated as an essential part of the health care system.

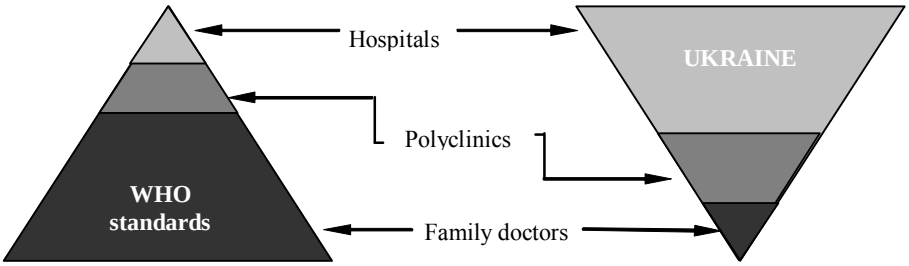

Fig. 1. Structure of health care provision

The number of hospitals, beds and staff personnel is defined by the Order of the Ministry of Finance, depending on the size of population in the region. The funds are allocated mostly to support the existing health care facilities, but not to finance needs for health care in the region. We should note that during years of independence, the number of hospitals, hospital beds and health personnel was decreasing. But, it was rather done by administrative closures due to lack of financing resources, and, thus, was not always at the benefit for the public. Such policy contributed to the imbalances in the access to the health care services in different regions, in particular, in rural areas.

Regardless centralized regulation of health care sector in Ukraine, there are regional disparities in the indicators. In particular, the number of physicians and middle health personnel varies between the regions (see Fig. 2) indicating the different level of access to the health care services in different regions.

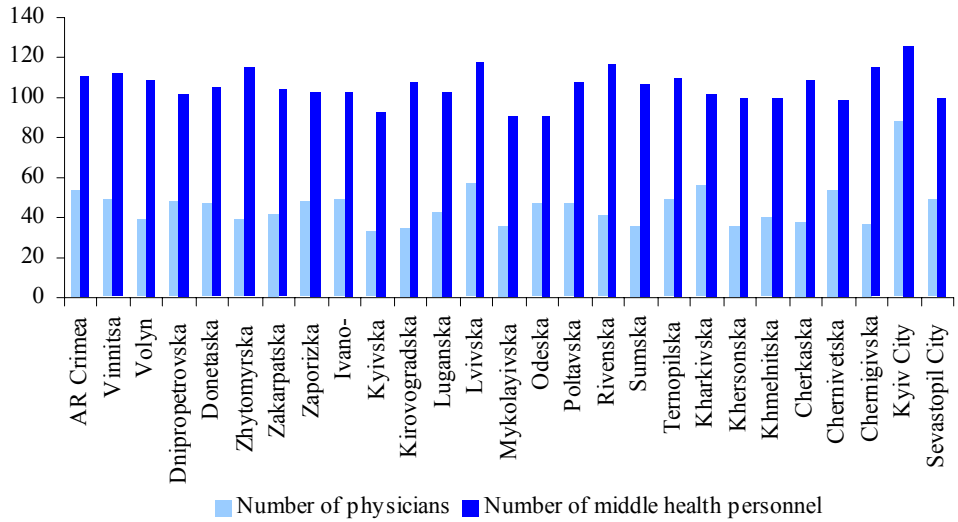

Fig. 2. Number of physicians and middle health personnel per 10 thous. persons by regions in 2005.
Source: The State Statistical Office of Ukraine

Sources of financing

The most health care institutions are publicly owned, and financed from central and local fiscal expenditures (68% of total financing). While over the years public health care spending increased in nominal and real terms (Table 2), per capita spending remains rather low by international comparison (see Appendix A3).

Table 2. Real annual health care expenditures (HCE) and their share in GDP in 2002–2006, Index 2002 = 100

	CB HCE			SB HCE		LB HCE	
	Total HCE-Index	% GDP	Per capita HCE-Index	Total HCE-Index	% GDP	Total HCE-Index	% GDP
2002	100	3.34	100	100	0.7	100	2.64
2003	121	3.63	122	140	0.88	116	2.75
2004	133	3.41	135	188	1.01	118	2.4
2005	149	3.15	152	154	0.77	126	2.38
2006*	160	3.71	165	168	0.82	162	2.96

Note: CB — Consolidated fiscal expenditures, SB — Central fiscal expenditures, LB — Local fiscal expenditures, HCE — health care expenditures.

* —estimate.

Source: State Treasure Reports for 2000–2005, The State Statistical Office of Ukraine, own calculations.

Due to low spending many hospitals are not well equipped, and most are poorly supplied with diagnostic materials, drugs. As a result, patients are increasingly forced to pay privately in order to circumvent inadequacy in and unresponsiveness of the health system. The private spending account for around 32% of total health spending, half of which is attributed to purchase of pharmaceuticals, while the rest are informal payments.

Health Care Spending

Spending by economic categories: Significant increases in health care spending were mostly attributed to the administrative wage increases, which resulted in increased share of wages in the health care expenditures. In 2005 more than 60% of public health care funds were devoted to wage payments (see Table 3). According to the information of the Verkhovna Rada in 2006 share of wages reached almost 70–75% of total health care spending, while most countries devote a bit over 42% of total general government health expenditures to paying its health workforce and a bit over 50% of total health expenditures.[4] In Ukraine the wage level in the sector remains one of the lowest in economy and wages are usually not connected to the quality, quantity and type of services provided. Low wages coupled with poor control contribute to prevalence of informal payments in the sector.

[4] World Health Report for 2006.

Table 3. Structure of the consolidated health care spending according to economic budget classification in 2000–2005

	Wages (with payroll)		Utilities payment		Purchase of goods, materials, services		Capital expenditures		Other	
	UAH bn	% CB HCE	UAH bn	% CB HCE	UAH bn	% CB HCE	UAH bn	% CB HCE	UAH bn	% CB HCE
2000	2.48	50.76	0.56	11.40	1.32	26.96	0.33	6.81	0.20	4.06
2001	3.26	50.45	0.59	9.16	1.76	27.25	0.49	7.59	0.36	5.55
2002	4.10	54.45	0.65	8.67	2.07	27.52	0.56	7.46	0.14	1.89
2003	5.10	52.57	0.80	8.20	2.67	27.47	0.91	9.42	0.23	2.34
2004	6.42	52.81	0.83	6.83	3.04	24.97	1.62	13.3	0.25	2.09
2005	9.33	60.28	0.92	5.97	3.51	22.65	1.32	8.51	0.40	2.59

Source: State Treasure Reports for 2000–2003, Ministry of Finance Budget Reports.

Administratively increased wages result in lack of funds for capital spending, which does not allow health establishment to modernize their equipment and implement new types of diagnosis. In 2005, less than 30% of the health care budget was spent for purchases of goods, materials and services; and roughly 6% constituted the utilities bill. Capital expenditures constituted in 2005 around 8.5% of total health care expenditures. However, from this amount only 60% was used as investment into equipment and purchase of durable goods (see Appendix A4). Due to rather low investment, replacement of old infrastructure and equipment is very slow. According to the WHO the replacement ratio of most health facilities is about 2% (Lekhan, 2004).

To sum up, the public spending is directed towards financing the existing status quo in health care, investments remain low, and restructuring of the sector is hampered.

Spending by functional categories: As it was argued above, the most health care providers in Ukraine are hospitals rather than policlinics. On average 80% of spending is attributed to financing inpatient care. The preventive care remains underdeveloped. The level of health care financing as well as its structure varies between regions (see Fig. 3). Basically, data reveals that high-income regions provide the residents with better-financed health care services, what again mirrors the different access to health care services among regions.

Lack of managerial autonomy, incentives and absence of competition

The existing system relies on health care planning and regulation by central and local authorities. The managers of health care establishments lack incentives and abilities to increase efficiency and responsiveness to patients needs. The principle of purchase of medicine on the central level creates a situation when HCPs lack necessary medicine, while having a stock of needless medicine.

At present, health care providers (HCPs) administer broad budgets, where funds are allocated not according to provided services, but to the existing facilities. In such a system patients are seen as a cost factor and an item of spending, where each additional patient and treatment cuts into the budget. HCPs have few incentives to become more productive as this has no impact on the budget (Handrich, 2005).

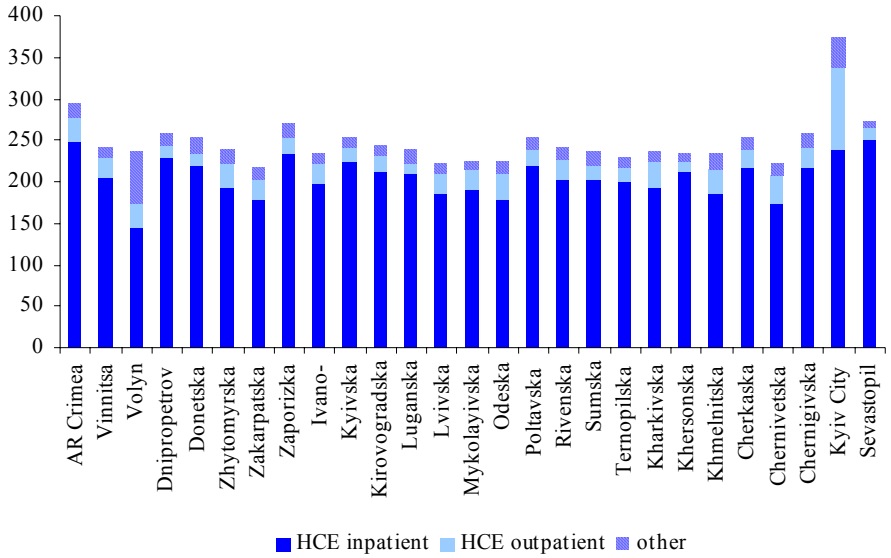

Fig. 3. Health care *per capita* expenditures in 2005, UAH.
Source: The State Statistical Office of Ukraine

Besides, there are difficulties with receiving extrabudgetary funds by HCPs due to their status of budget entities and some legislative loopholes. The HCPs are restricted in receiving private payments for the treatments, as according to the Constitution they should provide all services free of charge. Besides, the legislation does not foresee the possibility for them to receive money from insurance companies. But still the heads of the HCPs find their way to work with insurance companies. Often, the heads of HCP stand behind the decision on creation charitable funds and health cash desks, what make it possible for the health care establishment to receive extra-budgetary funds.

Patient's choice and competition between health care providers (HCPs) are almost absent in the sector due to the administrative 'catchment' principle directing patients for receiving "free" medical services at the public clinic/ hospital at their official place of residence.

Where private and public HCP could compete for privately paid medical services the rules differ. For example, private HCP are prohibited by regulation to issue sick-leave documents. Many restrictions prevent the market entry of private HCP, like the prohibition to open private maternity hospital and mental hospital. Besides, even though by the Law the private health care establishments have a right to use narcotics while treating patient, the respective government resolution restricts this right: private establishments can use only anesthetics, but not narcotics. Therefore, the private HCP cannot make surgery with anesthetization with a use of narcotics, which is often needed. Besides, private emergency cannot make an injection of narcotic in case a person has myocardial infarction — the private emergency then has to call public one and ask them to make an injection. Very important issue is a *de-facto* restriction of the right of private health care provider to participate in local tenders for health care services.

The lack of competition and management autonomy creates weak incentives for public HCP to deliver high quality medical services and work more productively.

3.3. Regulation and development of the private health insurance in Ukraine

The existence of private health insurance (PHI) in Ukraine is foreseen in the Law 'On Insurance' (approved in 1996). The Law stipulates general conditions for insurance, such as insurance risks, exceptions from insurance cases, restrictions, *etc*. The detailed insurance conditions (*e.g*. insurance premiums, terms and conditions of insurance payments) are defined in an insurance contract. There is no real legal rule defining relationship between public health care system and PHI. Basically, the PHI plays a role of substitute for public financing as gives a chance to people to be treated better.

For now, there is no legal regulation of the cooperation of insurance companies and health care establishments. The insurance companies do not have a way to influence directly the quality of services provided by the HCP. Legislation lacks clear provisions that define basis and procedures for establishing fees for health care. Therefore, the price of services depends on the bargaining power of insurance company and health care establishment.

Only near 1% of population is covered by health insurance. Low incomes of Ukrainians are one of the major factors of poor development of the PHI. Another explanation is a little trust to the private insurance companies. The share of the PHI in the structure of health care expenditures remains low (around 0.5–2.0%). Most of health care establishments are not included into the PHI schemes.

The insurance premiums differ from USD 100 and USD 800 per year depending on the volumes of health care services, list of health care providers, *etc*. Insurers foresee restrictions on the provision of different services and drugs. Often the treatment of chronic illnesses is not covered by the PHI.

In Ukraine most incentives to purchase a PHI are attributed to the failures of the public health care system, *e.g*. a desire to overcome the restrictions of the 'catchment' principles, the jump over long waiting lines in public hospitals and poor health care provision. Patients that have or had private health insurance policy are rather satisfied by care they receive. During focus groups and interviews they acknowledge that insurance policy grants an opportunity to receive higher quality health care. They also mentioned time saving and, as a result, easier access to health care services. On the other hand, patients argue the PHI does not always stimulate health personnel to provide quality health care services. The explanation of such behavior was found after the discussions and interviews with health personnel. In particular, health personnel often consider treatment of patients with PHI policy as an additional task, as they either are not paid additionally for this or are paid very low benefit (see Story 1). Therefore, the PHI does not solve the problem of low working incentives for health personnel.

Story 1. Health establishment X has a contract with insurance company Y and is obliged to provide clients of insurance company Y with full complex of medical services. The client of insurance company Y approaches medical doctor A working in health establishment X and specializing in, for instance, neuropathology. The consultation was about 20 minutes. Of course insurance company Y pays something to health establishment X for providing such services. However, a particular doctor, who treated patient, does not necessarily receive additional money from his employer (health establishment X). Even in the opposite case, the amount of payment for time spent for service provision

to patient with private insurance policy is significantly lower than possible "shadow" payment from patient who pays "out of pocket". In its turn, the amount of bonus, which might be paid in this particular situation by health establishment X to doctor A, is calculated in the following way. The month salary of Doctor A is about UAH 500. The doctor per hour rate is about UAH 2.7. He treats patient about 20 min. As a result, the bonus received by doctor for providing the service is about UAH 0.9 (approximately USD 0.18).

The doctors are sometimes restricted by insurance companies to the certain list of drug and diagnostic examinations, which sometimes is not sufficient for providing quality health care. Thus, health personnel stressed that PHI policy does not always ensure patients in receiving high quality health care.

Special attention should be paid to attitude of *heads of health establishments* to private health insurance. They perceive PHI to be very useful for the health establishments, since they are aware how additional funds received from insurance companies are spent. According to them major purposes of spending money received through PHI are the following: (1) restoration / maintenance of premises (2) purchase of medical supplies, (3) improvement of equipment capacities, and (4) bonuses for health personnel. At the same time, health personnel mentioned that administrative premises, offices of department heads rather than medical premises are first subject of restoration.

To sum up, patients are satisfied with private health care insurance and are pretty sure that such insurance can ensure receiving quality health care. But, they note that insurance sometimes fails to bring attention of doctors, while informal payments reach this goal. Health personnel have suspicious and uncertain attitude to the PHI, as they perceive it as settlement of additional work, which does not provide them with sufficient remuneration. Indeed, heads of health establishments, knowing how funds from insurance are spent, evaluate cooperation with private health insurance rather highly.

3.4. Solving the problem at local level — alternative to the private health insurance

On the regional level the problem of insufficient government financing of the health care is solved through creation of so-called 'likarniani kasy', which is kind-of a sick-funds. Such organizations basically fall into the category of 'commercialization' measures, as authorities or other organizations, patients and health care providers appear in legal financial relationships.

The sick-funds are not regulated in Ukraine by specific legislation. The legislation on either charitable organizations or public unions is usually applied. Sick-funds are often created as public non-profit organizations that promote provision of quality health care and protect patient's rights. The participation in such organizations is voluntary. The number of sick-funds in Ukraine approaches 200 and according to some estimations number of participants might reach 5 m persons. According to available data 61.8% of sick-funds work as public unions, while the 31.2% work as charitable funds. The revenues of sick-funds are comprised of membership contributions of individuals or legal entities. Their activity is aimed at provision of health care, which cannot be received at the expense of government financing. On average more than 50% of revenues is spent for pharmaceuticals, and 30% is directed towards purchasing medical equipment, materials and diagnostic examinations. Around 10% of funds is spent for improving qualification of health personnel and additional

payments to them. Zhytomyr, Mykolayiv, Kharkiv and Kirovograd oblasts are the most active in forming sick-funds.

The development of the sick-funds seems to be the best in Zhytomyr oblast. Since this experience is recognized to be the most valuable, and showed that it ensures improvements in the health care provision, it is shortly presented in this chapter. 'Likarniana kasa of Zhytomyr oblast' (sick-fund — LK) was created in 2000 as non-profit, noncommercial, charitable organization by Zhytomyr oblast organization of the Red Cross, Zhytomyr oblast committee of trade union of health personnel, and Association of nurses of Zhytomyr oblast. While the sick-fund was first created only in the City, its experience was then implemented in all oblast districts according to the special decision of local authorities. The main goal of the LK is to conduct activities aimed at improvement of health care provision to members of the LK in case of their sickness through provision of medicines, diagnostic services and consultation during day inpatient treatment, and outpatient treatment in health establishments of Zhytomyr oblast; as well as promotion of developing health care sector in the region, improvement of health care provision, introduction of new forms of diagnostics and treatment. Therefore, collected funds are used for: medicines, diagnostic tests, supporting material and equipment basis of health establishment, introduction of new technologies, and charitable aid to members of the LK. As of July, 2006, around 14.14% of oblast population were members of the LK, from whom 56% working persons, 23% — children, 12% — pensioners. In the first half of 2006, 77.4% of received funds were spent on purchasing medicines and products of medical means. The rest were administrative expenditures (wages, capital expenditures, *etc*.)

There are defined two possible forms of becoming a member of the LK: collective (all employees of one enterprise become members of the LK according to the collective agreement) or individual. All citizens can be members of the LK, including children (children up to 18 years old become members if one of the parents is a member of the LK). The fees for participating in the LK can be paid either by individual or by employer. The membership fee does not depend on the income level, but is set at the flat level of 3% of minimum wage with the discounts for children and students.

The LK has signed agreements with the number of health establishments. According to agreements the LK provides health establishments with medicines, reagent and other materials as targeted charitable assistance. The LK also cooperates with family physicians. In every health care establishment, with which the LK works, there are special medical experts who make sure that treatment is done correctly and according to the standards.

The LK has clear rules of treatment including coverage and restrictions. The treatment, which is financed at the expense of the LK, includes only therapy of the main disease and its complications during 12 days. The continuation of treatment at the expense of the LK over 12 days (but not more than 24 days) is possible only in case of in-patient treatment after the respective decision of the consultation between specialized doctors.

The positive features of the activity of the LK include the rules of coverage and restrictions, which are hotly debated by policy makers. Besides, the membership fee is set at the flat level. Therefore, experience of the Zytomyr LK can be really valuable while developing policies for reforming health

care system in Ukraine, especially taking into account that government tries to keep government financing and introduce another pillar of financing in the form of insurance.

3.5. The actual working of the health care system

The important question for any transitional social system is how the institutions work in reality. In order to respond to this question during, during the focus groups and interviews we have discussed such issues as: (1) main problems of health care system from patients (2) financial principles of hospital works (3) professional ethic and work incentives for heath care personnel towards work.

Main problems of health care system

The perception of main problems of health care system by patients and doctors is different. The patients stressed on the following problems:

1. Impossibility to receive quality state guaranteed health care without 'informal payment';
2. No guarantee of timely provision of quality health care even in case of 'informal payment';
3. Insufficient qualification of health personnel;
4. Careless attitude of health personnel to patients.

According to the health personnel the main problems of health care system are the following:

1. Low salary, which does not reflect the social role of health personnel in the society;
2. Poor material, technical and diagnostics basis of hospitals;
3. Low incentives for professional development;
4. Careless attitude of patients to their health.

While health personnel stated that they provide quality services, patients do worry about the quality even in case of informal payments. Both groups of stakeholders blame each other for lack of attention: while patients think that they do not receive sufficient attention from doctors, doctors believe that patients should be more responsible for their health. According to doctors' opinion, absence of care-seeking behavior of patients is one of the key problems today. Both patients and health personnel indicated the low level of prophylactic measures. According to focus groups discussion with patients, lack of confidence in doctor and informal payments are key reasons of unwillingness of people to go for prophylactic measures. People often visit a doctor only when having tremendous health problems.

The interesting fact is that health personnel claims that low incentives for professional development of doctors, in particular promotion incentives, is a problem of health care sector. Often, wages of highly qualified doctors do not really differ from the wages of not qualified health personnel.

Heads of health care establishments about financing problems

The qualitative analysis has indicated that heads of health care establishments apply two basic approaches while dealing with insufficient financing: the structural changes and the fund raising. The

structural measures include: (1) decrease in the number of permanent health personnel (especially it concerns nurses), (2) temporary forced leave of permanent heath personnel, (3) energy saving, (4) reduction of numbers of beds (after receiving permits from responsible authorities). Often, heads of health care establishment look for additional funds and refer to: (1) provision of paid services (often through opened charitable funds or hospital cash desks, where patients have to pay contributions), (2) contracts with insurance company, (3) leasing free premises. Sometimes, patients have a possibility to pay officially for being served faster, being in a nice room in the hospital, *etc*. The allocation of extra funds is defined by heads of health care establishments and typically includes maintenance of premises, purchase of medical supplies, improvement of equipment capacities, and bonuses for health personnel.

Professional ethics of Ukrainian health personnel

The professional ethics of Ukrainian health personnel is rather complex issue. On the one hand, patients-respondents claimed that often when they go to a different doctor they hear a question: 'what a stupid doctor has treated you?' On the other hand, there exists the principle of 'mutual responsibility' in the sector, what makes it impossible for the patient to execute their rights on proper treatment.

Another problem is a moral dilemma of accepting shadow payments by health personnel. During focus groups of health personnel the respondents sounded like accepting the behavior of shadow payments as well as perceiving it as appropriate. At the same time, all responding health workers claimed that their attention is the same regardless the fact whether patient pays anything or not, which was not supported by answers of patients, who claimed that the attitude is really different. However, responding health workers defined the group of 'some' who treats differently patients due to the fact of payment or not.

Work incentives of health personnel

While analyzing work incentives for health personnel, we segregated five work incentives for health personnel (see Table 4), which correspond to the list of incentives, derived by other researchers (Benett, 1999). The qualitative part of analysis has indicated that only two out of five defined incentives are present in Ukraine, in particular, desire to be socially beneficial and possibility to receive "shadow" income. However, the latter incentive was evaluated by patients as being against of human moral norms. Therefore, in Ukraine work incentives for health personnel are rather weak, what does not allow for improving quality of health care provided, and increasing productivity.

3.6. Informal payments: pillar of the system

In Ukraine, the health care sector is characterized by prevalence of informal payments, which reduce the access to the health care, especially for poor households.[5] These payments contribute to

[5] Under informal payment we understand the direct payment of patient to health personnel for health care services the person is entitled to for free.

delays in care-seeking behavior of patients. The qualitative analysis indicated that possibility to receive 'informal payments' is one of the work incentives of health personnel and at the same time one of the reason of patients' frustration. Our findings indicate that the problem of informal payments in this sector is institutional one. The system of informal payments creates the paradox. On the one hand, the system of informal payments is unable to equalize access to the health care, as poor are still restricted from quality health care. On other hand, this is almost the only mechanism that makes the system work. In Ukraine, the informal payments bring equilibrium outcome, though not an efficient one.

Table 4. List of work incentives of health personnel

	List of Incentives	How respondents and focus group participants perceive the particular incentive?	Is this a work incentive in Ukrainian conditions?	Is this incentive positively evaluated according to human moral norms?
1.	Desire to be socially beneficial	More or less satisfactory	Yes	Yes
2.	Level of official salary	Low	No	Yes
3.	Possibility to receive "shadow" income	High	Yes	No
4.	Differentiation of official salary of medical doctors according to level of their qualification	Absent *de facto*	No	Yes
5.	Differentiation of official income of doctors according to treatment provided to patients	Absent *de facto*	No	Yes

The results of focus groups and interviews revealed that quality health care could be received as an exception ("*if a person is lucky*"). Usually, in order to receive quality health care a person should *informally pay* to doctor. The situation is similar both for being treated in hospitals and policlinics. Moreover, patients receiving treatment in public health establishment should not only pay informally for doctor's consultation, but also pay for drugs, bandages, and other consumables.

Many respondents claimed that approaching the *recommended* doctors is the best way to receive quality health care. Therefore, often people try to look for doctor they are acquainted with or recommended to. In this case, a person again takes a decision to pay for the health care informally.

While analyzing results of focus groups and interviews we find *three main reasons* why patients prefer to make "*informal payments*". First, patients pay *before* treatment in order to ensure receiving a good and careful treatment. Second, they pay *before* treatment in order to receive health care services of sufficient quality. Third, they pay *after* treatment if they are satisfied with the quality of provided health care services. Therefore, while the first two reasons play a role of insurance policy,

the latter one is made in the form of gratitude. On the point of view of patients, the informal payments are more efficient way to insure them from bad treatment, than purchasing policy from insurance company.

Very important issue is a *de-facto* restriction of the right of private health care provider to participate in local tenders for health care services.

According to health care specialists, informal payments from patients are mainly made due to two reasons. In particular, patients pay *before* the treatment in order to ensure sufficient conditions for providing health care and *after* the treatment when they are satisfied with health care services provided. During the interviews, the health personnel explained that under sufficient conditions for providing health care they mean better room, better medicine, *etc*.

While reasoning of '*after*' payments is similar by content both for patients and health personnel, meaning gratitude, the reasoning of the '*before*' payments differ. Patients are rather unanimous in arguing that they would not receive quality treatment unless they informally pay for that. Indeed, the health personnel stated that they treat equally patients who pay or does not pay for their treatment. Basically, they referred to Hippocratic oath and assured us that each doctor treats patient carefully and nicely without any relation to fact of "informal payments". But, patients informed about abundance of examples when person does not receive any health care without informal payment. None of our respondents or participants of focus groups discussion evaluated the necessity of "out of pocket" payment as completely negative phenomenon. Of course, in general it is perceived to be rather negative, but respondents said that they are ready to pay and consider this as an accepted behavior.[6] Patients usually claim that the major reason of informal payments is low wages of health personnel. Indeed, health personnel argued that even in case of increase of their wages it is impossible to guarantee that practice of taking informal payments from patients would disappear immediately. According to them it became a "habit" from side of patient and even rather part of such social ritual as a "visit to doctor".

Story 2. A woman of 55 years old was transported to the hospital with simple fracture of leg. Doctor inspected her and her leg was put into plaster. Next several days she does not fell any attention from side of health personnel. And only after informal payment to the head of department, doctor provided her with needed treatment.

Story 3. Woman of 50 years old was transported to the hospital with hypertensic crisis. During 3 hours nobody came to her. And only after her relatives provided with money the doctor who was on duty, the woman was examined by.

During focus groups health personnel claimed that there are no poor doctors, meaning that they can earn enough money in the form of informal payments, if they are qualified and smart enough. At the same time they claim that there are higher chances to earn more in hospitals. The answers on share of incomes received from informal payments differed. While talking about themselves they claimed

[6] Norm is defined following Durkheim (1995). It is social fact that widely distributed with society.

that the share of informal payments did not exceed 10%, but for the group of 'some' this share reached 70–80% of total income.

It seems that there is no scheme of distributing informal payments. The health personnel usually keeps what was received. There were identified cases, when the doctor (often dentists) are paying rent to health care establishment for their room and equipment and then freely takes whatever was earned.

To sum up, *informal payments became a usual social norm* of Ukrainian society at least in mentality of Ukrainians. This is a mechanism that produces some kind of equilibrium in the health care system. Though this equilibrium s not an efficient one, informal payments become one of the challenge of health care reforms in Ukraine.

4. HEALTH CARE IN POLITICAL AGENDA AND RECENT POLICY DEVELOPMENTS

In this section we present the agenda of health care policies in Ukraine. The section starts with the findings of interviews with policy makers and analysis of the programs of several parties made. Then we proceed to the description of recent policies in health care sector.

4.1. Policy makers about health care system of Ukraine

The results of interviews with policy makers indicate that there is no unified perception of problems and clear vision of reforms in health care sector among policy makers. The common points of view might be summarized as follows:

1. The article of the Constitution on free health care provision is not likely to be changed.
2. The term of 'free health care' should be clearly defined. Basically, all policy makers agreed that there should be a certain level of guaranteed by state health care.
3. In case of introduction of compulsory health insurance, the contribution should be a part of unified social tax, which is still to be introduced. If health insurance contribution causes the increase in overall payroll tax, the share of shadow wages will increase.
4. There is a necessity for public control over the health care system in Ukraine, meaning that accountability of health sector should be increased.

4.2. Political parties about health care reform

In March 2006 Ukraine had Parliamentary elections. According to the results, the following parties got to the parliament: party "Regions of Ukraine", Block of Yulia Tymoshenko (BYT), "Public Union 'Nasha Ukraina", Socialist party of Ukraine (SPU) and Communist party of Ukraine (CPU).[7]

[7] The research team participated in the project on drafting Suggestions to Coalition agreement for the future Parliament coalition (see Appendix A6).

The analysis of the programs of these parties shows that the health care reform becomes high in the agenda. However, except for "Nasha Ukraina", other parties failed to present sound suggestions on their view of reforms in this sector.

The common position of the parties is a combination of current tax financed system with compulsory health insurance. The difference between the positions concerns the fact whether it would be private or state insurance system, and who and how will be contributing to this system. While dealing with the issue of sources of financing (taxes vs. insurance contributions), the parties do not devote attention to the correction of structural failures of the system. However, as experience of other countries suggests the increase in financing does not correct failures of health system in the long run. Basically, the "Nasha Ukraina" and the BYT only indicate that such structural changes as introduction of institute of family doctors, changes of financing principles as well as higher attention to primary health care, are required. But they lack a clear vision on approaches of incorporating these elements into the system.

The Parliament Coalition (formed in late June 2006) rather generally formulated its strategy on health care reforms. The Coalition agreement foresees the health care reform through prioritized development of primary health care, diagnosis of different illnesses and introduction of compulsory professional examinations.

To sum up, though political forces have declared health care reform being high in their political agenda, they have not yet developed clear measures to be taken for every announced reforming step.

4.3. Policy developments

Ukrainian legislation lacks the comprehensive concept of health care reforms, which would stipulate what type of health system is to be built in the country after reforms. The views on health reforms by different policy-makers are fragmented and concentrate mainly on the issue of increasing financing.

During recent years, the government has not proceeded far on the way of health care reform, though several program documents were developed and discussed in the public. The major issues discussed were provision of primary care by family doctors and introduction of compulsory state health insurance (approximately in 2009). The switch to contracting basis of purchasing health care services is foreseen in the programs. But, there is a lack of developed approaches on the implementation of these steps.

The Coalition Government proclaimed the comprehensive reforms in the sector, starting with the introduction of compulsory health insurance. The insurance is to be financed at the expense of contributions attached to wages. This is envisaged in the draft laws, developed by two Ministries simultaneously — the Ministry of Health and the Ministry of Labor and Social Policy. The procedure of drafting two draft laws within the government indicates once again, that there is no single view on even one aspect of the health reform — health insurance. The draft laws are rather different in fore-

seeing the contribution rates payments, administration of the health insurance, *etc*. The draft laws do not envisage any other reforms needed in the sector.

Simultaneously, the people deputies drafted and registered a draft law on the introduction of health insurance. According to the draft, the health insurance is to be provided only by state health insurance company, which will create monopolization of the health insurance market. The contributions are to be set be set as at a flat rate, which might be considered as a positive step.

To sum up, the Government as well as the Parliament concentrates mainly on the necessity to increase health care financing. Much less attention is devoted to the implementation of reforms aimed at improving efficiency and quality in the sector.

5. INTERNATIONAL EXPERIENCE

The transformation from the central planning towards the market-based relationships in the health care sector implies the risks of reopening the market imperfections. Some transition countries introduced the market forces to overcome the failures of the health care system mainly related to the over excessive government regulation. The reforms in these countries are mainly aimed at the redefining the role of the government and switching to the market mechanisms, while regulating the relationships in the health care sector. The governments implement steps towards more efficient reallocation of resources through market mechanisms, reinforcement of the institutional capacity through the decentralization of the management responsibilities. Many transition countries involved the managed competition for improvement of the efficiency and targeting subsidies for prevention the market failures. The privatization of health establishments was often used for improving efficiency of health care provision.

In this chapter we devote attention to international experience on regulating or reforming selected issues of health care system, in particular, management independence and commercialization, working incentives for health personnel, and financing principles.

5.1. Financing principles

There are different principles of financing health care (see Table 5). Beveridge type of health care is mostly or only financed at the expense of public funds. The social insurance is predominant in Bismarck type. For Beveridge and Bismarck systems the performance or fee-for-services financing principle are typical. In Semashko type, financing is allocated to fund the existing health sector infrastructure. The voluntary private insurance is developed in all countries, providing better access to health care services to population. In many OECD countries PHI rarely exceeds 12% of total health care expenditures reflecting the nature of PHI as of additional element to the public health care system. While reforming health care system, many countries tried to change the financing principle. Some countries, in particular Poland and Czech Republic, have tried to change this through introduction of health insurance. However, they found it complicated to succeed on the way of such reform.

Table 5. Payment system in OECD and Ukraine

	Predominant type of Health care system	Share of population covered by PHI (%)	Share of PHI in total health expenditures (%)	PHI in % GDP
France	Bismarck	86	12.8	1.20
USA	Private insurance	70.3	34.8	4.59
Canada	Beveridge	70	11.2	1.03
Australia	Beveridge	44	7.1	0.65
Germany	Bismarck	10	12.5	1.34
Ukraine	Semashko	1	0.25	0.01

Source: Docteur (2003), Colombo (2003), the Ministry of Health Care of Ukraine.

Both national financing and insurance can bring good performing results as well as have some drawbacks. The more important are the principles of health sector financing, as they should motivate good performance and efficiency of health sector (see Table 6).

Table 6. Provider payment system and incentive effect

Payment type	Definition	Incentive effect				
		Incentive to increase activity	Incentive to decrease activity	Incentive to shift patient' cost to others	Incentive to target to poor	Controls cost of doctor employment
Fee-for-services	Payment for each medical act	Yes	No	No	Maybe	No
Salary	Payment per unit of time input (*e.g.* per moth)	No	Yes	Yes	No	Yes
Capitation	Payment per patient for care within a given period (*e.g.* a year)	No	Yes	Yes	No	Yes

Source: Maynard (2006), p.148.

According to Dubois (2006), the challenge of reforms in former Soviet Union countries is that they contain paradox of aiming to reward performance and empower management and health personnel, while at the same time implementing downsizing and redundancy.

The Estonian reform is a nice example how the system can be changed. In particular, it reduced overcapacity of hospitals through their closure and merges, rationalized services, corporatized hospitals, and introduced fee-for-service principle of financing. Due to the latter, HCPs restructured

production process, changed input mix and reorganized services (Figueras, 2005). The results of the reforms were not as encouraging as expected as the government was reluctant to close hospitals.

5.2. Managerial independence and commercialization

International reform experience in countries with tax financed public health care systems demonstrates that the introduction of market-type relationships and elements of competition into public (local) "monopolies" like hospitals could lead to significant improvements of services supplied with higher qualities at more affordable costs (Jakab, 2002). In combination with incentive regulation the public owned health care sector could increase its efficiency and service quality, and introduce better responsiveness to the patients. As international experience suggests, for achieving this goal the government may commercialize and liberalize the management of hospitals. One option would be to contract out the management of hospitals to independent profit oriented management companies or trusts, while the hospitals would remain in public ownership. Policy-makers usually choose from a wide range of options for such private sector participation (also known as public-private partnerships PPP) from short-term service and management contracts (1–5 years), medium term lease contracts (10–15 years).[8] The terms and conditions of such PPPs need to be specified for each case. In cases where the management company or trust is not fulfilling its contract obligations or is going bankrupt the hospital remaining in public ownership would be given to another operator. Almost all European countries use today mixed (owned), but socially responsible health care delivery systems.

One step further would be the outright privatization of hospital. In particular, in Sweden, in 1998 all hospitals (except for emergencies) were put on the market, while the universal health care system financed from public funds was maintained.[9] Nevertheless, the government introduced the guarantees for some important operations. As a result, introduced reforms increased the productivity and efficiency of the health care system in Sweden. The privatization of health establishments was also applied in Czech Republic, where about 95% of primary health care as well as nearly entire network of outpatient services and pharmacy services was privatized. In certain cases, communities became the owners and operators of small hospitals, while doctors, pharmacists, and other operators are often the owners of outpatient services and pharmacies. Small hospitals were often privatized as commercial companies, but were further financed from statutory health insurance.

The government also should create incentives for equitable care provision. One of the elements of incentives could become a case-based payment. This principle is aimed at ensuring all people to be

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[8] A brief overview of various options and models for public hospitals is provided in Public Policy for the Private Sector: Public Hospitals: Options for Reform trough Public-Private Partnerships. World Bank Group, private sector and Infrastructure Network, Note Number 241, January 2002.
http://rru.worldbank.org/Documents/PublicPolicyJournal/241Taylo-010802.pdf

[9] Hjertqvist, Johan, Turning to the private sector in health care: The Swedish example, Montreal Economic Institute, Economic Note October 2003.
http://www.opas.org.br/servico/Arquivos/Destaque963.pdf

treated in the public hospital regardless who manages it. Therefore, the floor and ceiling estimates and even a description of case mix can be provided for every particular hospital taking into account a demographic and health situation in the region.

5.3. Independent regulator and purchasing health care services

As experience of other countries reveal, success of reforms also depends on the independence and credibility of the public regulator. In this way the conflict interest potentially arising from the fact that the public sector is shareholder and regulator at the same time is avoided.

The health care performance can be improved by changing the models of purchasing in health sector. All models, either national health services or social health insurance, have some common elements for purchasing: 'linking of health needs, plans and priorities to the allocation of resources or decentralizing provider management and introducing competition between providers' (Figueras, 2005). While developing purchasing principles, the broad approach should contain rules for contracting, payment principles, competition between providers, *etc*. Before defining a contract conditions, the government clearly identifies the needs for health care services, the cost-efficiency of different treatment, ways of purchasing health care services, and list of health care providers.

5.4. Motivation of health personnel

The evidence and theory reveal that motivation of health personnel is important for high performance of health care sector. The independence of management of HCPs is essential for motivation of health personnel. The empirical evidence suggests that linking performance to promotion leads to improved productivity and better motivation (Benett, 1999). Therefore, while defininf the remuneration of health personnel the services they provide and their qualification should be taken into account. Some studies indicate that rather job satisfaction, training, responsibility, promotion and recognition than a pay level are primary motivation for better work of health personnel.[10] The feedback of patients plays an important role in emphasizing the performance of health workers. Often, the Hippocratic oath is considered to be a type of motivation. On the contrary, poor management, lack of materials and equipment serve as demotivation factors.

6. CURRENT REFORM AGENDA

6.1. Summary

The major features of Ukrainian health sector could be summarized as follows:

- the health care reform is only declared, but nothing specific has been done;
- the principle of financing existing HCPs rather than services provided;

[10] See for details Dubois (2006), Benett (1999), Dieleman (2006), Manongi (2006), *etc*.

- provision of health care services rather on the hospital than on primary level;
- the coverage of priority services through private sector is restricted;
- there is an inequity of health care generation and allocation patterns;
- the motivation of health personnel is rather absent and managerial autonomy is restricted.

The performance and quality should be the major subjects for health care reforms in Ukraine. While elaborating policy recommendations the restrictions on reforms should be taken into account. The major restriction in Ukraine is an existence of equilibrium in the sector, which is created and supported by informal payments. So, some stakeholders benefit from the status quo and might oppose reforms.

6.2. Reform measures for improving health care system: point of view of main stakeholders

The reforms in any countries can hardly be successful, if they are not supported by the stakeholders they are aimed for. One of the aims of the qualitative part of the research was also to clarify the expectations of patients and health personnel concerning health reforms in Ukraine. The findings of focus groups and interviews indicated that people expect implementation of following reforms:

- The salaries of health personnel should be increased to the sufficient level, which corresponds to their social role. Besides, the differentiation of salaries should be ensured.
- Health personnel should be provided with conditions, which enable them to provide quality health care. So, equipment and diagnostic capacities of health providers should be improved.
- The system of incentives for professional growth of health personnel should be introduced. This includes possibility of trainings and carrier growth.
- The role of the preventive and prophylactic measures as well as awareness among population concerning the responsibility for their health should be increased.

6.3. Policy recommendations

The biggest challenge of any health care reform is represented by the absence of the first best solution for reform that would suit all countries. The reforms and the system, which is built as a result, largely depend on the historical developments, mentality of population as well as values of policy makers in the country. This should be taken into account while elaborating policies and drafting a comprehensive concept of health care reforms. In this chapter we present our point of view on the way of reforms in Ukraine. We believe that reforms in Ukraine should be conducted in *two major stages*:

1. Undertake reforms aimed at correcting deficiencies and improving efficiency of the health sector;

2. Turn to the issue of introduction of compulsory health insurance.

Stage 1: While conducting the first stage reform measures, one of the most important goals that should be reached is the reduction of informal payments. For this the government should put efforts

in order to renew the trust of people in public health care, raise salaries of health personnel, ensure good quality of health care and improve accountability and transparency of HCP.

As the government does not have sufficient funds to provide all health care services free of charge, the list of state guaranteed health care should be brought in line with the available funds in the health care sector. While defining the list of guaranteed health care the experience of the Zhytomyr LK might be considered. Such approach is more suitable for Ukraine taking into account the current situation. First, the widespread poverty makes private financing affordable only for few. Second, the introduction of the compulsory health insurance is not also a option for Ukraine due to the demographic situation (ageing and shrinking contribution base) and already high payroll tax. If the health contribution is added, the wage payments will be push further into the shadow. Besides, introduction of compulsory health insurance in a present structure of the system will only increase spending, which are wasted. Therefore, in the meantime Ukraine should keep tax financed health care system with defined guaranteed list of health care services covered.

Budget allocation should be switched to the fee-for-services basis. This means that local government entities should contract the health care establishments and pay them for actually provided services and not for assigned number of potential patients and infrastructure the health care establishment has. The international experience indicates that such a financing scheme creates incentives for the health establishment to restructure and work more efficiently. Simultaneously, the HSP should be granted a status of economic entities, which would enable them to operate own budgets as well as receive extra-budgetary funds. Of course, we admit that after such reform, which should be accompanied with the cancellation of 'catchment' principle while providing state guaranteed health care free of charge, there will be a shift of patients' flows from one health care establishments to others. Therefore, some transition period for switching the financing principle should be introduced. However, in the middle run some health care establishments will be necessitated to restructure (*e.g.* reduce the number of beds, lease the unneeded rooms), limit the number of services provided, if they have not succeeded to attract enough patients through providing quality treatments. At the same time, the system of state subsidies of health care establishments in rural areas might take place.

The introduction of fee-for-service financing scheme should be accompanies by the effective control on services actually provided. Otherwise, Ukraine might face the situation of high prices, provision of unnecessary services, *etc*. For making financing principles more transparent and clear the Ministry of Health should approve clear performance standards and valid quality indicators, including measures for health outcomes. The methodology of price setting for health services should be defined. The Ministry of Health together with the Ministry of Finance should be responsible for developing principles of expenditure control on the level of both local authorities and level of health care establishments. The introduction of standards, price setting mechanisms and performance goals will enable the government to conduct sufficient monitoring the quality of heath care.

While regulating prices the government might choose from a variety of options. The price should respond to the cost of health care provision by the most efficient provider (a benchmarking princi-

ple). In Ukraine, where most of health care is provided by public sector, the government can also use the budget caps, which are set taking into account both levels of output as well as efficiency of hospitals. However, the government should be careful since restraining prices for a long time could limit the ability of HCP to attract qualified personnel. In order to avoid the switching of HCP to provision of the most expensive health care services, the government might use the case-mixed financing. Later, in order to restrict households' consumption and demand of health care, the government can introduce co-financing schemes, which has proven to reach the aim they are introduced for. Such co-payments will help to solve the moral hazard problem that exists otherwise.

At the same time, the government should shape its policy on the application of market principles in the provision of health services. This should involve greater commercialization and freedom of contractual relationships. In particular, the management principles should be changed. The management of the HCP should become autonomous in taking the decisions on employment, funds management, *etc*. The possibility of contracting the management, as it is done in many countries, should be also available. The heads of the health care establishments should be managers rather than doctors by the education. In such a situation they will be able to restructure the facilities and introduce incentives for work of health personnel. In particular, the remuneration of health personnel should depend on the treatments conducted as well as their qualification. Besides, the management of the HCP should introduce clear rules for promotion and training, as these are important elements of incentive scheme.

While improving the performance of health care system, the government should ensure the competition between public providers as well as between public and private insurance companies. For this, equal rules of the game should apply for both public and private companies. The local self-governments should have a possibility to contract not only public, but also private companies for providing health care. Consequently, the system of recording, accessing and transferring health data should be created.

As not all health care is to be tax financed, the PHI will become important as would play a complementary role to the publicly financed health care system. So, the PHI should be clearly defined in its relation to the state guaranteed health care services. The regulation on the private health insurance should enable health personnel to provide quality health care. Besides, it might help in formalizing high informal payments as well as money spent for purchasing medicines. At the same time, the government should target existing medicine subsidies to the most vulnerable groups of population rather than to different categories of people.

The policies also should aim at promoting health of the population. For this the role of preventive and prophylactic care should be increased. This will allow reducing expensive spending for specialized health care.[11] Childhood immunization should be enhanced. The policies should concern not only prophylactic measurers, but also alcohol and tobacco use, nutrition, *etc*. In order to decrease

[11] The evidence proves that increase in the hepatitis incidents occurred in Ukraine in the end of 90s and beginning of new century is explained by the lack of childhood immunization in the end of 80s and beginning of 90s.

alcohol and tobacco consumption the government might use experience of the OECD countries, in particular, conduct public awareness campaign, introduce advertising bans and increase respective taxes.[12]

Stage 2: Only after the aforementioned reforms are implemented, deficiencies of the health care system are corrected, and efficiency increased the government can start working on the issue of introducing compulsory health insurance. However, the government is better to reject the idea of introducing compulsory *state* health insurance. Both state and private companies should be eligible for providing health insurance. This would ensure competition on the insurance market and will only be an advantage to population. The government instead should be responsible for the supervision and regulation of the health insurance market. In particular, the affordability of private insurance by high-risk people should be ensured. As the OECD experience indicates, this might be done through fiscal incentives, subsidies and targeted regulation. Besides, the consumers should have an access to information, which would facilitate his/her choice of health care coverage.

It is important to set an insurance contribution rate at a flat level. The wage-attached contribution will increase a payroll tax, what could contribute to the payment of wages in shadow, thus reducing the base for contribution payment. We believe, that local self-government should pay contributions on behalf of children and low-income people. At the same time, the level of contribution should be the same regardless the income level.

In the long run the government should also consider such a market principle as privatization of some health establishments. As the experience of Sweden indicates, the privatization could be conducted even under the tax financed health care system. As a result, the performance of HCP improves.

Current Ukrainian legislation on health policy is rather systematic and takes into account WHO standards. However, there is a significant law enforcement gap and some provisions of legislation are controversial. Therefore, the government should take steps towards improving enforcement of existing legislation as well as approve necessary legislation changes (see Appendix A6).

7. CONCLUSIONS

The health care sector in Ukraine remains unreformed, keeping the substantial overcapacities inherited from the Soviet Union. The health care is declared to be free of charge, but private payments both formal and informal are common in Ukraine. Insufficient government financing created the situation that promoted segregation of population by the level of income, place of residence, and, thus, contradicts to the constitutional guarantee of free health care provision to all. As a result, the current health care system is delivers poor results and lacks equity.

[12] See for details *Towards High-Performing Health System* (The OECD Health Project), 2004 (Brookings Institution Press).

The revealed drawbacks of the system include insufficient financing, improper funds allocation, lack of incentives, low managerial autonomy and absence of competition between providers. The absence of motivation for health personnel leads to poor performance. While the private health insurance helps people to receive health care services of better quality, it is not soundly regulated and plays rather substitutive than complementary role of the state financing system. In the situation of improper work of the health care system key stakeholders produced new rules of cooperation. For instance, patients are trying to overcome careless attitude of doctors and poor quality of health care services provided via informal payments. At the same time, the health personnel explains the need of informal payment by their low salaries as well as by poor material and diagnostic provision of health care establishments. However, new system of relations does not ensure equity and equal access for Ukrainians. Besides, rather institutionalized informal payments do not guarantee provision of quality health care services, though they create some kind of equilibrium in the system.

While both patients and health personnel anticipate the reforms, they do not have clear vision on what type of system is needed. At the same time, the policy makers, though defining health care reforms high in their agenda, failed to elaborate a concept of health care reforms in Ukraine.

Our research has indicated that performance and quality should be the major subjects for health care reforms in Ukraine. While elaborating policy recommendations the restrictions on reforms should be taken into account. The major restriction in Ukraine is an existence of equilibrium in the sector, which is created and supported by informal payments.

The reforms should ensure better finance allocation, improved incentives, more efficient management, introduction of market elements, definition of role of key stakeholders, including government, health care providers (HCP), and patients. The policies should be aimed at creating regulated market of health care provision, which is characterized by competition and will meet the needs of the population. After deficiencies of the health care system are corrected and efficiency increased the government can consider the possibility to introduce compulsory health insurance, which will be provided by both public and private health insurance companies.

APPENDICES

A1. Parameters of the health care system of Ukraine and the EU-25

Parameters of the Health care (HC) system	Ukraine		EU-25	
	2000	2004	2000	2004
Life expectancy at birth, in years	67.86	67.71	74.55	73.69
Life expectancy at birth, in years, male	62.30	62.03	70.33	69.51
Life expectancy at birth, in years, female	73.62	73.63	78.72	77.84
Tuberculosis incidence per 100000	66.90	81.24	23.07	29.16
Cancer incidence per 100000	317.93	329.73	437.88	411.78
Cancer of the cervix, per 100000		6.60		2.51
Hospitals per 100000	6.19	5.64	2.72	2.73
Hospital beds per 100000	881.57	872.85	649.61	680.43
Physicians per 100000	300.44	301.27	278.24	270.35
Physicians, surgical group of specialties (PP), per 100000	53.55	53.03	34.66	33.23
Physicians, obstetric & gynaecological group of specialties (PP), per 100000	25.22	24.24	17.44	16.86
Physicians, paediatric group of specialties (PP), per 100000	47.53	47.74	25.52	26.86
Dentists (PP) per 100000	39.57	40.76	43.19	43.27
Pharmacists (PP) per 100000		49.68	60.60	53.78
Nurses (PP) per 100000	781.03	777.47	617.59	633.47
Average length of stay, all hospitals	14.90	13.90	8.55	9.56
Total health expenditure as % of gross domestic product (GDP), WHO estimates	5.00	5.80	6.13	6.80
Public sector health expenditure as % of total health expenditure, WHO estimate	58.10	66.50	74.06	74.21
Private sector expenditure on health as % of total health expenditure, WHO estimates	41.90	33.50	25.79	25.94
Salaries as % of total public health expenditure	36.00	59.90	29.49	34.21
Private households' out-of-pocket payment on health as % of total health expenditure	30.50	26.30	22.78	24.89

Source: European health for all database, World Health Organization, Regional Office for Europe.

A2. Qualitative analysis — method's choice and technical details

Method's choice

Focus groups. Focus groups discussion was chosen as a method of studying the opinions about quality and accessibility of health care taking into account the following arguments. Fist, the literature proves that focus group research is a direct, sensitive, and interactive method of assessing pub-

lic opinion, accomplishing what pull studies cannot (Luntz, 1994). Second, according to the American Statistical Association, qualitative data received from focus groups is considered as being extremely valuable when vivid and rich descriptions are needed. The latter is especially important for answering such research question as how the health care system operates de facto.

But our decision about use of the focus groups is based not only on necessity of get rich description of health care sector in Ukraine. Following to Luntz (1994) the key to understanding why qualitative research in general and focus groups in particularly are so important today is the following: "unlike traditional quantitative research, focus groups are centrally concerned with understanding attitudes rather than measuring them". He also stresses that the focus groups' discussion approaches attitudes and priorities tangentially by allowing respondents to talk freely and to choose descriptive categories significant to them (rather than to researchers). In our research the crucial point is understanding of people' attitudes to quality and accessibility of services provided by health care system and attitudes towards reforms of the health care system in general and its financing scheme in particular.

Besides, the advantage of focus groups is a possibity to gather information about insights of experts in a particular sphere (Greenbaum, 1997). Focus groups are a good way to find out perceived norms of a certain group. In our research we use focus group of health care specialists in order to obtain information about their working incentives, their attitudes to health care system as well as their opinions regarding the introducing different co-financing schemes for health care system.

The results of focus groups in our study serve for the following purposes:

1. Description of existing health care system de facto (including: (a) working incentives of health personnel, attitudes towards the reforming of health care sector and different co-financing schemes, including attitudes to compulsory and voluntary health insurance; (b) attitude of patients to the existing health care system and approaches for overcoming the drawbacks of system).
2. Elaboration of policy recommendations.

Target audience include providers and consumers of health care (health personnel and patients).

In-depth interviews. When it is important to explore a subject in detail or probe for latent attitude and feeling, the in-depth interview is an appropriate technique to use (Kumar 1999). In contrast to focus groups, in-depth interview gives a chance to follow-up questions and probe for meaning. Also people may want to tell something openly only after intensive discussion or in face-to-face format (without influence from other people). For this reason we decided to carry out in-depth interviews with health personnel and heads of health care establishments to find out their opinions and attitudes to different aspects of health care system, including such issues as informal payment of patient.

Taking into account that in-depth interviews can also provide a history of behavior, reveal divergent experiences and develop other research tools we use this methods for collecting stories of patients about their experience of receiving health care, in particular, informal payments.

Therefore, the results of in-depth interviews in our study serve for the following:

1. Follow-up questions and probe for meaning in order to get depth description of existing health care system de facto (including different aspects of health care system, such issues as informal payments of patient to doctor, the working incentives of health personnel, attitudes of health personnel to the reforming of the health care sector, attitudes to compulsory and voluntary medical insurance).
2. Collecting "live" story of patients about Ukrainian health care system.
3. Elaboration of policy recommendations.

Target audience includes providers and consumers of health care (health personnel and patients).

Standardized interview with open-end questions. Based on in-depth interview findings the standardized questionnaire with open-end questions has been developed. The main purpose of using this research tool was to increase a confidence of the health personnel to our research that should stimulate them to answer "inconvenient" questions. First of all, these are questions concerning informal payments and scheme of redistribution of informal payments within health care establishment. Also the standardized questionnaire allows getting information from health personnel not only from Kyiv city but also from other regions.

Special attention has been paid to developing the standardized questionnaire for policy elite representatives. In the project proposal we have planned to conduct the focus groups with policy makers. The political crisis resulted by the Government resignation and the number of corruption scandals in the middle of September of 2005 as well as beginning of election campaign 2006 had negative impact on the implementation of this project activity, since during the first months of new Prime-Minister assignment many policy makers were in the uncertainty about their personal future, while people deputies and other politicians became busy with the election campaign. In such situation initiation of any group discussion with policy makers was impossible. But we were able to organize face-to-face conversations with members of the Parliament and representatives of executive bodies. Therefore, instead of focus groups discussion we conducted interviews with representatives of this group. We would like to emphasize that it is the first experience to study "alertness" of top-level policy makers on the health care reforms under Ukrainian condition. Based on the conducted interviews with policy makers (including members of Ukrainian Parliament) we intend to present their point of view on the main problems of financing health care systems, possible ways of health care reform.

Therefore, the results of in-depth interviews in our study serve for the following:

1. Get more information about "informal payments" issues.
2. Get opinions of health personnel not only from Kyiv city but also from other regions.
3. Get information about top-level policy makers' attitudes towards the main problems of financing health care systems, possible ways of the health care reform.

Target audience includes providers of health care (health personnel) and Policy decision-makers (member of Parliament, representative of executive bodies).

Technical details

Focus groups. Since the health care reform concerns different groups of the population, in our study there were we conducted 4 focus groups discussions, approaching several types of audiences (see Table 7). Patients were distributed to different focus groups relative to their age.

Table 7. Main characteristics of the focus groups

	Target audience	Number of participants	Ages	Gender	Specialization	Duration
1	Patients	9	19–22	Mixed		1h 45 min
2	Patients	11	25–35	Women		1h 56 min
3	Patients	9	36–55	Mixed		1h 43 min
4	Health care specialists (doctors)	7	30–55	Mixed	Surgery (1) Therapeutics (1) Thoracic Surgery (1) Narcology (1) Psychiatry (1) Urology (1) Otolaryngology (1)	1h 48 min

In-depth interviews. The procedure of in-depth interviews was the following: a certified sociologist interviewed a test person in detail about research topic using a discussion guide. If respondent has agreed the interview had been audio-recorded. If not, the interviewer made remarks during and after interview. Interview's time varied from 20 to 100 minutes. Numbers of interviews are:

- 10 in-depth interviews with heads of health care establishments.
- 10 in-depth interviews with consumers of health care services.

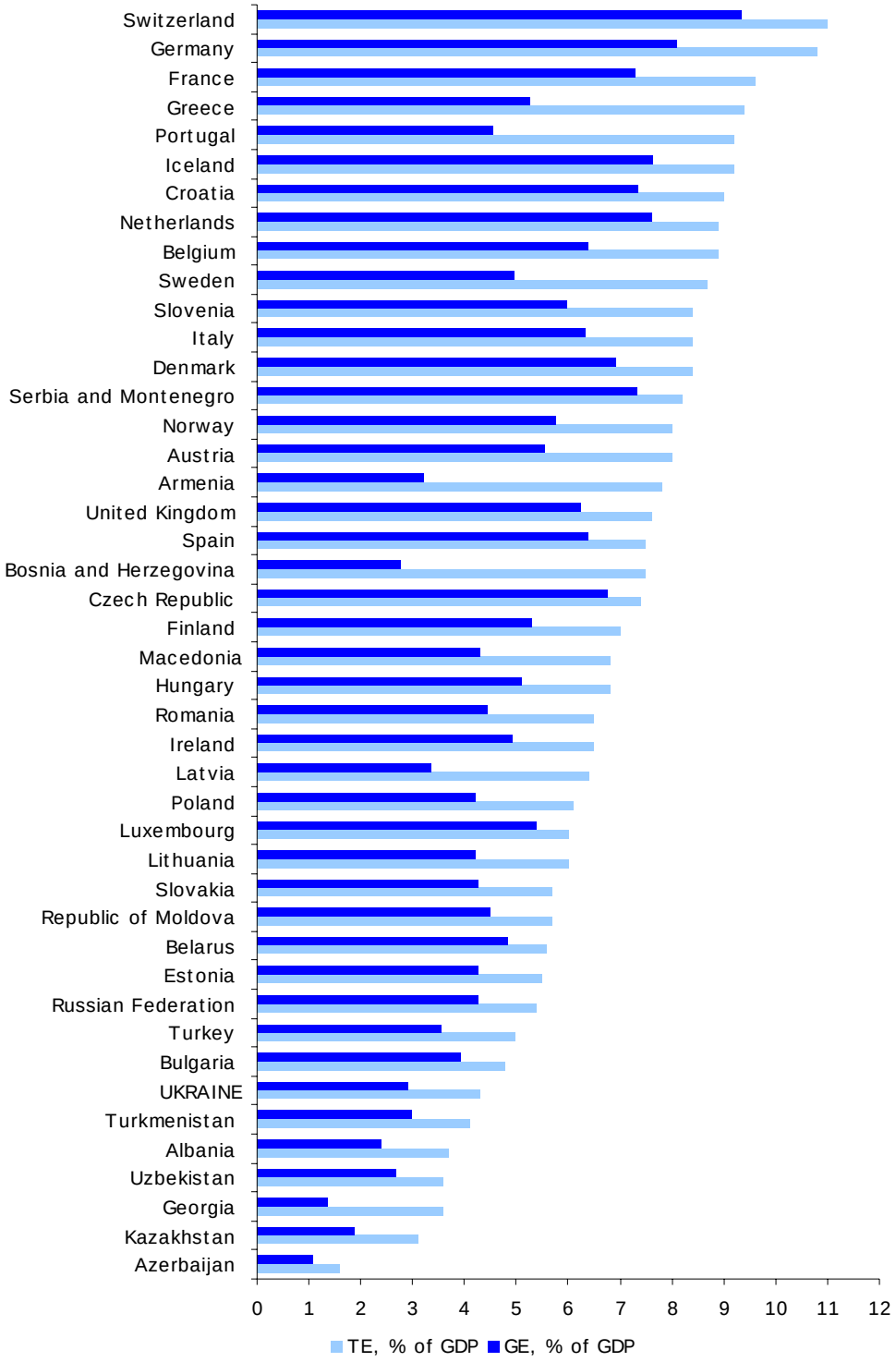
Standardized interview with open-end question for health personnel. The procedure of filling-out of standardized questionnaire with open-end questions was the following. By random choice we selected a pull of health personnel. The pull consisted of doctors with different specializations, ages and genders. They represented the health care establishments of different ownership types (municipal, state and subordinated to various ministries) and different regions. The respondents who were in Kyiv City filled out the questionnaire after face-to-face interviews. The respondents from other regions of Ukraine only filled out questionnaire. For coordination of this work we used the IER network of interviews team leaders in regions.

Total number of questionnaires is 45. They covered Kyiv City (15), Donentsk (8), Zhytomyr (10), Poltava (3), Dnipropetrovsk (5), Cherkassy (4).

Standardized interview with open-end question for representatives of political elite. The questionnaire consisted of 7 questions. The respondent answered the questions after getting acquainted with the questions Some interviews have been audio-recorded. Interviews took about 15–18 minutes.

Total number of interviews is 9. It includes members of Parliament (4) and top-level representatives of central and local executive bodies (5).

A3. Expenditures on health care — international comparison



Per capita total expenditure on health (TE) and per capita government expenditure on health (GE), at average exchange rate (USD), 2001.

Source: The WHO Statistical Information System, http://www.who.int/whosis/en/index.html

A4. The structure of consolidated health care expenditures according to economic classification

	2000	2001	2002	2003	2004	2005	
	%	%	%	%	%	UAH m	%
Total	100.00	100.00	100.00	100.00	100.00	15476.47	100.00
Current expenditures	92.30	92.10	92.50	90.58	86.70	14159.42	91.49
Expenditures for goods and services	91.30	91.10	91.60	89.37	85.21	13929.35	90.00
Wages of budget employees	37.00	38.30	40.00	38.84	38.65	6821.89	44.08
Payroll tax	13.80	14.00	14.40	13.72	14.17	2508.04	16.21
Purchase of goods, materials and services	27.00	28.20	27.50	27.47	24.97	3505.36	22.65
Payment for business trips	0.20	0.30	0.30	0.35	0.28	38.63	0.25
Payment for utility services and electricity	11.40	9.50	8.70	8.20	6.83	923.50	5.97
Heating	5.30	3.90	3.50	3.20	2.47	314.96	2.04
Water supply	1.70	1.50	1.40	1.35	1.31	184.95	1.20
Electricity	2.90	2.80	2.60	2.47	2.07	277.25	1.79
Gas	0.80	0.60	0.60	0.51	0.39	50.34	0.33
Other communal services and electricity	0.70	0.80	0.70	0.66	0.59	96.00	0.62
R&D	2.00	0.80	0.70	0.78	0.33	131.94	0.85
Interest payments on liabilities	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Subsidies and current transfers	1.00	1.10	0.90	1.21	1.48	230.07	1.49
Subsidies and current transfers to enterprises	0.20	0.30	0.20	0.30	0.73	102.08	0.66
Current transfers to population	0.90	0.70	0.70	0.91	0.75	127.55	0.82
Capital expenditures	6.80	7.90	7.50	9.42	13.30	1317.05	8.51
Acquisition of fixed assets	6.80	7.70	7.40	9.38	12.84	1169.44	7.56
Purchase of equipment and of durable goods	4.30	4.70	4.60	6.63	9.44	752.76	4.86
Capital construction	0.10	0.20	0.30	0.06	0.64	91.72	0.59
Capital repair	2.40	2.90	2.50	2.69	2.76	324.97	2.10
Purchase of land	0.00	0.10	0.00	0.00	0.01	1.69	0.01
Capital transfers	0.00	0.00	0.00	0.03	0.45	145.82	0.94
Capital transfers to enterprises	0.00	0.00	0.00	0.03	0.45	145.82	0.94
Capital transfers to population	0.00	0.00	–	–	–	–	–
Crediting	0.00	0.00	0.00	–	–	–	–

Source: the Ministry of Finance of Ukraine.

A5. Coalition agreement — The health care system reform

The Suggestions to the Coalition Agreement of the Deputies Factions in the Verkhovna Rada of Ukraine (May 2006)

(The coalition agreement was written by the consortium of organizations that comprised of the Institute for Economic Research and Policy Consulting, the Razumkov Center, Center of Legal Reforms in the framework of project financed by the International Renaissance Foundation, Kyiv office of Eurasia Foundation and representative office of Fund of Conrad Adenauer in Ukraine. The drafted suggestions in the chapter on health care policy are based on the project results.)

The health care system in Ukraine poorly performs its functions. The population of Ukraine does not trust the existing health care system and the health care services are predominantly provided on the most expensive in-patient level. The role of the primary level of the health care remains rather insignificant. The allocation of the financial resources is performed on the basis of principle of financing existing infrastructure but not on the basis of fee for service. There is a lack of incentives for improvements of the efficiency of the health care system and introduction of the structural changes.

Priority 1. Provide Ukrainian citizens with the high-quality and accessible health care

(1) Introduce the list of guaranteed by the state free medical services.

(2) Emphasize the importance of the primary level health care.

(3) Encourage the healthy life style and widen the range of prophylactic methods in the health care system.

(4) Eliminate the principle of provision the free health care services by the place of registration/residence permit. The patients should have a right to freely choose the doctor and later the insurance company.

(5) After the introduction of unified social contribution and its further reduction and introduction of reforms in the health care sector, in the medium term to introduce health insurance that would allow to provide the aid both by the public and private specialized insurance companies. The competition between public and private companies will stipulate for the diversity of the health care system as a whole and the insurance policy in particular. The State must provide insurance to the poor people.

Priority 2. The introduction of the efficient financing of the health care system.

(1) Separate the health care policy development function from the executive function, in particular, the budget execution function and managing the health care establishment function. The Ministry of Health Care should be responsible for the development of standards and framework agreements for the activities in the sector.

(2) Switch from the principle of financing existing institutions, staff, and services to a fee for service basis.

(3) Introduce the principle of paying the salaries according to the results of the activity that would create incentives for the health personnel work more efficiently.

(4) Define the property rights in the health care sector, liberalize the market and introduce the commercial principles of managing in the health care establishments.

(5) Remove the barriers for competition between different health care providers. There should exist equal rules of the game for the public and private health care establishments.

(6) Introduce of the contract relations between the customers (State) and providers of health care services (health care establishment of any form of property)

(7) Clearly define the role of private health insurance and its correlation with guaranteed by the state health care.

Priority 3. Protection of patients' rights

(1) Define the mechanism of protection the patients' rights on the legislative level. In particular, patients should have the right to obtain the information on the methods of their treatment.

A6. Necessary legislation

The reforms are based on the legislation approved in the country. In order to improve performance of health care in Ukraine, the policy makers should develop and approve regulation that would:

- Amend the Constitutional provision of providing all health care free of charge. The Constitution should guarantee the universal coverage of all population by the basic list of quality health care, which is to be approved by the Government and the Parliament.
- Amend the provision of the Constitution on the impossibility to reduce number of state and municipal health establishments. This would allow for better restructuring in the sector, introduction of commercialization measures, and later privatization of some health establishments.
- Change the legal status of public health care providers to the economic entities, which would allow them to operate with funds received.
- Approve standards of service provision, which would allow for effective control and monitoring of the HCP work.
- Approve the methodology of estimation prices of health care as well as standards for expenditure control.
- Switch financing towards fee-for-service basis. The respective regulation should define services, standards of their provision and determine the price regulation.
- Liquidate the principle of providing health care free of charge only in the residential health care establishments. This would promote the competition between HCP as well as improve access of population to quality health care.
- Stipulate procedures of contracting between local authorities and health care providers.

- Create conditions under which the management of the health care establishment could be a separate private entity, which works under the specific control.
- In the longer run, foresee the regulation of the privatization of health care establishments in Ukraine.
- In the longer run, approve a law on introduction of compulsory health insurance, which will be provided by public as well as private health insurance companies. The flat insurance contribution should be foreseen. The insurance for low-income people should be covered by the local authorities at the expense of special subvention from the central government.

The list of changes is not complete. However, this will be a start of creating necessary legislative framework of health reforms in Ukraine.

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