



National Health Reform Strategy for Ukraine 2015-2020

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Message from the Minister of Health of Ukraine



In August, 2014 Ministry of Health of Ukraine initiated the development of National Strategy on Health Reform Strategy to revitalize and speed up the process of reforms in Health sector through elaborating strategic approaches to improve the quality and access to health care and ensuring the mitigation of financial risks for population.

The process of writing this Strategy for Ukraine coincided with difficult, at the same time promising times for the country. Ukraine just went through tragic and glorious events of Revolution of Dignity, and had to enter the other «revolution» – the one of building strong public institutions and prospering society.

Many internationally renowned experts responded to the call of Ukrainian government to create a group of experts that would design the reform strategy in health. After going through a tough competitive selection process, I, as well as other 11 individuals formed a Health Strategic Advisory Group. Aspirations and expectations were high – the society wanted change and health care was one of the spheres where this change was long awaited and expected.

The challenges facing Health sector have changed enormously since Ukraine earned its independence. As in many countries around the world health of Ukrainians is being shaped by the same powerful forces: demographic ageing, rapid urbanization, and the globalization of unhealthy lifestyles. Under the pressure of these forces, chronic non-communicable diseases have become the leading cause of morbidity, disability, and mortality. And the system was not able to effectively address these new challenges.

My great aspiration is that ideas developed in this Strategy would turn into wide array of practical endeavors, starting with government initiatives and draft of laws and also civil society activities. I also hope that professional organizations will organize themselves around these ideas. They should take all their efforts to further develop action plan in each and every sector of health care. I believe, the document reflects tools and directions that can help the Government to make right decisions to translate the growing demands on health reform into evidence-based action. The Strategy argues that health care reform is a powerful social equalizer, contributing to social cohesion and stability.

It is important to initiate and implement the reform with constant attention to maximize the efficiency and effectiveness of available public financing through enacting smart policies and adopting wise decisions. The Strategy brings precision to the understanding of problems, and it offers the solutions that work best.

There are two central goals of the document: to stimulate the right kind of reform, but also to open the eyes of policy-makers to the power of health and health care as a decision-making tool. With these goals in mind, the document demystifies the reform landscape, gives it a structure, and demonstrates the potential of different kinds of activities to support the most efficient expansion of services.

Decentralization and bottom-up initiatives have to become a new reality in health sector. The Ministry of Health is by no means a body to take care of each and every aspect all the time. Every professional and civil society organization has to recognize their responsibility for their future and take a lead in their respective sector of interest and expertise. Only together we can undertake this reform.

A handwritten signature in blue ink, appearing to read 'Olexander Kvitashvili'.

Minister Olexander Kvitashvili

Executive summary

The current status of Ukraine's Health System (hereinafter «HS») is characterized by the following:

- Ukraine lags behind European counterparts in terms of life expectancy and also its mortality patterns are of a chronic disease in nature strongly linked to risk factors such as levels of smoking, levels of obesity, levels of physical inactivity and levels of excess alcohol consumption
- Ukraine spends a fair amount of its per capita GDP on health, but its per capita GDP levels are less than most of Europe. With that said, many countries achieve decent age specific mortality rates and life expectancies with little per capita spending on health.
- The healthcare system in Ukraine is sclerotic and basically based on the Shemasko model with very rigid public finance management procedures.

Key determinants for such situation are in-depth deficiencies accumulated in the national HS due to long-lasting absence of modernization, a disregard to population needs and modern international trends in strengthening HS and substantial pockets of inefficiency and corruption.

The proposed National Health Reform Strategy for 2015-2020 (hereinafter – Strategy) is a component of the National Action Plan of Reforms, which was declared by the Order of the President of Ukraine (Decree №5 / 2015 of January 12, 2015 «On Strategy for sustainable Development «Ukraine – 2020») and the Government of Ukraine (the Action Programme of the Cabinet of Ministers of Ukraine approved by the Verkhovna Rada of Ukraine on December 11, 2014 № 26-VIII). The Strategy is a framework document which sets the context, vision, principles, priorities, objectives and key measures in the Ukrainian HS in the coming period.

The Strategy forms the basis for policy development and decisions making in health, including decisions on the revenue and allocation of budgetary resources in the health sector. The purpose of the Strategy is to identify the key problems of the health system, and potential directions for solutions to form a new state policy in health, including the underlying regulatory transformation and implementation of new financial mechanisms promoting human rights in health care

This document was prepared as a general non-detailed plan to achieve the goal of the Strategy, which will be implemented by the authorities with the involvement of civil society. The document offers a clear and reasonable explanation of the activities that should be a priority in this area. So, it forms the basis for the evaluation and revision of existing programs, regulations and development of new ones. (e.g. the strategic plan for the development of human resources, hospital master plan, a strategic plan for the development of palliative care, a strategic plan for the development of public health, etc.).

The future health system should be based on three underlying principles that the Ministry of Health and the Government see as fundamental, need to be applied across the sector and need to be reflected in any new subsequent development, namely being:

- **People-centred**, which means: (i) the health system should put people's voices and needs first; (ii) quality, safety, duration and depth of contact, closeness to communities and responsiveness to changing requirements are key aspects of the new health

- ▶ services the reforms intend to build; (iii) health systems are social institutions, which operate through chains of relationships between different health systems actors - including administrators, health care providers, service users and researchers - each acting in their respective contexts. As such, systems thrive on mutual trust, dialogue and reciprocity, and their effectiveness correlates to the quality of these human relationships.
- **Outcomes-oriented:** which means that: (i) results-orientation (health outcomes, financial protection, cost-effectiveness, and patients' responsiveness) should guide all decisions at all levels; (ii) the health system should nurture an atmosphere where all staff performance in terms of service delivery results is assessed regularly, and improved continuously; (iii) systemic reforms such as the greater use of private providers for service delivery, etc., should be pursued if and only where they can lead to better results, for example lower unit cost of provision for the same service quality. It is therefore essential and a priority to improve the quality and breath of the performance information base upon which decision makers take their decisions, which is currently extremely poor and limited.
- **Implementation-focused:** which means that it is not enough to bring forward good ideas, but it is essential to prepare, implement and monitor detailed reform plans, which clearly specify responsibilities, timeframe, and accountability mechanisms. . New models of health finance should be efficient and realistic to reduce financial barriers to access health services and medicines and reduce financial risks of illness.

1 Health Status and Health System

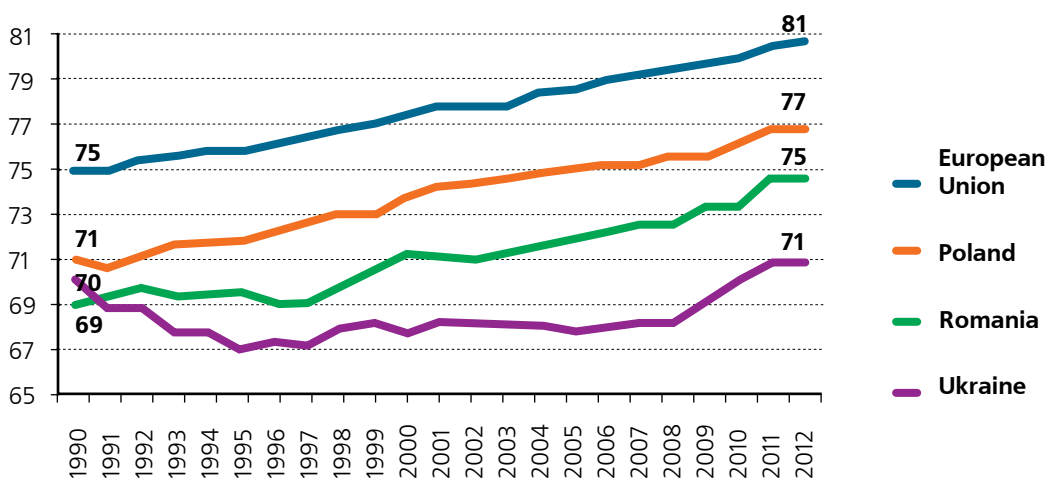
Main Policy Issues

In 2012 Average Life Expectancy at Birth, LEB, in Ukraine was 66.1 years for men and 76 years for women, which is low compared to European averages (72.5 and 80 respectively).

Combined with migration, the current health status has caused a demographic crisis as a result of which the population has been reduced by 7 million (from 52 to 45.3 million) over two decades.

1. Life expectancy at birth, years

Source: World Bank, 2012



Ukraine presents one of the worst health profiles in the European region, characterized by high mortality, morbidity and disability rates. In terms of mortality, it is second in the European ranking, increasing by 12.7% between 1991 and 2012 while it dropped by 6.7% in the European Union. Notably deaths in the working age population account for one fourth of the total (in men one-third of all deaths, with 3-4 times higher probability of death than women in all age groups 16 – 60 years)¹. Mortality by cause of death is dominated by non-communicable diseases (NCDs) such as cardio- and cerebrovascular disease, cancer, metabolic diseases, etc. and has remained unchanged in recent years. In 2013, cardiovascular disease were the leading cause (66.5%), followed by neoplasms (13.9%) and «external causes» in the third place (6%).

Those alarming figures confirm the fact that the vast majority of Ukrainians are excessively exposed to risk factors such as smoking, excess drinking, unhealthy diets, lack of physical exercise, pollution, etc. More than half adult Ukrainian men for example smoke regularly, compared to about 25% in Western Europe.²

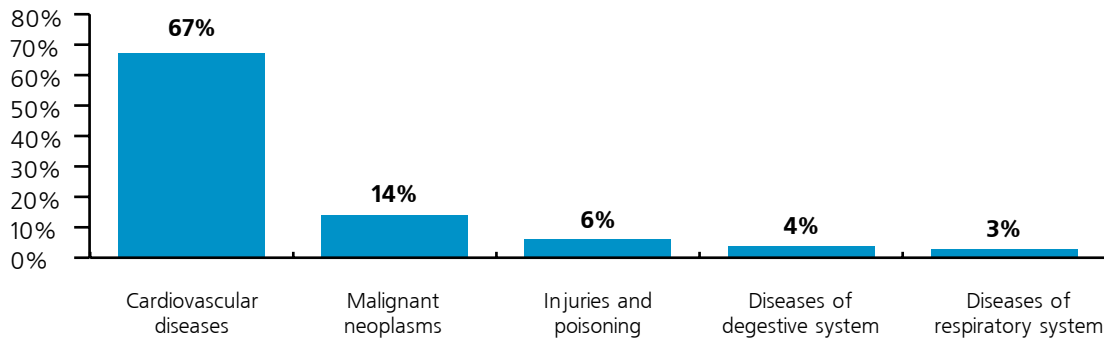
One of the key determinants for such situation is the poor economic performance of the country. The Gross Domestic Product (GDP) in Ukraine in 2013 amounted to 1.46 trillion UAH (USD177,4 billion), which on per capita bases mean far lower values than even the lowest values of the European Union, EU. The evolution during recent years is shown in the figure below. Due to the economic crisis and military conflict situation is only getting worse in 2014-2015.

¹ WHO database «Health for all», 2012

² WHO database «Health for all», 2012

▶ **2. Leading causes of death in Ukraine, %**

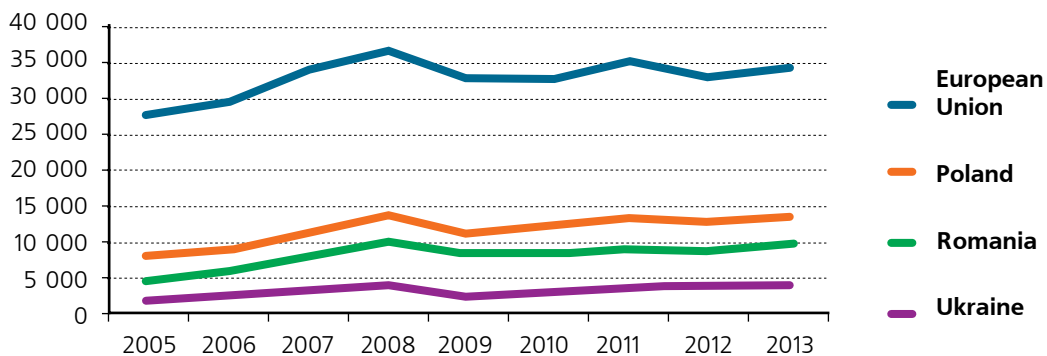
Source: WHO, 2013



Other key determinants are in-depth deficiencies accumulated in the health system. For a start an numerous fragmented set of outdated public high-level health institutions at national level have failed to ensure effective interventions affecting the broad determinants of health (poverty, housing, employment, etc.) that were necessary for Ukraine to prosper as a modern society. Despite the myriad of formally mandated inherited and new institutions, public health in Ukraine lives in a magmatic, non-prioritized chaos -different legal and technical documents, for example, describe arbitrarily the area of «public health services».

3. GDP per capita, current USD

Source: World Bank, 2013

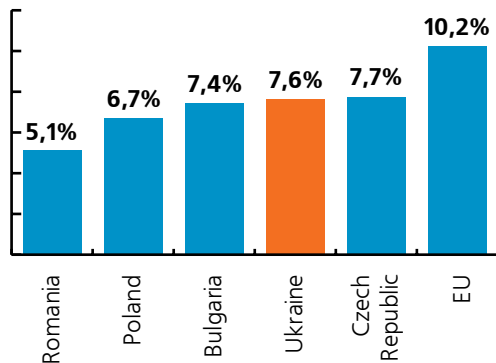


Much more decisively for the purpose of this strategy is the failure of a health system plagued with archaic arrangements and a not person-centered, inefficient operation to deliver effective, quality services to citizens. Organizational, legal, financial, managerial, economic, structural, staffing, informational, sectorial and other fundamental errors preclude Ukraine from achieving human capital gains. This is so despite the fact that Ukrainians spend on health a substantial amount of their income. In 2012, total health expenditure, THE, was around 7.7% of the GDP a proportion in fact equal or even higher than those in countries that joined EU after 2004, and higher than those in countries of the region such as Poland, Romania, and Estonia -which provide better coverage to their citizens and obtain better health results. Because of the low level of GDP per capita, this percentage translates in a per capita health expenditure equal to only UAH 2391.7 (some US\$ 299) in 2012, significantly lower than the

- ▶ 3340 of the EU average -which also includes Czech Republic with US\$ 1432, Poland with US\$ 854, Bulgaria with US\$ 516 and Romania with US\$ 420).

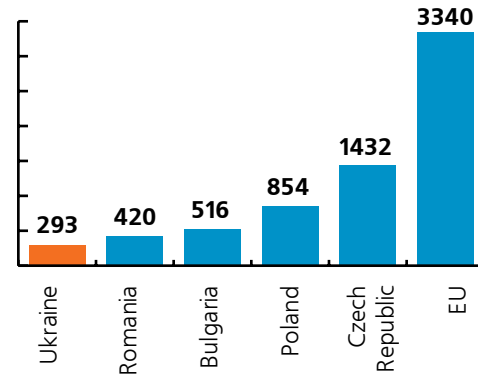
4. Total health expenditure as % of GDP

Source:
World Bank, 2012



5. Total health expenditure per capita, current \$

Source:
World Bank, 2012

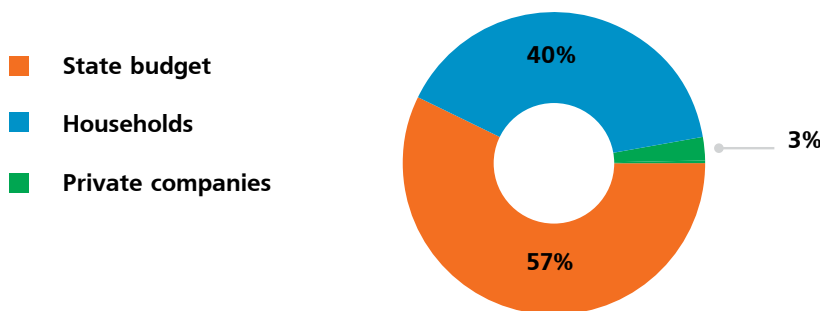


In addition, there is a radical mismatch between what the state promises and what is able to provide. On paper, the health system proclaims that it provides universal access to unlimited care, free at the point of use in public medical facilities, but in reality citizens have been for years unprotected from the impoverishing consequences of health expenses in case of disease. Expenditure from public sources (4.4% of GDP) only covers 57% of the total services people use/need.

Furthermore, expenses of health facilities are dominated by fixed costs (salaries, for example, account for some 71-74% of the total)³, leaving very little space for actual service provision -that is, treating patients, buying medical supplies and consumables, renewing technological endowment, etc. This means that services are either not provided or when they are, citizens have to bear upon their shoulders much of their cost – for example, annual spending on medicines in public institutions is only 5-6% of the total expenses and decreasing, which forces households to pay for the overwhelming majority (according to National Health Accounts 94-95% during 2005-2012) of pharmaceuticals and other medical supplies, leading to the situation when patients avoid seeking for medical care⁴.

6. Total health expenditure by sources, %

Source:
National Health Accounts,
2012



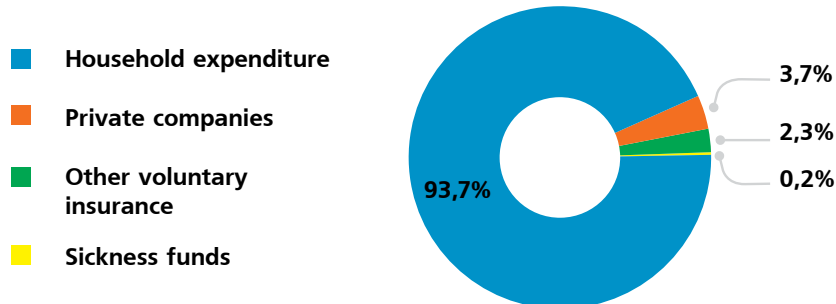
³ Health Systems in Transition: Ukraine, European Health Observatory, 2010

⁴ http://ec.europa.eu/research/social-sciences/pdf/policy-briefs-assprocee2007-02-2013_en.pdf



▶ **7. Structure of private health expenditure, %**

Source: Ukrstat,
2012



Private expenditures on health in Ukraine (in 2012, 46 billion UAH, 42.3% of THE and 3.2% of GDP) were among the highest within EU and Eastern European countries -only after Bulgaria⁵, but the vast majority of these private expenses were paid directly to providers, without any pooling that could have ensured cross subsidisation and joint financial protection. More specifically, households paid 94% of private sector funding as Out of Pocket expenses, OOP, while private health insurance, employer based coverage and non-profit organizations sponsoring was marginal -see figures.

These high levels of OOP can cause catastrophic levels of health expenditure for those who seek care, and/or prevent households from seeking care. For example, according to a 2011 household survey, 22.6 percent of those who needed to buy medicines were not able to get them, primarily for affordability reasons, while the concentration index for utilization of inpatient services was 0.21, signaling severe inequality in utilization of hospital services in favor of the rich. Among the 40 percent poorest households, 10.2 percent reported spending more than 25 percent of their total non food expenditure on health⁶.

Health service institutions face other constraints as well. Their public financing (variable as a fraction of total income depending on whether they are a hospital or an ambulatory institution) comes from the budgets assigned to them by their respective patrons (mostly regional, district and municipal/village authorities), who in turn are financed from allocations from the central budget. Such resource allocation to each individual health facility is done along specific norms/ formulae, mostly based on the inputs -doctors, beds, etc.- decided by central planners (and basically meant to maintain the status quo, with some additional oiling of the system through under-the-table payments).

In addition, budgets are «itemized» according to a rigid economic classification. Facilities have no freedom to transfer funds from one budget line to another and assign resources to their respective service provision activities (e.g. prioritize personnel versus utilities, surgery versus internal medicine or equipment versus consumables). Instead they must spend all funds (unspent funds at the end of the year will have to be returned and could lead fiscal authorities to reduce the facility's budgetary allocations for the next year by the same amount) and do so exactly as allocated, which makes hospital management almost irrelevant, not to say counterproductive⁷. For managers, thus, keeping hospital infrastructure inflated and hospital stays prolonged pays more than behaving rationally and saving, or re-profiling spending patterns.

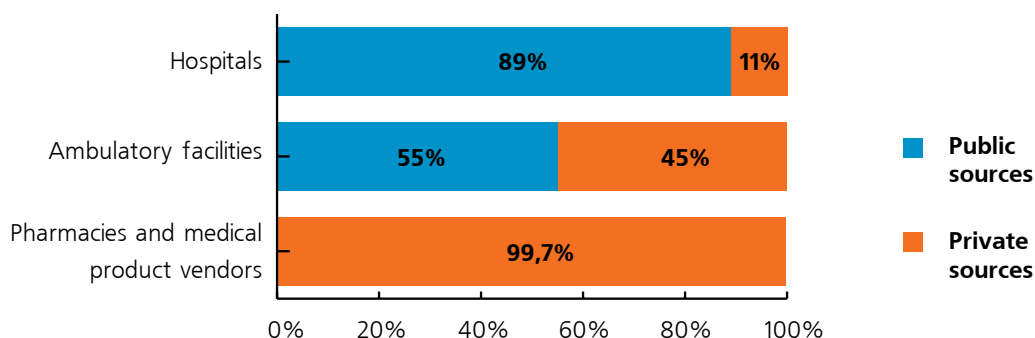
⁵ WB database at <http://data.worldbank.org>, 2012

⁶ GettingBetter: ImprovingHealthSystems Outcomes in Europe and Central Asia, World Bank Report, 2013

⁷ The situation could be changed after introduction of the changes into legislation as of January 1, 2015

▶ **8. Public and private health expenditure by types of facilities, %**

Source:
 Ukrstat, 2012



Inefficient system design and operation make things even worse. In theory, the central Ministry of Health coordinates the totality of the institutions in the public sector, among which Ministry of Finance and local authorities distribute the public funding gathered from general taxes. In reality, almost three fourths of the total financing for health goes to health facilities and staff employed at regional and local level.

Of the one fourth which is spent on nationally owned establishments, approximately 40 percent goes to establishments owned by several other ministries, not Health Ministry (namely Defense, Internal Affairs, Transport, Labor and Social Policy, etc.). Employees and retirees of these other Ministries receive health care from these facilities but generally also use on an ad hoc bases mainstream government facilities for other needs – which obviously creates redundancies, duplication and waste -in addition to the intrinsic irrational use of resources entailed in having parallel networks to serve the same needs.

All this has resulted in the exorbitant numbers of over 2,200 hospitals and over 400,000 hospital beds (5,22 hospitals and 890,7 beds per 100,000⁷) in the public sector -many more in per capita terms than not only neighboring countries but also the EU⁸. However 75% of those beds have an extremely low service production capacity, as they are located in small facilities (municipal and district hospitals, municipal single-disease -TB, STD, etc. hospitals, dispensaries and rural hospitals), some in a dilapidated state. Because of lack of investments and other constraints, very few are able to provide complex care (e.g. modern cardiac surgery or cancer treatment).

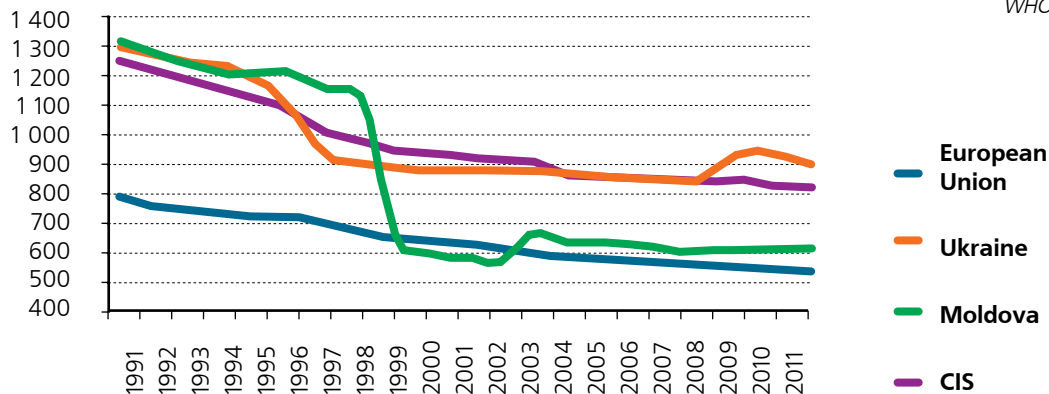
In addition, Ukraine has a massive network of different types of specialists such as cardiologists, orthopedic surgeons, ophthalmologists, urologists, etc. based out in 8,300 polyclinics at rayon and larger town/urban area hospitals and specialist single-disease dispensaries (TB, HIV/AIDS, etc.). They were originally meant to work upon referral from stand-alone points, outpatient clinics and polyclinics – separated and/or attached to district and rural hospitals – supposed to provide first level health services as Primary Care facilities organized via catchment areas that group populations in the rayon. PHC centers however are staffed by a physician and a nurse (in rural areas, by feldshers and/or midwives) who provide limited services in an environment of low technology and no incentives for quality, which has deteriorated their professional competence over the years. As a consequence, most patients bypass PHC to seek care directly from specialists -who indeed are usually happy to provide care in exchange for some official or unofficial payment.

⁷ WHO database "Health for All", 2012

⁸ European database on human and technical resources in health systems, WHO, 2012

▶ **9. Hospital beds reduction (per 100,000)**

Source:
WHO, 2012



Pre-hospital and hospital emergency medical services (EMS) are another separated sub-system that does not meet homogeneous appropriate requirements of quality, access, effectiveness and equipment. Misuse of resources is more the rule than the exception in this context.

From 2011 to 2014, a reform pilot initiative in Dnipropetrovsk, Donetsk and Vinnytsia oblasts and in the city of Kyiv incompletely piloted elements of restructuring PHC and EMS and new financing mechanisms, including contracts with health care providers, incentives for labor reimbursement and referral mechanism for regulated access to secondary and tertiary care. One of the reasons why the 2011-2014 pilots could not be evaluated is because there was no collection of data on service delivery quality, efficiency, coverage, etc.; baseline measurements were just non-existent, and no rigorous monitoring/follow up were introduced to check if performance was improving or not after the pilots.

This worrying picture is compounded by rapid ageing of the population and a decrease in the number of doctors (often misinterpreted when presented on per capita bases, due to the decline in the population) and even more notoriously, of nurses and other qualified health staff. Low wages irrespective of the volume and quality of work carried out in a deteriorated technological and professional environment, plus rigid working rules led by arbitrary decisions of politically appointed bosses have had an impact of the ethics, morale and social appeal of health providers.

The private sector meanwhile is very small – there virtually are no significant private health insurances and few private hospitals – and consists mostly of pharmacies, medical facilities (predominantly outpatient), and privately practicing physicians. They receive their financing mostly through direct payments from the population -there is virtually no outsourcing from public facilities.

In summary, the political leadership and the executive as well as legislative branches of the Ukrainian state have kept unaltered the health system inherited from the Soviet period – an integrated Semashko model publicly financed and owned, hospital-centered, with extremely fragmented governance and with services focused on individual acute treatments and minimal prevention. They have disregarded population health needs and proven unable to respond to the overwhelming burden of NCDs (the system was designed after World War II to fight infectious diseases and traumas, which in general are single-cause and less determined by personal behavior, as well as mother and child health issues, at a time when communication was difficult and medical technology not expensive). They have also ignored international

- ▶ trends in modernizing and strengthening the health system (for example, offering space to the initiatives of the private sector) and have failed to provide policy guidance in vital areas such as IT. Evidence abounds that they have also cultivated substantial pockets of inefficiency and corruption. ■

2 Stakeholders, Values, Goals and Objectives of the Future Health System of Ukraine

The new political situation is in itself the clearest demonstration of how Ukraine has changed, and for that reason, citizens will not accept a health system that fails to serve their needs and honor their aspirations in sensitive areas as health, disease and disability anymore. Conserving the existing system in the fields of management, financing, staffing, etc. would only lead to deteriorated public health, deepened problems in financial resources use, increased inequality in access to health care by the vulnerable populations, further population dissatisfaction with medical servicing and government policy, etc. A shy modernization mostly in primary and emergency health care as it was starting to happen recently, without changes in other system areas would not be very different either. **The only acceptable course of action is overhauling the current system in a deep but controlled manner.**

Regardless of age, residency or social status, people feel themselves entitled to a much better treatment; they despise an over-bureaucratized and corrupt management system that does not provide for timely response to personal and societal needs, factoring-in risks and making use of all possible resources. They want the system to be responsive to their expectations and requests.

International experience shows beyond doubt that a well performing system, capable of using available resources in a socially responsive manner, would provide effective universal health coverage, promote shared values of solidarity, equity and participation and protect everybody from the catastrophic consequences of disease, promote transparency and accountability for performance; become more responsive to people's needs, preferences and expectations. This requires a better link between the health of the nation, the national economic development and the well-being of citizens.

The modernizing reform of the Ukrainian health system should be presided by goals and objectives able to embody societal values and aspirations; in the best tradition of modern, democratic Europe, human rights for health should be compatible with economic and social development and political stability, preventing waste and corruption. Ukraine needs to put the legal, financial, economic, structural, managerial, organizational, information and communication fundamentals at work for achieving the best possible outcomes in terms of health gain (level and equity), financial protection, responsiveness to citizens demands and expectations and overall efficiency.

The follow key principles will guide the Health system in all its activities:

A guaranteed package of services available to all

This principle applies irrespective of gender, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it provides and to pay particular attention to groups of society where improvements in health and life expectancy are not keeping pace with the rest of the population.



▶ **Following the national standards of excellence and professionalism**

This principle targets the provision of quality care that is safe, effective and focused on patient needs; the support, education, training and development of staff; and the leadership and management of institutions

Patients empowerment

Respect, dignity, compassion and care should be at the core of how patients and staff are contacted – not only because that is the right thing to do, but because patient safety, experience and outcomes are all improved when staff are valued, supported and patients are recognized as equal partners in care process.

Collaboration across organisational boundaries in the interest of patients, communities and the wider population.

HS is committed to working jointly with other local authority services, other public sector organisations and a wide range of private and voluntary sector organisations to provide and deliver improvements in health and wellbeing.

Value for money and the most effective, fair and sustainable use of limited resources.

Public funds for healthcare will be devoted solely to the benefit of the people served.

Accountability to the public, communities and patients that it serves

The system of responsibility and accountability for taking decisions in the HS should be transparent and clear to the public, patients and staff. The government will ensure that there is always a clear and up-to-date statement of HS accountability for this purpose, while national and local authorities will systematically report to the citizens on achieving respective health outcomes.

Together they constitute a set of values that are expected by society

Working together for patients

The value of «working together for patients» is a central tenet guiding service provision in the HS and other organisations providing health services. Patients as consumers must come first in everything the HS does. All parts of the HS system should act and collaborate in the interests of patients, always putting patient interest before institutional interest, even when that involves admitting mistakes.

Respect and dignity

Every individual who comes into contact with the HS and organisations providing health services should always be treated with respect and dignity, regardless of whether they are a patient, carer or member of staff. The HS aims to foster a spirit of candour and a culture of humility, openness and honesty, where staff communicate clearly and openly with patients, relatives and carers.



► Compassion

Compassionate care ties closely with respect and dignity in that individual patients, carers and relatives must be treated with sensitivity and kindness. The business of the HS extends beyond providing clinical care and includes alleviating pain, distress, and making people feel valued and that their concerns are important.

Improving lives

The NHS seeks to improve the health and wellbeing of patients, communities and its staff through professionalism, innovation and excellence in care.

Everyone counts

Nobody should be discriminated or disadvantaged, and everyone should be treated with equal respect and importance.

If Ukraine will succeed in creating a new health system which is people-centered, outcome oriented and implementation focused, it will obtain the following main objectives:

- it will improve the health of the population (increase life expectancy, decrease morbidity and mortality);
- It will move towards better financial protection, so that no one citizen will be impoverished because of illness, or denied necessary medical care because they cannot afford it;
- it will ensure that health systems are prepared for and able to respond to crises.

As a means to these ultimate objectives, key intermediate goals that the reforms will pursue are the following

- Supporting, promoting, enhancing and creating environment for individual responsibility for citizens' own health;
- Guaranteeing free choice of service providers;
- Creating a more transparent, accountable, business friendly environment in the health-care sector;
- Prioritizing assistance to the most disadvantaged part of the population.

Shared Responsibility

The system should be based on the understanding of responsibility for all aspects of one's life, including the healthcare and maintenance of wellbeing. Responsibility for health should be a collaborative effort among individuals and the societies in which they live. Individuals should care for their own health and help to pay for their own healthcare, and societies should promote health and help to finance the costs of healthcare. Though access to care tends to dominate discussions of social responsibility for health and often receives the largest portion of society's resources, one should not forget the importance

- ▶ of environmental health, public health and health promotion. These strategies would be highly cost-effective and may even encourage personal responsibility, by creating social and physical environments that enable individuals to maintain health and avoid disease.

Freedom of choice

The freedom of choice is a major driving force in the free market competition in other sectors and a basic European value. In the health sector, because of asymmetries of information between patients and doctors and insurance market failures, competition cannot be left unregulated. Yet, without any competition as in the past and with resource allocation system which is completely disconnected from patients' choices, it would be impossible to create sound economic incentives among service providers and other health-care market players. Patients should have the right to choose their service providers based on their geographic location, quality of care, professionalism of medical personnel and availability of wider range of services.

Business environment

Medical services can also be run by the business, using business principles and they must respond to the needs of consumers and compete with each other to improve the quality of service at a minimum cost for the patients' benefits. Today no one is arguing about necessity of restructuring of service provision. Managers of individual health facilities, whether public or private should have the freedom to make necessary changes that improve quality and efficiency of care and the government has to remove artificial barriers. In a freer environment, where choice of provider is in the hands of patients, medical facilities will concentrate on providing high quality care, use modern technology and management to attract more patients, thus increasing their revenues. Services may be subsidized by the state through public funding, but the service provider network cannot solely depend on government subsidies and be disconnected from patients' accountability and choices.

Public Finances

By effective use of public funds, we mean directing public resources to most needy part of population. In this regard, the government has wide range of opportunities to adopt the experience of many developed and developing countries having used different targeting arrangements. The better-off part of the population should be encouraged to take care of their own health risk management, while disadvantaged are taken care of and should be subsidized according to their need to the extent possible within the budget.

The Strategy seeks for the way to resolve deep inequity and deficiency in health sector and to place Ukrainian health system on the path leading to Universal Health Coverage, while responding to citizens' need of establishing financially, socially and politically prudent relations between them and the health system.

This task seems even more difficult given very low health expenditure, not expected to grow sufficiently soon due to complex economic situation and military conflict. The steps proposed in the document will by no means bring Ukraine's health system quickly far ahead in terms of reaching the UHC. However there is anticipation to establish a solid ground for building a more equitable and responsive system in the longer run.

The SAG acknowledges that the free market principles such as price competition, profit, and free choice apply to the health sector significantly differently than to other sectors of

- ▶ economy. Therefore, strong regulatory role of the State in ensuring quality, equity, fairness and sustainability should be clearly recognized.

Establishing a person-centered outcome oriented and implementation focused health system, strengthening public health and increasing the human capital of Ukraine, however, cannot be done just by enumerating high level goals; it rather requires their specification and decomposition into a set of intermediate results in the fields of access to and utilization of quality health services, choice, continuity of care, safety, institutional productivity, etc. And after having outlined the desired goals and objectives as per the above, Ukraine needs to choose and explicit decisions concerning how the health system will unfold its functions (groups of similar activities):

- Controlling either communicable or non-communicable diseases requires access to and utilization of quality preventive, diagnostic, therapeutic, rehabilitative and caring health services – including pharmaceuticals – by the population, to be defined under specific conditions of institutional productivity, continuity of care, safety, etc..
- The production of those services could be either «made»by the public sector or «bought»from the private sector, offering choice to the citizens according to their preferences. The role of the private sector and its core parameters (size, regulation, relationships, etc.) need to be determined.
- A staffing system which does not meet the sector’s needs in terms of adequate retention and increase of the human capital in its quantitative and qualitative terms will only contribute to wasting money, but criteria to enhance human resource development and management need to be well thought out;
- Procurement and supply management system which are wasteful, inefficient and frequently corrupt do not guarantee that equipment, drugs and necessary vaccines are available at reasonable cost when needed, but their operation cannot simply be stopped without alternative systems, for obvious reasons;
- Poor mechanisms of inter-sectorial coordination and interaction for promoting health will only maintain institutionally and functionally underdeveloped public health;
- An information support which banks on paper-based, de-personified health recording and reporting, makes impossible comprehensive monitoring and evaluation of resources for efficient operational management and strategic planning, yet IT technologies are expensive;
- Furthermore, information and communication performed mostly in an unprofessional and reactive manner will not unleash the energy that is necessary to improve the health of the population, but transparency is easier to proclaim than to achieve

The Ukrainian government has a mandate to conduct reforms in many areas and a unique political window of opportunity to do so; decisions is about how the health system will affect people’s lives and the country’s economy for many years; in addition, major choices at the beginning of the process will be difficult to change later, and this imposes exceptional responsibility on the government. For those reasons, two additional requisites of the proposed changes are that they will have to

- (i) minimize avoidable suffering and
- (ii) be implemented transparently.

In other words, strategic decisions of all kinds need to be made in the months to come. The next section tries to facilitate choices in the core parameters of the objectives pursued. ■

3 Health System Architecture

Strategic Options
for Ukraine

No doubt, the future health system in Ukraine should be aligned with its accession to the International and European community, which entails an evidence-based transfer of world modern arrangements, practices and experiences to a Semashko- post-Soviet model, concerning:

- What personal and population services should be produced, how, where, by whom;
- How sufficient funding could be raised, pooled and allocated, from what sources;
- How the entire system will be governed (planned, regulated, etc.) in order to obtain the desired results in the most transparent and efficient manner, and
- How the necessary inputs (human resources, building, technologies, information, etc.) could be «gathered»?

Evidence shows a substantial range of options and «models» for each of the above health system functions within the EU umbrella; countries share common principles and approaches that should be properly considered in the design of options for the future health system of Ukraine -signaling by the way the possibility to avoid confrontations while respecting legitimate ideological differences. Some countries use preferentially primary health care services whereas others are more inclined to rely on hospitals; some prefer public employees whereas others use more private providers; some rely on insurance schemes whereas others use more budgetary arrangements; some countries have stringent regulations in areas that in other countries are not subject to particular specifications, etc.

The above, however, by no means suggest that functional options make no difference, and preferences will be explicitly or implicitly expressed here while proposing options, as follows:

Service production and delivery

Primary care strengthening

Given the current situation and post-soviet tradition with human resources distribution, in the short run there will be no way to abandon the present mix of family medicine, pediatrics, obstetrics and gynecology, health care at home that provide primary care. However, clear primary care-strengthening initiatives will be immediately launched with a new role, establishing general practitioners as privately operated entrepreneurs (following the UK, Netherlands, Denmark examples), especially in rural areas. The gradual introduction and support of private practice primary health care (PHC) will be accompanied by retraining doctors and changing requirements for licensing of this type of practice.; Gradually introduced private PHC practices will be providing services in parallel with the public institutions and their services will be covered through the same funding mechanisms – from the public budget or through the medical insurance mechanism when introduced through similar funding mechanisms (capitation principle of prudent risk). PHC financing should be ensured through the ordering for services at regional level.

Subsequently, primary care physicians who carry out private practice, will have the opportunity to join the team or «cooperatives» to make collaboration and earn some specialization.



- ▶ The principle of free choice by the citizen (registration with one «chosen doctor» subject to competition) could be used to take advantage of a characteristic feature of PHC - that doctors care for several patients – individuals and families – related to each other, who live and/or work in close proximity and whose lives are inter-related.

Primary care physicians will be given an exclusive right referral of patients to specialists through contracts with the relevant institutions. The system should not explicitly prohibit contact the patient directly to a specialist, but can offer a number of advantages and incentives (including financial) for the services referral.

Hybrid payments are a convenient way to transition from an input-based system to one that pays for value. A reasonable approach here could be a mix formula with risk-adjusted capitation to take into account the costs of providing care to individuals or groups (pure capitation pays only a set fee per patient, regardless of age, gender and health status), fee for service (an incentive for physicians to provide more treatments), and some pay for performance (incentivising quality and efficiency on clinical and cost-saving outcomes, instead of quantity). New services remuneration will be established.

Hospital reform

The number and the structure of hospitals in Ukraine need to be urgently optimized, re-profiling those beds and hospitals which consume funds and bring little value to patients and society. In the context of a single hospital network for the entire country, all medical facilities should provide access to patients and follow the same general rules, subject to procurement agency contracting (see below in the Financing section). Three levels of care provision – local hospitals, regional (geographic regions, not administrative) hospitals and central referral hospitals- could be proposed for that network.

Specialized, single profile institutions could be transformed into multi-functional medical network to provide a range of services – even if some single-profile facilities could remain intact for some time. «Parallel health systems» will in any case be abolished in a reasonable period of time, with hospitals operating under different ministries becoming of the same status as other facilities, contracted by the purchasing agency on equal bases – yet given the current situation, Military medical facilities may remain intact.

Ukraine needs to recognize practical differentiation between acute care and long-term care. Acute care will serve a severe, medical condition, is typically administered by specialized medical practitioners in areas such as intensive care and/or emergency medicine, before discharging the person to continue recovery at home. Long-term care in contrast is generally indispensable for people whose chronic physical disability or mental disorder makes it difficult for them to take care of their own needs, requiring a nurse or other health-care practitioner in their residence or in an institution.

Overall a Hospital Master Plan (probably made of sub-national Master Plans, as adequate) will document under a new light the existing resources and needs and provide suggestions for network optimization, based on access and financial efficiency. The Plan(s) would enable the government to determine which hospitals could be kept as service providers in the public sector (with or without merging), which ones could be privatized, which ones should remain as acute care facilities, and which ones should be re-profiled as «chronic or long term care», etc.



▶ The government will then be in a better position to decide how to proceed with the next steps, – either on «big-bang» or more «organic development bases» – depending on the response of key stakeholders, after the plan will be elaborated (see below «Provider autonomy» in the Governance section). Image and diagnostic services, or non-medical services (food, laundry, etc.) for example are natural candidate areas in terms of PPPs. In Ukraine, furthermore, NGOs have proven themselves effective in the prevention of HIV AIDS; they could be used for leading those services even after Global Fund leaves, although this would probably require social debate.

The state should create and articulate clear policies regarding high-tech centers – not too much – but they must provide access to advanced technologies and become centers of development and change agents. It is assumed that these institutions must first abandon the state maintenance and upgrade to diversification of funding sources. Overall Hospital Master Plan should include provisions and requirements for such centers to avoid their exclusion or monopoly.

Public Health

The state role and responsibilities in public health will be rationalized and legislation streamlined. It is planned to shift the focus from total control (elimination of SES) to increasing responsibility for maintaining health and promotion of healthy lifestyles, strengthening social participation and emergency preparedness against health threats, for example epidemics.

The main function of the state public health should be establishment and launching new policies and strategies for the prevention of diseases and promotion of health.

By amending legislation initiated and the state will promote public initiatives aimed at addressing main risk factors (for example, creating smoking-free environments, discouraging trans-fats, using helmets in motor vehicles, promoting healthy behavior and healthy diet, support the physical exercises and sports).

New public health priorities such as surveillance and monitoring of disease, response to disease outbreaks, vaccination, laboratory diagnosis of health threats, water and food safety, safe living environment (including the impact of environmental and industrial factors) will be re-formulated.

Tuberculosis, HIV and viral hepatitis for a long time remain a public health priority. Maternal and child health, sexual, reproductive and mental health should be reflected in the Strategic Public Health Plan.

National Center for Disease Control and Public Health will be created by merging number of institutions with key public health functions to improve strategic planning of the public health services, their administration and implementation.

Restructuring could include establishing sub-central public health units and labs based on the network of health facilities currently involved in this field.

.A strong sub-national public health infrastructure – perhaps with PHC structures connected with Centers for Disease Control and Public Health – could play a role in achieving short-term gains by selectively addressing «low hanging fruits»(cancer screening, salt intake, physical activity), etc.



- ▶ EU/Ukraine Association Agreement, Chapter 22 on Public Health, will serve as one of the guiding document for PHS strengthening as well.

Further Public Health Service development should be guided by special Strategic Plan addressing 10 Essential Public Health Operations (EPHOs) in accordance with the European action plan for capacity building and public health services with the appropriate cost and frame

Emergency Services

Only after fixing the backbone of the regular health system (PHC and hospital services) the decision on whether or not, and how, to restructure emergency medical services, EMS, could be rationally addressed based on defined patient pathways. Proposals to develop a National Institute of Emergency Medicine as an umbrella EMS organization -not to mention Oblast Institutes of Emergency Medicine, Oblast-level call centers with telemedicine as part of emergency medicine; emergency medicine specialty for physicians, equipment and guidelines/protocols/algorithms for care, etc. – should only be considered in an ulterior stage.

Dental Care

Dental care should remain its separate status and work closely to PHC level. New approaches will be promoted and supported by the state targeted prevention and oral hygiene. It should be noted that the dentistry development without direct government supervision over the past 20 years has met with significant progress of technology and gave and incredible private investment in the sector. So government intervention will be limited to licensing by involving the relevant professional associations

Health Financing

Source of funding

It is beyond doubt that increasing public spending without restructuring the service infrastructure will not provide a viable, sustainable solution. Efforts are needed to re-distribute available resources and increase system efficiency -if only to bridge the gap between public commitments and the financial, human or infrastructural resources necessary to finance them -which is increasing the budget deficit every year. In fact, drastic debt-reduction measures seem unavoidable in the short run in the strategy being prepared by the government to get Ukraine out of the current economic crisis, but they will be adopted only after enhancing the efficiency and effectiveness of public spending and respecting the present economic capacity and budgetary resources -in other words, changes proposed in this strategy will be fiscally prudent.

Additional sources of funds and new organisational modalities of fund pooling (e.g. insurance) will be certainly considered in due course, but only after the transition process is placed on the right track. Given Ukraine's current context -with a relatively large informal

- ▶ sector- it is recommended that the bulk of public financing should remain sourced from general taxation revenues in order to reduce out-of-pocket expenditure. Earmarked taxes on alcohol/tobacco and health hazard product can serve as an additional source of funds, allocated first of all to reimbursement of drugs and primary care.

Purchaser – Provider split; the Purchasing Agency

In the short run Ukraine's strategic approach to increase efficiency of the money spent will be for the state to «get some distance from funding directly owned health facilities and leave the job to specialists» -that is, contract providers based on agreed reimbursement schemes.

Corruption during procurement is indeed a particularly sensitive issue, damaging both the health system and the reputation of the authorities. In practice, for example, one well-known quick way of solving extreme problems of corruption in the procurement of most pharmaceuticals is to outsource to international organizations that get involved in such an activity on behalf of developing countries. This decision by the way also brings economic savings due to the scale of international organizations procurement (for example, UNICEF is the world's largest purchaser of vaccines and WHO can provide discounted rates for specific medications).

Procurement of pharmaceutical products, however, is only a small part of the entire procurement system, which should be operated/ To this end, a semi-autonomous but publicly governed purchasing National Health Financing Agency (precise name to be decided) will be created to deal with centralised bulk payments and related negotiations under the political leadership of the MoH. Such an agency could in due course be contracted out – but doing so in the short run is simply not feasible because of the absence of suitable candidates. The above mentioned Agency will be responsible for purchasing Public Health services as well.

Resource pooling

With the bulk of public (and total) health funding originating from general taxation, initial pooling will occur primarily at central level. In order to improve efficiency and in accordance with decentralization principles, however, the majority of the central pool should be allocated to sub-national instances on a weighted capitation formula (territories with higher health needs should receive higher levels of public funding).

A balance thus needs to be found between some unavoidable consolidation of finances in a central pool for funding specific national hospitals and health programs plus for securing economies of scale when procuring medicines, medical equipment, etc and not removing funds from the local budget. Health services purchasing using pooled public funds should take place primarily at sub-national level under strict regulatory conditions. It is difficult to predict what could be a balanced solution, but a multi-level purchasing agency with substantial autonomy at oblast level to negotiate performance-based contracts with all providers -from PHC through to tertiary hospitals level- could be a valid alternative.

► Shift from input-based funding toward output-based purchasing

To improve efficiency, the system will move away from input-based financing. Payment mechanisms will be introduced that give incentives to providers to become more responsive to patients while at the same time efficiency and cost-containment are achieved – without underproviding services. Funding services at the PHC level using weighted capitation payments with adjustments for services and performance would appear to be a good option -more precisely, risk adjusted capitation mixed with fee-for-service, pay-for-performance etc.

In specialised and hospital care in general «money will follow the patient», which will be given center stage. Introducing global budgets is usually step one in the payment system reform during such transitions, before shifting to case-based payments -the main advantage of doing so being first and foremost ensuring the availability of reliable baseline information. Hospitals should also be allowed to retain their savings, using them for other purposes, or rolling those over to the following years⁹. Incorporating case-based payments into a hospital payment system would incentivize hospitals to improve efficiency as case-based systems reimburse hospitals based on the approximate inputs needed to treat a specific case (thus making not profitable for hospitals to provide unnecessary services or to encourage unduly lengthy stays). Under right supervision -the use of tools such as Diagnosis Related Groups, DRGs, allows for hospital performance comparison- hospitals could be financially motivated to use only appropriate means to treat patients, improve quality of care as well as eliminate waste eventually addressing excess capacity to more reasonable levels of beds, size and/or number of departments.

Supporting the involvement of the private sector, both as voluntary (private) health insurance and as private service provider is a crucial step -see also the section on Governance. However, during the urgent phase of health reforms the recommendation is for Ukraine to dismiss too-radical «big-bang» changes in issues such as revenue generation mechanisms (e.g. introducing social health insurance) or pooling -that is, preserve the tax-based revenue generation as well as the pooling structure unaltered.

Introduction of the health insurance

It is imperative to create conducive environment for the development of health insurance in long term perspectives. For these purposes shifting employers' contributions for health insurance from taxable profit to the expenditure side is essential. However, there needs to be a regulatory and monitoring system in place first, to avoid another tax elusion scheme to open up, without clear advantages in terms of effective health insurance coverage. Over time, revenues generated from health insurance must improve financial situation of the healthcare network and relieve the burden on budgetary public spending.

For a couple of years when this expert group recommends to focus on reforms of the resource allocation criteria/payment systems (see above), and not to change the sources of financing significantly, for the introduction of health insurance, during this period of time two specific healthcare packages should be created and financed through public resources.

⁹ Partially introduced by legislation since January 1st, 2015

- ▶ **1.** «Universal uninsurable package» (UUP) includes health protection and medical care, which is funded by the state and the population is provided regardless of their place of residence or financial circumstances. Universal uninsurable services will include a number of medical services that have historically been funded by the state, the public health, uninsurable chronic diseases, and risk associated with catastrophic expenses. The content of this package may be:
 - a.** Public health (immunization, TB and HIV outpatient and hospital services);
 - b.** Psychiatry;
 - c.** Orphan diseases;
 - d.** Urgent care for noninsured part of population;
 - e.** Co-financing of catastrophic health costs above a certain threshold;

- 2.** «State Insurance Package». The state provides health insurance premium payments for a more comprehensive package of services for the vulnerable population, within available resources.

In the first stage, the ministry will develop a UUP of services:

- The list of services covered;
- Define the market price of UUP, according to DRG classification for hospital services;
- Determine the amount of co-payments according to socio-economic statuses of beneficiaries (eg. Pensioners, unemployed, disabled etc.).

Once the budget for UUP is calculated, the next step will be to allocate the remaining of budget resources to buy packages of medical insurance services for the vulnerable groups.

Beneficiaries will be free to choose insurance companies participating in the government program; the government and insurance industry will agree on the minimum set of services and service standards of the insurance package.

Stewardship/Governance

Reform of the Ministry of Health

In line with Ukraine's European aspirations, the government's role in health care will be much more circumscribed; the Ministry of Health will be re-profiled away from OPERATIONAL functions, such as procurement, hospital operations, facilities maintenance, etc., emphasizing its policy-making dimension – in the policy jargon, «steering rather than rowing». The MoH should retain three basic functions:

▶

- ▶ • Health system steering through policy leadership and strategy development, producing and coordinating for example the production of Hospital Map(s), determining the orientation of health programs and negotiating priorities with key stakeholders -in some countries, for example a Health Program Agency and Mediation Service resolves conflicts between service providers, patients and the public purchaser, etc.;
- Regulatory oversight of all health related activities, including procurement. This can be done, for example, through MoH representation in the governing board of the proposed procurement agency and other autonomously run institutions such as a Licensing and Accreditation Agency for health facilities, a Pharmaceutical Agency responsible for pharmaceuticals registration and licensing as well as pharmacovigilance; a Health Technology Assessment Agency, etc;
- Ensuring Health Intelligence, Transparency and Accountability. Surveillance/ Emergency Response, for example, is undertaken by a network of labs and offices of the National Center for Disease Control and Public Health.

In all cases, the MoH should ensure accessible, reliable, valid, timely and transparent information at the disposal of all citizens. Similarly, the MoH will guarantee the supervision and political protection of patients' complaints in health facilities; publish data on comparative performance, etc. Also, it will focus on showing itself (and holding health institutions) accountable for results, a principle vigorously emerging in most EU countries.

Institutional Re-Profiling

The Ministry of Health composition and internal structure should in the future reflect its new profile, being staffed -at the risk of oversimplifying- with policy analysts and communicators over health service administrators and accountants («brain above muscle»). By definition, as part of the executive of the country, the MoH will cherish openness in the political process, focus on internal regulations and audit and strive for opening channels of communications with the general public. One option to create a better regulatory environment and improve stewardship will be to establish a dedicated unit/entity with a clear mandate and authority to set national compulsory information and e-Health standards, integrating and exchanging data – based on International standards: HL7/CDA and IHE.

For the same reason, other institutions (central and regional, sub-national authorities, purchasers, etc.) will undergo institutional capacity strengthening efforts in areas such as policy development, performance appraisal with application of modern information and communication technologies, accountability and health intelligence, quality assurance, patient complaints, civil society involvement, etc.

Professional self-governance will be promoted and supported

Partnerships with the private sector increasingly used not only regarding high-tech secondary and tertiary services (where profits are highest), but wherever the private sector proves to have a comparative advantage for it being most efficient. In general, PPP development will be increasingly guided by pragmatic, evidence-based approach, without fostering confrontation between the public and the private sectors.

► Provider autonomy

In most developed countries, the funding and income of service providers depend on the volume and quality of services provided to consumers -and within it, increasingly on the choices made by free consumers, rather than on bureaucratic preferences. At the same time, hospitals and in general service providers need managerial and fiscal authority to reinvest in infrastructural or technological improvements while remaining accountable for the public money spent. It is also important that they will be able to diversify their revenue sources in addition to public payers and occasional co-payments (e.g. through private insurance, etc.) as adequate.

Health care institution autonomy has to be increased in three main areas: financial management, personal delegation, and service development planning. Many steps are necessary in that regard, including: specifying the extent of delegation of authority; drafting legislation; developing financial management systems; building service agreement and performance measurement systems; determining personnel policies and transition agreements; and selecting and training managers. Success will require a participatory approach, involving both stakeholders and beneficiaries.

In political terms, the pace of hospital transformation is always a highly sensitive issue, with defenders of a «big-bang» approach usually arguing in their favour the clarity of outcomes and the shortening of any period of ambiguity. Obviously, there is no standard solution to such (by definition) context-specific dilemma, but international experience tends to support at this stage the defenders of a more gradual approach when they warn against irreversible steps and the danger of alienating potential allied stakeholders. An intermediate, acceptable solution would be empowering a controlled number of «independent» managers to spearhead hospital reforms subsuming group(s) of hospitals in a small network under a single management; managers would have freedom to innovate and make decisions concerning services' optimization with clear lines of accountability and a trial-and-error approach, while stakeholders get positioned and the MoH takes its time to decide.

The government's regulatory role in primary care, hospital care, and specialized medical care will be limited to establishing the infrastructure safety requirements, and the service delivery minimal quality standards. Satisfaction of set standards will be the guarantee for entering and operating in the market. Taking into account Ukraine's European aspirations, the government will retain the current regulatory requirements and at the same time recognizes all EU member states requirements for hospital and other medical facilities. Any standard satisfaction will be considered satisfactory for acquiring a permit of medical activities.

Essential health system inputs

Human Resources

The main input in any health system is its workforce. If the motivation of Ukrainian medical staff is to be reconstituted and professional remuneration in the sector is to be set at fair levels, an overall process of reform (including of undergraduate and graduate medical and nursing education, plus that of other health staff) must take place, with

- ▶ the goal to meet European standards. This would be the first step for restructuring human resource in line with the economic realities and real needs and demands of citizens through increasingly inter-country compatible training schemes (e.g. the Bologna approach within the EU).

There needs to be a clear-cut difference in the Ukrainian health system between professional entitlements as certified by academic and legal documentation and the workforce structure, which will only be created by the evolving reality of services; in such process, overall funding, hospital autonomy and competitive staffing will be critical.

The Academy of Medical Sciences has to stop functioning as a budget-funded entity and earn money through fulfilling the order of Government and society and carried out research project Higher educational institutions should work under Ministry of Education supervision while the law on university autonomization takes effect; enrolment shall be based on general entry criteria: external independent assessment with due guarantees of transparency, fairness and impartiality.

The only way to decide on the quantity, competence and structure of medical doctors, nurses, clinical pharmacists, health care managers, etc is through negotiation with the respective professions. Top down administrative cuts and radical competitive mechanisms would be unacceptable for different reasons, but realism dictates that no-action should also be ruled out. Only by involving professional leaders in the service delivery and financing reform will allow seeing the available options in perspective so supporting professional association is a crucial element of reforms.

Human Resources training and refreshment

Career progress has to be competitive, transparent and result-based, affecting downwards the quantity of medical specialties, for which professional self-regulation needs to play an important role; the starting point should be a free, open online registry of active professionals.

In contrast, the health professional will develop a contractual working link only with his/her respective facility (not with the State) for which a result-oriented competitive procedure will be key. During a reasonable period of transition -linked to the service delivery reform (see before)- salaries could be influenced by central negotiations between the state, the facilities and the professionals, but the salary levels will be determined by the market as soon as feasible.

The generalized demand for managerial staff will be resolved on competitive bases, emphasizing professional management competence. Health care and public health managers will be offered unified master programs in universities and management professional development, perhaps with access to remote learning modalities as increasingly seen in the EU.

Pharmaceutical Sector

The goal of pharmaceutical reform is to make available safe, affordable and effective medicines and health products.. Enforcement of, and control over, compliance with

- ▶ standards, rules and norms in pharmaceuticals based on conformity with the principles of good practices is becoming compulsory as per EU regulations. Now the EU accession-signed documents allow a number of important changes to be initiated in Ukraine.

While recognizing the high level of expertise of the NDRAs with strict regulatory procedures (the United States, Switzerland, Japan, Australia, Canada and the European Union) mechanism of mutual recognition of registration dossier assessment will be introduced for the medicinal products that have passed the registration procedure in the above mentioned regulatory agencies. This measure will improve physical accessibility of drugs by simplifying the licensing procedure.

In EU countries, mutual recognition and parallel import agreement are already extensively used in the pharmaceutical market. As prices of medicines differ substantially within the OECD, wholesalers will just seek the cheapest prices for import among the «authorized» ones.

Central executive authority responsible for licensing of business entities will assist the scaling up the wholesale and retail pharmacies network by reducing bureaucratic and legal barriers to the entering new companies into the market. GMP Certification procedures should be simplified which is favoured by Ukraine's membership in PIC / S.

Overall official data suggest that current expenditure on pharmaceutical in Ukraine is some \$4-4.5 billion -about 30% of Total Health Expenditure, with public procurement comprising a small share of total pharmaceutical expenditure. Given the dynamic nature of the sector it can be expected that results of the proposed reform would be perceived relatively quickly by the public -which will win great support for the reform process.

These arrangements would allow implementing free competition on an open market with sufficient safety reassurance. Introducing market liberalization would thus make price controls of medicines look like an excessive policy instrument; taking into account the economic problems and the importance of domestic manufacturing (the largest in former USSR),

Thus during the transition period mechanism of state prices regulation could be kept using National EML which should improve over the implementation of the reform by:

- Introduction of price registration procedures in accordance with EU requirements;
- External price referencing – for original drugs; Competitive Price referencing – for generics;
- Launching price reimbursement based on internal prices referencing;
- Monitoring the availability and accessibility of medicines in Ukraine.

National Pharmaceutical Manufacturers will be encouraged to produce drugs that are required by the public policy and included into the updated National EML.

Eventually, electronic tenders and transparent bidding opportunities will apply to international (non-residents of Ukraine) companies, on the same principles that work within the internal pharmaceutical market



▶ **To reduce the cost of drugs the state will maintain indirect mechanisms of influence:**

- At the physician level (by introducing and improving health care protocols and formularies, monitoring drugs consumption, prescribed by doctors, budgeting for reimbursement);
- At the pharmacists level (by supporting generic and therapeutic substitution, falling cost by parallel imports, strengthening pharmacovigilance etc);
- At the patients level (by introducing positive and negative reimbursement lists and guaranteed basic package; co-payment promoting, health insurance, including additional medical insurance). For ambulatory sector implementation of the co-payment principles utilizing reimbursement mechanism will become standard procedure in accordance with the requirements of the European Union.

Health Information

Information is vital for improving managerial activities. Strengthening IT capacity will improve data quality, sharing, usage and distribution of knowledge as well as of information. This will in turn contribute to improved transparency and accountability, efficiency in service delivery, empowered stakeholders, etc. New IT-services at the level of the MoH in medium term perspective would specifically enhance the MoH's capacity to plan, implement and monitor health programs, particularly in the area of NCD prevention and control, given their epidemiological preeminence. Technical and architectural specifications for health data integration at different levels could be designed, linked to the overall healthcare reform strategy.

Although the MoH does not directly computerize facilities -which operate as autonomous units in this regard- it may facilitate the conditions for it by creating supportive environment (e.g. by organizing IT education for physicians, and setting eHealth standards). Central reference registries would also allow shared use of basic codes and data defined by appropriate standards and regulations. The registries will include:

- Health data dictionary;
- Registry of health providers;
- Registry of health professionals;
- Registry of health services;
- Diagnosis- (ICD-9, ICD-10, ICD-10-AM) and procedure- (ACHI) coding systems.

On the provider level, fostering computerization and internet connection is a top priority, starting from PHC level. In due course, the MoH will define meaningful eHealth use requirements for all providers, in line with wider health reform goals as the standards for local information system development, and develop step-wise strategy for its implementation, starting from introducing managerial accounting and monitoring of chronic disease, maternal care and selected high priority communicable diseases.

Resources permitting, a unique patient identification (UPID) system and service would also go a long way in supporting the payment and organisational reforms, as well as in improving planning at different levels and care modalities. New integrative e-Health ser-

- ▶ vices (e.g. ePrescription, eConsultation, prevention monitoring, chronic care management etc) could also improve access to and quality of health services for citizens, support a more efficient service process for providers and improve overview of resource allocation and service quality for the MoH. Creating secure central data exchange and integration service will enable linking different information systems, which may operate on different protocols, including systems provided by private companies -subject to the requirements of interoperability. ■

4 Building the New Health System

Inclusive Policy Development and Action Plan

The upcoming strategy will ideally contribute to set the stage for a detailed Health Sector Reform Action Plan with proposals in the short, medium and long term. Changes will be achieved through:

- I. A number of Emergency Measures during the next two years (2015 and 2016)
- I. Followed by a period of adaptation, that may be phased out during next years.

Proposals of detailed actions in a democratic society should for obvious reasons be presented to, and shared in a transparent manner with, society at large. Everybody's contribution is required; political parties, civil society, professional associations, the media, etc. should have an opportunity to know and discuss whatever would be proposed. A streamlining of the fragmented and ineffective set of high level health institutions, for example, does need to be addressed rather urgently yet it could be seen by different stakeholders with different degrees of urgency.

The strategy also needs to specify a sequencing of reforms (certain things need to occur before others) and a list of actionable mandates -actions with costs attached- should concretize broad strategic directions (namely Service provision; Health finance; Health governance; Human resources; Access to pharmaceuticals and eHealth). Strengthening the purchasing function at sub-national level is a case in point; health facilities could continue to be owned by lower level local authorities, exercising supervision role over management -through the Supervisory Board, as envisaged in the (new) Law on Health Care Institutions. Managers should in turn be responsible for day to day management of the same facilities, determining the most effective way of organizing health services delivery. Their financing, however, could at the same time be consolidated at oblast level, so that only one level of government could plan the delivery system, and optimize it over time while deeper decisions are made.

Only through this approach consensus will be reached and sustainability for the necessary deep reforms in the next few months and years will be ensured. The Action Plan below should therefore be seen only as a possible check-list for facilitating the policy dialogue inside the government and within society at large. It is up to the government and key stakeholders to adopt it through a rational, well planned process of debate and decision-making. In all cases, as soon as decisions are made the chosen policies will need to be operationalized by a detailed Implementation Plan, which needs to be immediately elaborated with the following sections:

- 1. Objectives Development:** the ultimate objectives have to be split into «smaller», intermediate «expected outcomes»;
- 2. Product Identification:** achieving objectives requires certain products and outputs to be produced;
- 3. Activities and Tasks Identification:** achieving objectives requires identifying in detail activities and tasks to be performed;
- 4. Organisational Assignments:** each (group) of those tasks need to be assigned to responsible person(s) and units;
- 5. Resources Required:** both financial and other (all) resources need to be specified;
- 6. Timetable:** a reasonably detailed schedule is needed;
- 7. Monitoring & Evaluation Mechanisms:** what indicators will be used to evaluate progress and when will this be done?

The following proposals are made here:



▶ Short Term (2015-2016) Actions

- Set up, under the leadership of the Ministry of Health and in close coordination with the Presidency and Parliament, a mechanism to facilitate urgent, coordinated action at national level involving all available resources. Introduce coordination of donor support.
- Set up few task force groups targeted specific pillar of health system to elaborate strategy into Action Plans
- Speed up legislative changes intended to unleash the necessary urgent activities:
 - The Resolution of the Cabinet of Ministers of Ukraine No. 776 of September 18, 2013, «On Approval of the Concept for Development of a Health Care Financing System» shall be acknowledged null and void.
 - Order No. 33 of Feb. 23, 2000, «On Staff Normative and Sample Manning Tables for Health Care Facilities» will be abolished.
- A solution needs to be found regarding the Article 49 of the Constitution of Ukraine whose literal interpretation would in fact preclude any health system reform.
- Establish National Health Financing Agency, which will be responsible for medical service procurement as well as have oversight of pharmaceutical procurement in the country;
- Conduct a feasibility study for reasonable increasing Earmarked Taxes on alcohol and tobacco.
- Hammer out an «emergency» campaign on NCD prevention and control, starting from CVD and oncological diseases; shape up a public health system on the basis of the appropriate legislation.
- Develop an emergency benefits policy for low-income people and chronic patients. Establish a guaranteed level of free-of-charge health care, and then entitle doctors and hospitals to charge payment for services; revise the policy regulating fees for services. Scale-up drug reimbursement practices in outpatient treatment of patients.
- Start restructuring facilities, towards clear-cut delineation of secondary and tertiary care according to intensity of treatment. Eliminate duplication and reduce the need for available beds as per the existing norms.
- Launch the piloting of new payment mechanisms in three PHC locations and twenty hospitals.



- ▶ ■ Move forward to upfront, rigorous monitoring and evaluation arrangements. MoH should be ready for continuous in-flight adjustments, because reforms are not a one-stage process and obstacles along the way will need continuous adaptation and adjustments.
- Establish institutional fundamentals for doctors' self-governance
- Adopt Laws of Ukraine «On Health Care Facilities and Medical Servicing», «On Doctors' Self-governance», «On Mandatory Social Health Insurance»
- Prepare the process of decision making regarding the measures to be adopted during 2017-20 (see below).

Medium Term (2017-2018) Actions

- Carry out functional restructuring of the central and regional health care management bodies, enhancing staff qualifications, towards improving their performance under new conditions.
- Promote quality changes to the system of PHC, with extra equipment, reviewing core rules, introducing performance-based incentives, improving motivation. Continue staff training and professional development.
- Improve transparency and accountability tools and mechanisms related to autonomy of facilities. Introduce competitive contracting of managers.
- Use new financing mechanisms for payment of health services at bigger scale, introducing contractual relations between health service facilities and the purchaser and paying health staff with reference to volumes and quality of their work
- Review the norms concerning a guaranteed volume of health care, introducing programmatic budgeting and financing of facilities; set the grounds for implementing a DRG-based financing system in key hospitals;
- Continue the development of new evidence-based health standards and unified clinical protocols, and patient pathways. Adjust record-keeping and reporting and initiate a gradual transition to the electronic document flow modernizing managerial information.
- Develop a new regulatory framework for public private partnerships in the field of health
- Establish National Scientific and Research Institute for Health. ▶

▶ Long Term Perspective (2018 and beyond) Actions

- Approve the legislation on the health care quality management system factoring-in EU regulations.
- Set up a full range of legislative acts on standards, rules and norms of the system for assurance of quality and accessibility of drugs in compliance with EU regulations.
- Introduce licensing of doctors' activity and the contracting of doctors. Pursue the autonomization of all health facilities along a new type and contracting of their managers.
- Start the DRG-based financing of SHC facilities at bigger scale.
- Continue the development of the system of health education and the system of continuous health education. ■

Gratitudes

The document was created by Health Statagic Advisory Group (Health SAG).

Health SAG was established on the 24th of July, 2014, according to the Order of the Ministry of Health of Ukraine number №522 from 24.07.2014. HealthSAG was founded as a result of joint initiative of the country's leadership and the «International Renaissance Foundation» founder George Soros. The initiative was aimed at attracting highly skilled Ukrainian and international experts to consult the government on strategic approaches to reform, optimal use of international assistance, consolidation of donor policies to assist reforms in Ukraine, and addressing current issues.

After a number of meetings and draft documents by the SAG experts, this paper now summarises the proposals forwarded by national and international experts and reflects the legitimate aspirations of Ukrainian society regarding the future health system.

This paper includes a Situation Analysis and Roadmap with the «what's» and the «how's» of the strategic proposal (points 1, 2 and 3), plus a summary Action Plan (point 4) with the «things to do» both in the short term – say the next two years – and in the remaining years.

Health SAG consists of the Coordination Council and Expert Group. Coordination Council represents government (MOH), professional association (Ukrainian Medical Association), patients group (Patients of Ukraine) and multilateral partners (WB, WHO, IRF).

The members of the Expert Group were selected on the principles of transparency, fair competition and appropriate qualification. Almost 100 applications were reviewed by CC members, 12 out of which were selected, namely Ain Aaviksoo (Estonia), Tetiana Dumenko (Ukraine), Antonio Duran (Spain), Roman Fishchuk (Ukraine), Andriy Huk (Ukraine), Oleksandr Kvitashvili, (Georgia), Volodymyr Kurpita (Ukraine), Oleg Petrenko (Ukraine), Mykola Prodanchuk (Ukraine), Tihomir Stritzrep (Croatia), Igor Yakovenko (Ukraine), Robert Yates (the Great Britain).

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