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HEALTHCARE REFORM IN UKRAINE: INITIAL RESULTS PENDING

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- The launch of healthcare reform in Ukraine in 2018 was certainly a positive development after 25 years of repeated declarations of intent unsupported by practical steps. This deferment of reform has caused crises in the healthcare sector, leaving it up to people to pay for over 50% of medical services despite an official mantra of free healthcare.

- Practical implementation of reform was preceded by the drafting and adoption of a number of legislative acts establishing a methodological framework for the planned changes. The most important and most difficult component of the new mechanism was the transformation of the healthcare funding system, including the launch of the Medical Guarantees Programme, the transition to capitation standards in primary care and the principle of financing specific services in secondary and tertiary care.

- However, the practical steps needed to implement the new mechanism have exposed a number of problems, slowing the progress of reform. In particular, the methodology for developing a guaranteed scope of medical assistance to be financed from the budget has not been finalised. The drafting of prices and tariffs policies has not been completed. Legislative acts necessary for the introduction of health insurance have not been passed. These and a number of other issues must soon be settled with the help of experts.

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Chapter I. Prerequisites for Medical Reform, 2016–2018

A discussion on the need to reform Ukraine's healthcare system began after the country declared its independence, in 1991. Today, however, many experts believe that the public healthcare system and the organisational and financial modus operandi of medical institutions have not significantly changed or advanced. Despite the innovations introduced, the old Soviet healthcare model has survived largely intact. A brief look back at how Ukraine's healthcare system evolved to its current state can explain the nature of this conservatism.

From the 1850s to the 1930s, there was a model of solid care at the primary level based on strong expert medical assistance. Thanks to a system of fairly highly qualified doctors, many diseases could be treated where patients lived. These doctors provided not only therapeutic assistance, but also a wide range of minor surgical (e.g., injuries, fracture immobilisation, whitlow treatment, etc.), dental, obstetric, gynaecological, and other services. The highly specialised, tertiary level of care was provided by university clinics, which combined advanced research with practice.

In the 1930s, the model was tweaked and replaced with the so-called Semashko system, which made district hospitals providing assistance for nearly every nosology the key link in the system. Thus, the type of assistance previously provided at the primary level by local doctors was in large part handed over to district hospitals. The range of medical services provided by these hospitals was also gradually expanded to include the treatment of diseases previously dealt with at the tertiary level.

Although the main source of medical assistance shifted to the secondary level, primary care continued to play an important role in servicing the population in the form of rural paramedical and obstetric centres and emergency centres at polyclinics. With time, local general practitioners took over the function of attending to minor illnesses like acute respiratory disease, issuing sick leave certificates or hospital transfer orders in case of complications or if inpatient care was necessary. This model offered a number of advantages for ensuring adequate medical service:

- Medical practitioners were paid more, with compensation exceeding that of those working in banking, state insurance, trade or utility services, locall industry, consumer goods or food sectors;
- Standard protocols at the secondary level were clearly followed, guaranteeing consistency in the treatment system;
- Local general practitioners largely acted as family doctors, working in a particular area for a long time and therefore accumulating detailed information about their patients;
- Healthcare institutions at the secondary level formed a system of different specialisation profiles that included a system of early treatment centres (dispensaries), and special intensive (emergency) care hospitals began to be established;
- There was a broad network of rehabilitation facilities, including a ramified system of sanatoriums, and a system of daytime inpatient care centres began to be developed;
- Medicines were mostly prescription-based (around 40%), which ensured a responsible approach and compliance with treatment protocols by doctors. (Since medicines were manufactured in accordance with the state order system at state-owned enterprises or directly in pharmacies, also exclusively state owned, there was no private manufacturing of pharmaceuticals and thus almost no counterfeit medicines).

This model did not, however, have ensuring the recovery of patients as its ultimate goal. In fact, the performance of medical institutions and their staff was evaluated not by treatment results but by the number of visits, bed days and qualifications of medical practitioners. As a result, institutions and doctors were not particularly

interested in the effective treatment of patients. Thus, the sector increasingly lagged behind the most advanced models in technological, material and technical terms. Medicines were in constant shortage. After Ukraine declared independence, the issue of reforming the healthcare system thus arose.

In the first half of the 1990s, the country experienced a deep economic crisis that directly affected healthcare funding. Therefore, the concept of reform at that time was driven by the search for additional sources of funding. It was decided that the necessary funding should be generated by expanding the range of paid services and introducing compulsory health insurance (especially after Russia, a role model in many regards, introduced this insurance model in 1992). Medical institutions started making mutual payments, in particular when they serviced patients registered outside their coverage area.

Article 49 of the 1996 Constitution of Ukraine in fact slowed the introduction of market mechanisms. «The Fundamentals of the Ukrainian Law on Compulsory State Social Insurance»[1] adopted in 1998, considerably reduced the options for health insurance. Insurance companies were actually deprived of the opportunity to offer health insurance, which was based on a non-competitive model with creation of a semi-public insurance fund. In September 1996, the Cabinet of Ministers of Ukraine adopted Resolution No. 1138 «On the Approval of the List of Paid Services Provided by State and Public Healthcare Institutions and Higher Medical Educational Establishments»[2] which was based on constitutional provisions, and "froze" the use of non-budget funding for medical institutions.

The stalled reforms in the second half of the 1990s put the skids under the country's medical care. Reformist efforts resumed in the early 2000s, driven by several factors. First, on 29 May 2002 the Constitutional Court issued a ruling on the interpretation of provisions of Article 49, part 3 of the Constitution of Ukraine (provision of free medical assistance by state and public healthcare institutions).[3] In particular, the court found that medical services may surpass the scope of medical assistance and thus can be provided for a fee. This marked an important moment in the further reform process. The list of paid services had to be established by law, not by a decision of the government or the Health Ministry.

Unfortunately, none of the reformers did not move to build fully on this court's decision. Instead of passing a law to endorse the list of services, they constantly proposed regulations on co-payments for services, thus bringing to naught the ruling of the Constitutional Court.

Second, adoption of the Budget Code of Ukraine in the early 2000s allowed the state financial system to be regulated and the rules of budget funding to be clearly written, including for healthcare.[4] Ex-Presidents of Ukraine – Leonid Kuchma and Viktor Yushchenko – issued decrees on medical reform, the programmes of the reform were developed (in 2004 and 2007), and the government adopted certain decisions, including Resolution No. 955 from 11 July 2002[5] which regulated the implementation of the Programme of Free Medical Assistance Guaranteed by the State and defined the main

1. The Law of Ukraine «The Fundamentals of the Ukrainian Law on Compulsory State Social Insurance» No 16/98, 14 January 1998 (Vidomosti Verkhovnoyi Rady Ukrayiny, 1998, No. 23, Article 121).

2. Resolution of the Cabinet of Ministers of Ukraine «On the Approval of the List of Paid Services Provided by State and Public Healthcare Institutions and Higher Medical Educational Establishments» No. 1138, 17 September 1996 (Uryadovyy Kuryer, 26.09.1996).

3. The Ruling of the Constitutional Court of Ukraine in the case of the constitutional request of 53 MPs to officially interpret the provisions of Article 49 Part 3 of the Constitution of Ukraine «state and public healthcare institutions provide free medical assistance» (the Case of Free Medical Assistance) No 10-rp/2002, 29 May 2002 (Visnyk Konstytutsiynogo Sudu Ukrayiny, 2002, No 3, p. 19).

4. Budget Code of Ukraine, Law of Ukraine No 2542-III, 21 June 2001 (Vidomosti Verkhovnoyi Rady Ukrayiny, 2001, No. 37, Article 189).

5. Resolution of the Cabinet of Ministers of Ukraine «On the Approval of the Programme for the Provision of Free Medical Assistance Guaranteed by the State to Citizens» No. 955, 11 July 2002 (Ofitsiynyy Visnyk Ukrayiny, 2002, No 28, p. 73, Article 1324).

components of this Programme. Apart from defining the guaranteed part of assistance financed exclusively from the budget, the reform at the time sought to enhance the role of family doctors, change the distribution of funding to favour the primary level and ramp up the organizational, legal and financial independence of healthcare institutions.

The second half of the 2000s saw such novelties as the change in status of medical institutions to public enterprises, the creation of hospital districts, a capitation funding system in primary care and the funding of services rather than institutions (beds, radiators and so on). The issue of compulsory health insurance did not lose its relevance. Despite the large number of approaches and ideas proposed, however, none of the concepts saw the light of day. Some regions experimented with creating public enterprises, organizing the procurement of medical services and other innovations, but there was no systemic reform at the state level.

Meanwhile, negative processes were gaining momentum in the sector. In the 2000s, state and municipal medical institutions quickly commercialised their activities but in poorly regulated ways. Almost every patient paid for services through so-called charity funds and payment offices established under the auspices of hospitals. Patients were responsible for 60–70% of the cost for serious treatments, such as surgeries. The purchase and distribution of medicines fit the system “naturally” as budgeted funding was spent without any clear auditing or monitoring mechanism regarding their intended use.

The conceptual directions for healthcare reform were identified and approved by experts and systematised by government Resolution No. 208 on 17 February 2010.[6] Some of them are as follows:

- Clear categorization of institutions by the level of assistance and transfer of most of them to the status of public enterprises;
- Introduction of contracts for medical services;
- Identification of guaranteed volume and state regulation of paid services;
- Funding of primary care based on per-person spending standards with secondary care subject to a contract between the consumer and supplier of medical services according to the principle of payment for services provided with regard to public needs;
- Development of public-private partnerships;
- Specialisation of healthcare institutions, that is, the formation of hospital districts.

The World Bank, which joined the effort to reform the sector, suggested that a pilot project be carried out in two regions of Ukraine to test the directions.

The change of government in 2010 initially did not affect the reform programme very much. In 2010–11, a number of laws were approved (including amendments to the 1992 framework Law «The Fundamentals of the Ukrainian Healthcare Legislation»[7]), a procedure for the provision of assistance at various levels was laid out, sample contracts with family doctors were approved, and a draft resolution on hospital districts was prepared. World Bank experts provided practical assistance for implementing pilot projects in four regions of the country. After a change in leadership at the Health Ministry in 2012, the reform effort pulled up sharply. After the 2014 revolution, the issue of galvanizing reform re-emerged, with primary attention being paid to updating the conceptual directions and identifying priorities.

6. Resolution of the Cabinet of Ministers of Ukraine «Certain Issues Concerning the Advancement of the Healthcare System» No. 208, 17 February 2010 (Ofitsiynyy Visnyk Ukrayiny, 2010, No. 15, p. 8, Article 704).

7. Law of Ukraine «The Fundamentals of the Ukrainian Healthcare Legislation» No. 2801-XII, 19 November 1992 (Vidomosti Verkhovnoyi Rady Ukrayiny, 2001, No. 37, p. 189).

Chapter II. Current State of Healthcare Reform

2.1. Main Directions of Reform

A new concept of healthcare funding was presented in January 2016 and approved by the Cabinet of Ministers of Ukraine in Resolution No. 1013-r in November that same year.[8] The following directions were identified as the main ones:

- Introduce a state-guaranteed package of medical assistance;
- Create a single national customer for medical services;
- Create new opportunities for local government to exercise authority over healthcare;
- Ensure the autonomy of medical assistance providers;
- Make the principle that "money follows the patient" the key component of healthcare reform;[9]
- Develop a modern system of medical data management.

All the mentioned directions were not new, having been repeatedly proposed as components of the healthcare reform system. A guaranteed reform package had been introduced by government resolutions in 2002 and 2010. The previous reform concepts identified the main task of changing the financing system following the principle of payment for already provided services as well as the principle of "money following the patient". The creation of a modern electronic information support system was repeatedly considered by authorities at various levels. It was also identified as one of the main goals of the World Bank healthcare reform project launched in 2013.

The creation of a single national customer and the open declaration of the principle of patient co-payments for services can be considered the true novelties of this concept. Experts had discussed these proposals for many years, but this was the first time they were cited in official documents. The main task at the current moment is not just to reiterate the mutually acceptable directions in yet another strategic document. It is important to develop a mechanism for actually implementing these steps in the healthcare sector. It is time to put them into practice.

The Health Ministry set out to implement the changes embedded in the concept at the strategic level. Certain steps towards the goals set have been taken in the approximately two years since the government approved the document. In particular, laws were passed on the status of healthcare institutions, financial guarantees for medical services and the development of rural healthcare. A number of legal acts were also adopted to regulate the organisational and financial mechanisms for primary care, hospital districts, the cost methodology for medical services, etc. The National Healthcare Service, the single customer and manager of the lion's share of funding, was established.

However, the implementation of the mentioned strategies for reform elicited complaints from experts involved in the process and those involved in the delivery of services, namely, medical practitioners and patients. They were driven by a number of reasons, including the following:

- Certain peculiarities in Ukraine's legal, financial and administrative systems have impeded the development of some institutional mechanisms, so it has been difficult to overcome numerous

8. Resolution of the Cabinet of Ministers of Ukraine «On the Approval of the Concept of the Healthcare System Funding Reform» No. 1013-3, 30 November 2016 (Ofitsiynyy Visnyk Ukrayiny, 2017, No. 2, p. 175, Article 50).

9. This succinctly describes the funding procedure when money is allocated not to maintain an institution but only for a specific medical service provided for a patient. At the primary level, equal sums of money are allocated per patient at stable, standardised rates with possible differentiation by age or other factors. If a patient requires treatment at other levels of inpatient care, money will "follow the patient" and be sent directly to the institution where the patient is being treated in the amount that covers the cost of that particular treatment (Author's note).

obstacles posed by the existing organisational and legal systems;

- A number of important aspects were disregarded, including health insurance, the new role of diagnostics in modern healthcare, the emergence of new organisational and legal approaches that combine social and medical services, etc.;

- Organisational problems included a team of reformers that scarcely relied on parliament or the expert community, foreign consultants having little influence on the matter, and the medical establishment being insufficiently involved in the process.

Each of the reasons should be considered separately in the contexts of achievements, problems and prospects.

2.2. Autonomy for Medical Institutions

Reformist efforts with regard to autonomy for medical institutions are entering their final stage. In early 2015, before the new concept was published, a bill was submitted to parliament providing for a change in status for healthcare institutions.[10] The bill, written by a team of then-Healthcare Minister Alexander Kvitashvili, to a certain extent took into account the Georgian experience of healthcare reform. In particular, the initial drafts provided medical institutions broad autonomy, up to the point of conferring on them the status of business partnerships. The parliament's committee on healthcare, however, gave the reformers the cold shower. According to the Law on the Autonomy of Healthcare Institutions No. 2002-VIII from 2017,[11] public medical institutions can only hold the status of public non-profit enterprises while state-owned institutions can become state-owned unitary enterprises.

Codifying the new organisational and legal forms would allow medical institutions to become full-fledged economic entities, manage their revenues and settle the issues of human resources and material incentives on their own. One cannot, however, underestimate a number of factors that could slow reform in this direction.

Law No. 2002-VIII, adopted on 6 April 2017, made it practically impossible to continue the privatisation of state-owned and public institutions. Thus, Law amends Article 16 of the Fundamentals of the Ukrainian Healthcare Legislation, adopted in 1992, which bans the privatisation of state-owned and public healthcare institutions.

Why was this not a good development? With a new system of funding under development, medical institutions that received the status of economic entities could go bankrupt in the absence of the procurement of services. This could cause serious problems in terms of covering expenses, including utility bills and remuneration, leading to local governments having to subsidise these institutions through their budgets. The experiences of Georgia and the Baltic states show that privatisation was an effective solution for them, but this is not the case for Ukraine.

Given this, it is striking that Law No. 2002-VIII does not establish non-governmental and religious organisations as possible owners of medical institutions. This practice is popular around the world and such a model might have worked in Ukraine. The Law introduces state-private partnerships as playing an important role in addressing medical institutions' possible insolvency. Such an arrangement is not, however, regulated by the Law, although a similar reformist Law No. 2145-VIII, «On Education»[12] adopted in 2017, contains a relevant clause in this area.

10. Draft Law of Ukraine «On the Introduction of Amendments to Certain Legal Acts of Ukraine to Advance the Healthcare Legislation» No. 2309a-d, 10 December 2015.

11. Law of Ukraine «On the Introduction of Amendments to Certain Legal Acts of Ukraine to Advance the Legislation on the Operation of Healthcare Institutions» No. 2002-VIII, 6 April 2017 (Vidomosti Verkhovnoyi Rady Ukrayiny, 2017, No. 21, p. 19, Article 245).

12. Law of Ukraine «On Education» No. 2145-VIII, 5 September 2017 (Vidomosti Verkhovnoyi Rady Ukrayiny, 2017, No. 38-39, Article 380).

It would also be advisable to give medical institutions more rights to independently manage revenues derived from the services they deliver. In particular, Article 18 of «The Fundamentals of the Ukrainian Healthcare Legislation», adopted in 1992, says that "to improve the quality of medical services to the population, healthcare institutions may use the money received from legal entities and individuals, except as otherwise provided by law."[13] Article 78, part 12, of Law of Ukraine No. 2145-VIII «On Education», clearly states: "Educational establishments independently manage their proceeds from economic and other types of activity provided by their statutory documents."

The year 2018 saw the massive transition of medical institutions to the status of public enterprises. There was a clear impetus for this: medical institutions that did not change their status could have problems signing contracts for the purchase of services with the National Healthcare Service, the new manager of budget funding. It became evident at this stage that many institutions were not actually ready for a change in status, as the functioning of a full-fledged economic entity requires self-financing and infrastructure for accounting, technical support, planning and other departments. Provincial hospitals and polyclinics came across this obstacle in the form of a lack of funding to cover these expenses and managerial expertise.

In view of the above, it can be said that although the path of reform is the right one, its effective implementation will require clearing away many more obstacles.

2.3. Purchase of Medicines

Another practically implemented direction in the reform is the creation of the single national customer for medical services, the National Healthcare Service, which received its Provisions,[14] management, office and the first tranche of funding to finance the primary healthcare level in 2018. From the start, there has been no unanimous public support for the plan to create such an authority.

Critics most often used the following argument: Why is it necessary to create a state healthcare agency in addition to the Health Ministry?

Supporters of the concept, on the other hand, cited the experience of countries that have separate buyers of medical services. As a rule, however, these function not as bureaucratic institutions within a system of public services but as self-regulated institutions with a separate status free from limitations of public agencies. A "non-bureaucratic" status would allow the new body to make decisions after careful internal deliberation, including directly engaging non-governmental organisations in its work, which would add a verification component and additional expertise to funding and financial administration. The institution, by virtue of not being a public agency, would be able to implement exclusive functions in regard to tariff and contract policies, protection of patients' rights, etc. When it came to creating the agency, however, the "non-state" option for its status was rejected. Under the existing financial system, particularly within the framework of budgetary administration, the main administrator of funds must be a government agency.

One of the arguments for establishing an agency independent of the Health Ministry was the premise that healthcare institutions should be independent of the ministry regulating their sector. The situation has since radically changed, however. Law No. 2002-VIII on the Autonomy of Healthcare Institutions, adopted in 2017, made

13. With amendments introduced by Law of Ukraine No. 2002-VIII «On the Introduction of Amendments to Certain Legal Acts of Ukraine to Advance the Legislation on the Operation of Healthcare Institutions», 6 April 2017.

14. "The Provisions on the National Healthcare Service of Ukraine" approved by the Resolution of the Cabinet of Ministers of Ukraine «On the Creation of the National Healthcare Service of Ukraine» No. 1101, 27 December 2017 (Ofitsiynyy Visnyk Ukrayiny, 2018, No. 15, p. 29, Article 507).

healthcare institutions fully independent of the Health Ministry. Private healthcare, whose market has been growing significantly year after year, is in no way dependent on the Health Ministry either. Therefore, this rationale is no longer of significance.

One can hardly accept the argument that independence of the agency from the Health Ministry can ensure honesty, transparency and absence of corruption in budget administration. An equivalent of over 2 billion US Dollars, which the body administers, is of interest to many, regardless of the status of the administering body.

Nevertheless, the new executive body was set up. Law of Ukraine No. 2186-VIII «On the State Financial Guarantees of Medical Services to the Population», adopted in 2017,[15] ensured public control, but only time will tell whether this institution can function effectively in its independent status. The aforementioned Provisions on the National Healthcare Service contain a number of clauses that need to be agreed on with the Health Ministry.

2.4. Difficulties with the Funding System

The next two directions of reform — introduction of the medical assistance package guaranteed by the state and the principle that money follows the patient — are closely connected and difficult to put into practice.

The first draft of the bill on financial guarantees, prepared in early 2017, said that only three types of medical assistance would be provided for free: primary, emergency and palliative. Later, at the public's insistence, the list was extended to include paediatrics, prenatal care and birth. The co-payment principle was suggested for other types of medical care, including secondary and tertiary assistance, with the state determining its share of payments and that of other sources, such as the patients own savings, voluntary insurance and local budgets.

This approach was rejected during discussion of the bill. There was a risk that the Constitutional Court would invalidate the co-payment clause for non-compliance with Article 49 of the Constitution of Ukraine. A compromise solution was born: the law did not mention co-payment as a form of financing but provided for the adoption of the Programme of Medical Guarantees. This Programme would include all types of medical services whose financing through the state budget was guaranteed. Such regulations laying out parameters make state financing realistic propositions, as the state assumes responsibility to guarantee part of payments by reserving funding in budgets for them.

As for services not included in the Programme, however, the new legislation does not clearly explain how they would be covered. It was suggested that they could be paid for through other programmes in the state budget, local budgets, health insurance, legal entities and individuals and other legitimate sources of funding.

A local budget, however, cannot reserve funds for such treatment, and patients may not have sufficient money of their own. The reform does not offer a solution to this problem although the Constitution guarantees free medical assistance. This lack of resolution is going to become a massive problem.

Every year, patients make almost 8 million requests for inpatient care. One course of treatment on average costs at least 30,000 UAH, which includes medicines, salaries, equipment depreciation expenses, materials, overhead and accruals. If one multiplies 8,000,000 by 30,000, the product totals 240 billion UAH. Adding the cost of primary and emergency care, management expenses, treatment abroad, university and research funding and a number

15. Law of Ukraine «On the State Financial Guarantees of Medical Services to the Population» No. 2186-VIII, 19 October 2017 (Vidomosti Verkhovnoyi Rady Ukrayiny, 2018, No. 5, p. 5, Article 31).

of other mandatory expenses runs around 300 billion UAH. The state is unlikely to budget more than 150 billion UAH for healthcare. In fact, the state budget would not be able to cover half of the expenses. Not taking into account subventions, local budgets could pay only a third of the uncovered expenses at best. This means patients would have to pay around 100 billion UAH out of pocket, on average about 3,000 UAH per patient per year. Average figures for healthcare sector are not, however, reliable indicators. People do not fall sick uniformly, so money is administered asymmetrically. A sick person could spend dozens or thousands while a healthy one would pay very little money.

Hence, the question is: does the scope of guaranteed medical services declared within the framework of the reform match the scope required by the Constitution? Should the reform concepts ensure an extension of the list of services, in particular by introducing compulsory health insurance, a review of methodological approaches to the structure of paid services, the introduction of individual-targeted medical subsidies for complicated cases, a clearer classification of medical services and nursing as a social service?

Developing the Programme of Medical Guarantees is an equally difficult issue. As mentioned, a government resolution provided for a similar programme back in 2002, but it was never established in the 15 years that followed. Currently, the Health Ministry and the new National Healthcare Service are expected to produce the Programme drafts. Law of Ukraine No. 2186-VIII «On the State Financial Guarantees of Medical Services to the Population,» adopted in 2017, orders the gradual introduction of medical services to the population under the Programme of Medical Guarantees during 2018–2019. International experience does not bode well for its chances. A number of other countries have attempted to pass similar programmes but in vain.

It is extremely difficult for medical practitioners to divide diseases into those that are "more important," and require priority guaranteed treatment, versus those that are "less important," and whose treatment should not be guaranteed by the state. So, for example, if purulent bronchitis is treated free of charge, but patients get charged for the treatment of non-purulent bronchitis, delays in treatment at the initial stage of the illness caused by financial problems could quickly lead to a sicker patient. The same applies to almost any nosology. Clearly, a simplified structure of guaranteed financing that depends on the inclusion of particular diseases in the Programme is not a panacea for substantially improving the coverage of costs and needs.

2.5. Primary Level Reform: Initial Results and Challenges

Let us now have a look at the funding system under which actual services provided are paid for under the principle of the "money following the patient". At the initial stage, transitions in this regard are expected to begin at the primary level in accordance with the world's renowned healthcare model, that is, capitation, or setting health spending based on the number of people served. Every resident signs a contract with a primary-level doctor, and the amount of general funding depends on the number of clients signed. Funding is calculated by multiplying this figure by the spending rate. In 2018, two-thirds of the adult population signed these declarations (a form of a contract), and the government approved the relevant rates.

The steps that have been taken thus far indeed represent a positive intermediate result for healthcare reform. It is too early, however, to suggest that the primary-level reform is even close to completion. The declarations signed revealed that in almost 100% of cases, residents signed them with the local general practitioner to whom they had previously been administratively assigned. In addition, those people not registered with local self-government bodies and therefore could not sign up for polyclinics due to this lack of registration, can now select family doctors.

It is clear that the signing of declarations is not a goal in itself. The main goal is to use them as a tool to calculate the amount of funding. The government approved spending rates per resident to differentiate between amounts of pay to doctors depending on patient's degree of satisfaction with them as well as patients' age groups. At the same time, setting lower funding rates for primary care for those who have not signed declarations could cause legal problems. After all, the Constitution of Ukraine does not oblige citizens to sign declarations but guarantees equal assistance to everyone without exceptions. Under the new system, however, average funding per resident may not be equitable because every administrative unit (district, town) will have a different ratio of people who signed declarations versus those who did not. This means that some citizens will have a lower chance of receiving free testing, such as ECGs, X-rays, etc.

Still, this is not even the main problem. The initial experience of using the new funding method showed that even with the same number of assigned clients and their relatively uniform age bands, there can be a significant difference in the incomes of family doctors in various primary medical assistance centres or ambulatory clinics. This is because budget funding is allocated not to a doctor but to an institution. The heads of institutions draft estimates to ensure that various expenses are covered through this funding. So, one institution may spend more money on repairs while another pays more in salaries. Therefore, doctors' incomes are indirectly dependent on the number of assigned clients, but the reform has not made doctors the administrators of the funds. Hence, one task should be to bring doctors closer to funds.

To tackle this problem, one must first select the best model of primary care: its structure, functions and organisational and legal framework. Primary medical and sanitary assistance centres are still the core of primary care in the existing model. Over the course of the decentralisation and creation of united territorial communities, they are expected to take over primary care functions from districts. Recently adopted regulations – including the Health Ministry's Order No. 801 from 29 July 2016, which endorsed the Provisions on Ambulatory Clinics[16] the Order of the Health Ministry and the Ministry for Regional Development, Building and Housing «On the Approval of the Procedure for the Formation of Effective Primary Medical Care Networks» No. 178/24 from 6 February 2018,[17] the Health Ministry's Order «On the Approval of the Procedure for the Provision of Primary Medical Help» No. 504 from 19 March 2018[18] and a number of other decrees — laid the organisational and legal foundation for the development of a new model of primary care based on ambulatory clinics. Maybe bulky primary medical and sanitary assistance centres, with their unnecessary administrative expenses, must be gradually left in the past. That would bring family doctors much closer to the actual administration of funding.

This step has been delayed, however, due to a number of unsettled issues. One of the main issues is whether primary care should be limited to family doctors, general practitioners and paediatricians. Should the primary care system have a place for specialists, such as gynaecologists, surgeons, otolaryngologists, endocrinologists and others who currently service patients in primary medical and sanitary assistance centres (polyclinics) and have longer lines of clients queuing than family doctors do?

For the pilot projects in Dnipropetrovsk from 2011 through 2014, specialists were moved to the secondary level, for which consulting

16. The Decree of the Health Ministry of Ukraine «On the Approval of the Provisions on Primary Medical (Medical-Sanitary) Assistance Centres and the Provisions on its Units» No. 801, 29 July 2016 (Ofitsiynyy Visnyk Ukrayiny, 2016, No. 71, p. 212, Article 2407).

17. Order of the Health Ministry and the Ministry for Regional Development, Building and Housing «On the Approval of the Procedure for the Formation of Effective Primary Medical Care Networks» No. 178/24, 6 February 2018 (Ofitsiynyy Visnyk Ukrayiny, 2018, No. 19, p. 85, Article 648).

18. Order of the Health Ministry of Ukraine «On the Approval of the Procedure for the Delivery of Primary Medical Assistance» No. 504, 19 March 2018 (Ofitsiynyy Visnyk Ukrayiny, 2018, No. 23, p. 602, Article 848).

centres were opened. This step met with a lot of criticism. For communities with 10,000 to 20,000 residents, specialists can be included in ambulatory clinics, but for smaller communities, it does not seem reasonable. Other formats can be used in cities. In any case, the reform will not deliver its best results without settling the question of the provision of special services at the level of primary care.

There are also numerous open questions about the provision at the primary level of such services as diagnostics, inpatient care, emergency care and nursing of palliative and seriously ill patients. It is unclear how to organise efforts in these areas and whether capitation standards can be applied to these services. There is a danger that these functions might be transferred from primary care institutions to hospitals to have more funds to use as financial incentives for family doctors.

Another problem is that the declared principle of all free primary care services does not tie with the amount of funding being allocated. Even 500 UAH (currently 370 UAH) per person will not cover required tests, e.g., ECGs, inpatient care and so on. To sign as many contracts as required by the standard of 1,800 persons per doctor, around 15,000 doctors are necessary. Currently, there are around 10,000 of them. There must be a system of merit-based awards, for example, for the best results in prevention and control of dangerous diseases.

It can be said that the reform of primary care in Ukraine has only just begun, exposing problems that require solution. Thus, the initial results of reform show that success still lies ahead.

2.6. Finance Model for Inpatient Care

Ukraine's reform-related national legislation contains merely a definition of the financial mechanism for the secondary and tertiary levels of the healthcare system, but no practical steps have been taken to implement it.

The existing system of funding of inpatient secondary care is based on the distribution of allocations from the state budget through the system of subventions to local budgets in accordance with the number of residents in an administrative territorial unit and factors adjusting for differences in the cost of medical assistance. The distribution of funding to the regions is for the existing network of medical institutions — i.e., district, town and neighbourhood hospitals with standard staff, relevant remuneration terms, standard premises (such as wards) and respective utilities (lighting, water supply and heating), standard requirements for linen and materials and standard terms of supply for medicines and food. In recent years, local budgets showed increased funding, in particular for utilities. As a whole, however, the old upkeep system (based on Semashko principles), which does not take into account the amount and quality of services being provided, is still in place.

Under the new mechanism, medical services would be paid for based on actual delivery. It also requires setting tariffs for calculating the cost of purchases under contracts. If one or another service is included in the Programme of Medical Guarantees, the new body must transfer money to each hospital for the actual services it has provided, regardless of the number of beds, radiators or medical staff. At the same time, however, the signed contracts do not guarantee that an institution will have adequate funding, because despite the planned amount of assistance to every hospital, the new mechanism gives patients the choice of any institution, be it public or private. Therefore, some institutions may have fewer orders than expected.

One of key issue is the need to take into account not only the laws and mechanisms of the healthcare system but also those of the financial and budgetary systems. In particular, there are clear rules of budget financing involving an algorithm for the planning and allocation of budget funds. To formulate a budget request, the chief administrator has to calculate how much money the institution will tentatively need.

Budget allocations are then formed based on the budget request. After the budget is approved, the chief administrator signs it as a recipient. After the budget breakdown, it is possible to carry out budget appropriation, that is to allocate money if recipients have approved estimates.

At the moment, the National Healthcare Service must serve as the chief administrator. To prepare a budget request, it has to predict possible disease rates and the cost of treatment per each nosology covered by the Programme of Medical Guarantees, which, however, will only be approved along with the state budget at the end of the calendar year. The budget requests must be submitted several months earlier. Also, the new model does not provide an opportunity to identify all the recipients or the volume of appropriations per person for one or another period of the year because it is impossible, for example, to predict in what hospital or region and exactly when an appendectomy will be done. This means that it will be impossible to develop accurate allocations, do breakdowns and calculate appropriations before the start of a calendar year. The new model does not fit the country's branched treasury system. Without a breakdown of funding among the regions, the treasury cannot make millions of payments totalling some 100 billion UAH.

In short, it will be very difficult to fit the new funding system into the framework introduced by the 2001 Budget Code of Ukraine. In the majority of countries where the funding system is based on per service payments, an insurance scheme is involved. This type of system has a very different financial philosophy behind it. Contributions are paid into insurance funds, where they accumulate without reference to administrators or recipients, without advanced distribution planning in line with a budget breakdown. Having been notified about an insured event, the insurer issues money from the fund, runs an expertise and makes a payment.

Budget funding and insurance payments co-exist in many countries with well-functioning healthcare. The sources complement each other. As a rule, budget funding alone would not be enough. That is why it is necessary to use other sources, in particular insurance. The motivation for and mechanisms for using the sources are different.

Budget funding is used to secure basic guarantees of the functioning of the healthcare system. There is a list of institutions whose financial support to a certain agreed extent should not depend on the number of services provided. Thanks to this guaranteed funding, these institutions can make sure their wards are heated and cooled, operating rooms are properly sterilised, medical staff receive salaries and so on. The classic system of financing is usually prioritised for certain types of medical assistance. Emergency care and intensive treatment wards must be financed depending on the number of beds, operating rooms, ambulances and so on. Operating rooms must constantly be cleaned and disinfected, ambulances must have fuel regardless of the rate of accidents.

This type of assistance should not be financed only after an official is notified, for instance, by victims of a road accident. Therefore, Ukraine's proposed model must be amended to include some form of basic guaranteed distribution that takes into consideration the existing medical infrastructure (beds, wards, medical staff, etc.). This infrastructure requires stable funding, with some adjustments, to ensure its effective functioning. Apart from emergency care, this may also apply to prenatal care and obstetric services, medical assistance for children and palliative patients. The state must guarantee funding for medical assistance to these groups of the population along with the necessary number of doctors and nurses, lighting, hot and cold water supply, and heating.

Other types of medical services in Ukraine can be financed using the proposed co-payment mechanism. Payment for the delivery of services under the Programme of Medical Guarantees is based on information and documents entered by

a provider of medical services into a healthcare database. A provider files a report through the database identifying the medical services and medicines it delivered to a patient. Payments are made in the order in which reports are submitted. There can, however, be problems with implementing this procedure.

Every year inpatient institutions administer around 9 million cases. This means that on average some 750,000 requests need to be processed per month, or 25,000 requests per day. Even if full-fledged departments are set up in every region — the issue of the transfer of authority from the chief administrator has not been settled — the region will have to process around 1,000 cases per day. Even if 10 workers spend all their days processing them, each of them would have to handle 100 requests at a rate of 10 minutes per request at best. What kind of verification and control would there be in this case? We will have a huge mechanism which will administer funding without the expert assessment of quality and designation of services provided with regard to established diagnoses. Besides, it would require significant budgetary spending to finance the operation of such a newly established payment system.

The operation of this massive payment mechanism could be ensured through a system of compulsory insurance in which the insurer would serve as the intermediary that conducts expertise, evaluates cost and transfers money.

2.7. Additional Aspects of Secondary Care Reform

Introduction of the new funding mechanism entails several other problems in addition to those noted above.

The Health Ministry insists that during the first stage of the reform, contracts be signed with all accredited hospitals, and that over time, competition and the principle of "money following the patient" will regulate the network of medical institutions. So, uncompetitive institutions will change specialization to satisfy the needs of the population. At the same time, considering the declared principle of signing contracts for the purchase of service deliveries in advance, it will be necessary to assess how many services per every type of disease one or another institution can practically provide. At the beginning of every year, each institution must declare its potential capacity to carry out a certain planned number of surgeries, procedures and other courses of treatment and then sign a contract based on this assessment. It is therefore necessary to develop a methodology for evaluating the capacity of each medical institution.

The amount of funding depends not only on the volume of purchases but also on tariffs for this or that service. Unfortunately, the procedure for calculating the cost of a service, approved at the end of 2017, is of a theoretical or methodological nature. The approval of unified tariffs for calculating the cost of services has not been ensured. The DRG (diagnosis-related groups) system has been awaiting implementation for almost five years now. This system, used in the majority of developed countries, identifies diagnosis-related cases and sets standard rates for these groups. Without settling the issue of standard rates, the launch of the new system is impossible.

A separate issue concerns advance payments to medical institutions even before they are paid for services delivered. Without advance payments in the absence of subventions, institutions cannot ensure health services because they will not have money to pay staff or even to buy detergents. For instance, at the start of reform in Moldova, advance payments constituted 70% of all funding. According to the conditions of the reform, if an institution is state-owned or public, it can receive advance payments against its declared capacity "in cases described by the Cabinet of Ministers of Ukraine," but not on general grounds. The Cabinet of Ministers, however, is yet to identify these cases, and there are serious concerns that it may ultimately entail

case-by-case control and decision-making about who should receive advance payments.

During the introduction of the system of payment for delivered services, Ukraine must be ready for the possibility of insufficient budgeting. The existing system, based on subventions, guarantees institutions stable but not particularly generous financing that covers payment of salaries, utility services, etc. Under the new system linked to the incidence of disease, it will be possible to exhaust planned funding because it is difficult to predict the number of incidents and the cost of treatment involved. Therefore, it is necessary to consider the issue of creating a mandatory financial reserve.

If the principle of payment for delivered services is implemented, there is a risk that medical institutions will offer more expensive treatment and administer inpatient care even in cases where ambulatory or outpatient treatment would be enough. This increases the necessity for checks and verification. Unfortunately, these safeguards are ambiguously interpreted in the new mechanism.

It is not clear why the law limits the share of paid services to 20% for public institutions. Most of these institutions would likely lose the competition for patients to capital, regional and private hospitals as far as items included in the Programme of Medical Guarantees are concerned. Essentially, adding the restrictions on paid services will pave the way for underfunding district hospitals and ultimately to their subsequent decline.

Some district and town hospitals are directly involved in the implementation of another direction in the reform — the creation of new opportunities for local authorities to exercise their healthcare powers. The reform calls for a transparent division of financial responsibility between state and local authorities. The state undertakes to finance the Programme of Medical Guarantees while local self-governments direct funding from their local budgets to the development of public healthcare institutions. This plan conceals serious danger.

Local authorities are still in control of a large number of medical institutions. It is clear that the major share of funding from the state budget channelled through the Programme of Medical Guarantees will end up at medical centres in big cities, including private ones. What should local authorities do if as a result of the new mechanisms their local institutions cannot support themselves financially, especially if they receive the status of public enterprises whose operation is based on the principle of self-sufficiency? They cannot be closed because it is forbidden by the Constitution, but it will be impossible to maintain them because local budgets will not provide funds for them.

Another sensitive issue in this regard is the delivery of medical and social assistance to vulnerable groups, including those with low incomes, seniors and the chronically ill. These people regularly check into district or town inpatient care facilities for a planned course of treatment, rehabilitation or treatment of a chronic disease. Local healthcare institutions play an important social function in these instances.

The new mechanism offers minimal guarantees that this medical and social assistance will be purchased at state expense. It is highly likely that the Programme of Medical Guarantees will mostly cover acute diseases while regular, planned treatment will be charged to local budgets. Vulnerable groups, however, tend not to have money for co-payments, and local budgets do not have the required resources either. The new approaches put medical care out of the reach of such people, leaving them with social care only. In the meantime, social care institutions cannot even, in practice, provide certain basic medical services like shots, IV drips or massage, not to mention operations or prescription medicines because pursuant to the law, only medical institutions can provide these kinds of assistance.

A major share of diagnostic tests is done at the local level. As far as this direction is concerned,

it is not entirely clear whether diagnostics will be comprehensively covered by the Programme of Medical Guarantees. Most likely, the Programme will pay for treatment while the financial burden of diagnostic examination will fall on local institutions and local budgets.

Unfortunately, the reform practically does not foresee a co-ordination in financing from the state and local budgets. In turn, this affects what guarantees local authorities can provide. Impoverished subsidised regions left without subventions from the state budget could face big social problems.

2.8. Decentralisation and Medical Reform

Decentralisation stands to have a great impact on healthcare reform as many powers are delegated from regions and districts to united territorial communities. The laws adopted by Ukraine over the past three years allow united territorial communities to receive income that they can use to finance certain types of medical assistance. The transfer of this power has not, however, been completed. The existing legal framework still leaves a good deal of administration functions with the districts. Thus, it is necessary to create practically from scratch a system of primary care at the level of communities. This can be done by minimizing the involvement of a district polyclinic.

Communities would require their own network of general practitioners and paediatricians, gynaecological services along with a laboratory, a decision-making mechanism for transfers to inpatient care or a sanatorium and a number of basic secondary-level services, including uncomplicated surgeries. Trips to a district centre for a course of outpatient support therapy could be made redundant. It would be reasonable to organise monitoring and doctors' support for scheduled chronic patients, ensure social and medical care for palliative patients and basic dental services. To create a full-scale medical base at the level of communities, however, the government needs to pass a number of crucial measures to complement the adopted package of reforms.

An important element of the healthcare reform system in the regions is the creation of hospital districts covering areas with up to 200,000 residents on average. Here all medical services can be localised (except for the treatment of the most difficult diseases requiring the involvement of leading medical experts). Such hospital districts are to include intensive care hospitals that provide emergency and scheduled surgeries as well as intensive treatment. A hospital district must have an accurately calculated ratio of hospitals offering scheduled treatment, maternity hospitals, highly specialised early treatment centres, rehabilitation facilities, and a hospice. The creation of hospital districts will allow communities to concentrate experts and hold regular training for them, including introducing new methods and techniques, European protocols and so on. One or two hospitals in each district will provide assistance per every disease profile, not the way it is currently done, through a myriad of district and town hospitals. Financial flows will also be streamlined while patients will finally be able to assess the quality and comprehensiveness of the services provided.

Ukrainians are, however, unlikely to observe all these positive effects any time soon. The existence of the old district and regional infrastructures parallel to the newly infrastructure will not facilitate swift changes, to put it mildly. The real levers of control remain in the hands of districts, and their authorities may not be especially willing, for example, to change the profile of their hospital to a hospice. At first, officials will get support from district residents who will have to commute, for instance, to a neighbouring district centre for a simple surgery. The changes in medical institutions' profiles will in many cases mean that doctors will have to move and be forced to deal with all

the concomitant problems involved in that, like finding new schools and kindergartens for their children, new housing, jobs for their spouses and so on.

It seems clear that effective implementation of the reform at the local level requires resolving a large number of administrative, financial and technical problems. Implementation of the last direction of reform — development of a modern system of medical data management — should be considered from a technical rather than a methodological point of view. The Health Ministry needs to be more active in creating the E-Health system based on international standards.

CHAPTER III. Future Prospects of the Reform

As noted above, certain steps have been taken in the direction of required transformations for reform, but many problems remain. Resolving these problems requires two approaches: adjusting and advancing the decisions adopted and introducing previously excluded levers.

3.1 Prospects for Compulsory Medical Insurance

The introduction of compulsory medical insurance is one of the main and most-discussed points suggested for inclusion in the package of reforms. When in 2017 legislators passed Law No. 2186-VIII, «On the State Financial Guarantees of Medical Services to the Population», establishing the legal framework for reform, there was discussion of amendments for integrating compulsory medical insurance into the developed set of measures. In particular, it was proposed that compulsory medical insurance be included as a separate chapter in the law, develop its main provisions and later specify the details through of the Cabinet of Ministers' resolutions. Neither the government or most MPs, members of the specialised committee, however, agreed to it. The Health Ministry does not seem to be considering compulsory medical insurance as an element of reform at all while MPs believe that there should be a separate law on compulsory medical insurance, especially since three similar bills have been under consideration in the parliament for two years already. None of these bills has, however, had a first reading, so the prospect of compulsory medical insurance has for years remained illusory.

Why has there been no progress in the matter over the 12 years of discussions on the need to introduce compulsory medical insurance despite a dozen bills? There are several reasons.

Medical insurance would not be effective until standards and protocols for medical services are adopted. Unfortunately, that matter has remained unresolved for the past two years. International samples were proposed but transition to them is not regulated and is voluntary for institutions. The situation is similar as regards legally approved prices and tariffs, another requisite component of compulsory medical insurance. It would be dangerous to launch compulsory medical insurance without set prices.

Another acute problem is that compulsory medical insurance will impose an added burden on economic entities, which will have to make insurance payments for their employees. Contributions from citizens are considered to be in violation of the Constitution of Ukraine. As a result, contributions for unemployed categories of people will increase the burden on the state and local budgets. One of the reasons behind resistance to compulsory medical insurance is that a large number of medical professionals are not interested in its introduction because it will affect the off-the-books income they receive directly from patients.

The most controversial issue, however, is who controls money flows in compulsory medical insurance. There are three main candidates, and

each, as always, with its own powerful lobbyists: the insurance market (i.e., insurance companies); an independent social fund of medical insurance; and a medical insurance fund under the Health Ministry (or the government or the newly established National Healthcare Service).

The situation in the healthcare sector — especially as the budget will only cover a portion of medical services within the framework of the Programme of Medical Guarantees — makes the introduction of compulsory medical insurance imminent. Otherwise, a lot of citizens, especially those from vulnerable categories, will be left alone to bear the quite high cost of treatment. District and town healthcare institutions will quickly degrade. It is not a given that the Programme of Medical Guarantees will work like a charm, and all medical expenses will be fully covered.

3.2. Reform Stages and Patient Routing

Obviously, there should be a balanced and effective approach to the introduction of medical insurance. It is also important to find the best model in terms of capacity, cost and directions of use. It cannot be introduced separately from other organisational and financial mechanisms. It is also necessary to develop a comprehensive model within which patients' routings are analysed. There are several routes.

The first situation involves an emergency or urgent situation, like an accident, sudden attack, sharp exacerbation, loss of consciousness and so on. In these cases, patients would be delivered to hospitals through the system of emergency assistance. The second situation is when a person feels sick for a certain period of time, is in pain, feverish or weak, experiences visible physical changes, nervous breakdown, sleep problems, dizziness, problems with relieving their physical needs, etc. Under the current model, the person contacts a family doctor with whom they have signed a contract. To determine a course of treatment, the doctor needs to schedule diagnostic tests or a treatment course if the affliction is obvious, for example, an acute respiratory illness. The third situation is when a person is aware of his or her disease and is a chronic patient who visits doctors in a planned and regular manner, often in line with a certain schedule, or if a chronic disease worsens or flares up.

The first route after a surgery or intensive treatment course may be for additional treatment at rehabilitation institutions, ambulatory clinics or outpatient care facilities.

The second route in most cases runs through the diagnostics system. Depending on test results, it may continue in several directions: intensive treatment in inpatient institutions, scheduled treatment at a local secondary-level hospital or as outpatient care or ambulatory treatment under the supervision of a family doctor.

The third route, for long-term chronic patients, does not necessarily require a visit to a family doctor. In some countries, the functions of a family doctor are parallel with doctors specializing in a particular chronic disease. This specialist, depending on the level of aggravation of the disease, can recommend a scheduled or intensive treatment course through outpatient care or a continued ambulatory therapy. An effective system of medical services must take into account how patients move along each of the routes.

The first route is directly related to the system of emergency care, including the delivery of patients by ambulances and their treatment in intensive care hospitals. The maintenance of this system must be based on the budget insurance principle. Delivery centres are first-aid stations while hospitals as such have to be maintained in accordance with the principles of the Semashko system, that is in the status of institutions. At the same time, the cost of treatment of one patient or another must be

calculated individually with regard to the cost of medicines, reagents, depreciation of equipment, additional charges for payroll depending on the difficulty of a treatment, which, in general, together constitute the so-called insurance cost. Basic rates for certain types of expenses and terms under which certain deviations from the basic rates are permissible can be used. The insurance cost, namely an individual part of the cost, is reimbursed through the mechanism of compulsory insurance on the condition that every citizen is insured.

It would be reasonable to finance the first part of maintenance costs of intensive care institutions by allocating special subventions that would cover the cost of the delivery system — ambulances, intensive care hospitals, rehabilitation facilities where treatment continues in line with protocols (for example, sanatoriums for people after apoplectic fits, heart attacks, orthopaedic surgeries) and special early treatment centres. It would be best to allocate such subventions at the level of hospital districts because emergency and intensive care must depend on the number of residents. Until the organisational and legal issues of hospital districts are settled, however, this task will be impossible to fulfil.

The second route begins with a family doctor. The mechanisms of this type of medical assistance and its funding in the global practice have been fairly well established. They are being implemented in Ukraine as part of the reform. The success of this effort will in many ways depend on the delegation of responsibility from an institution to a doctor, that is on making primary care doctors' work as individualised as possible. Certainly, it does not seem realistic now to switch family doctors to the status of individual entrepreneurs. It would be reasonable, however, to support progress in this direction because it will make doctors more responsible, turning them into the actual administrators of funding. Only in this case will the system of "money following the patient truly work", ensuring financial support for the transfer of patients to the next level. In that case, one can then talk about laying the foundation for a regulated fee system.

In this case, there is an urgent need to introduce a balanced bonus system in which doctors' income will depend not only on the number and age of patients but on a range of quality factors primarily involving the assessment of transfers from a family doctor to secondary inpatient care. In particular, all cases of hospitalisation can be divided into the following categories:

- Accidents and unexpected complications;
- Aggravation of chronic diseases;
- Diseases requiring hospitalisation and were not timely identified at the primary level;
- Diseases promptly identified at the primary level and against which a family doctor took all possible measures;
- Diseases identified by a primary care doctor and whose treatment a patient ignored.

One more delicate issue should be taken into account. Ukrainians still have the Soviet-era mentality that once one feels slightly unwell, one should see a doctor. Thus, a long line forms outside the family doctor's offices. In the end, in many cases, the doctor recommends a standard range of well-known medicines that, if they do not require prescription, can be bought in drugstores without visiting an ambulatory centre. Doctors have too much work to do for no good reason; there is no time for prevention, therefore their work becomes inefficient. Perhaps, it is necessary to consider the introduction of so-called thresholds for primary medical care as in many countries — that is, issue guidelines identifying a set of symptoms and syndromes and other health parameters required before calling a family doctor. If such threshold parameters are absent, people should treat themselves according to common practice. Such an approach would save budgetary funding, and family doctors could dedicate more time to serious cases. Similarly,

it is necessary to develop a set of "critical thresholds for hospitalisation."

3.3. Approaches to the Organization and Financing of Diagnostics

Primary care can be advanced if the population is subjected to comprehensive medical examination to assess the general health condition of every citizen, identify latent diseases in chronic and acute forms and collect basic information about contributing factors, such as lifestyle, living conditions and environment. Based on the results of such examinations, every person can have a medical profile that provides family doctors with up-to-date information. Such examinations should be made mandatory by law, which would enable a more effective introduction of medical insurance.

The next leg of this route concerns diagnostics because further profile of medical services will depend on its results. This appears to be the most difficult route. As mentioned, the current model of reform does not pay sufficient attention to this issue. Currently, diagnostics is done at all levels of medical assistance. At the primary level, some diagnostics, such as ECGs and X-rays, are done in a polyclinic (primary medical or sanitary assistance centre). The regulations adopted in 2018 envisage that budget funding for them be guaranteed although the actual capacity of laboratories and the coefficient of 370 UAH per patient hardly make it achievable. If a patient is sent to hospital, they undergo diagnostics twice: before hospitalisation and during treatment. The development and introduction of the Programme of Medical Guarantees have not clarified whether the budget covers the full cost of diagnostics during inpatient care. That said, a diagnosis cannot be established until tests are done, so it cannot be known until after testing whether the disease is one covered by the Programme of Medical Guarantees. In case of a serious disease, a patient will be transferred later to a hospital of a higher (tertiary) level, where he or she will be subjected to diagnostic procedures for the fourth time, but there is no clarity on who will pay for those either.

Considering this, it would be more effective to introduce a mechanism whereby the state creates a network of specialised diagnostic and consulting centres with state-of-the-art equipment and professional staff. These centres must become universal institutions, offering diagnostic services to all patients at all levels of assistance. The diagnostics prescribed by doctors or medical institutions must be free for all patients. Diagnostics at patients' own initiative should be offered for a fee.

Provided that every person is insured in a system of compulsory health insurance, diagnostic results will serve also to register an insured event. If diagnostic results show that a person requires intensive treatment, he or she must be sent to a relevant institution, where insurance will cover the mentioned individual treatment cost. If diagnostic results suggest ambulatory treatment, insurance payments will be used to refund the cost of medicines. If after a visit to a diagnostic centre a patient is prescribed a treatment course or outpatient care, it would be reasonable to proportionately split the expenses between an insurance payout and local budget payments.

3.4. Reform at the Local Self-government Level

The third route requires a more intricate system of organisation and financing. Chronic patients require more supportive care in accordance with standard protocols. As a rule, these are patients with cardiovascular, gastroenterological and urinal diseases or diabetes but also a number of other nosologies. Scheduled treatment is accompanied by doctors' prescriptions and procedures, including IV drips, physiotherapy and shots given by junior medical staff. In developed countries, a large share of the market

is represented by medical-social institutions, so-called nursing centres and social care hospitals. These institutions lie somewhere in between the medical and social sectors, providing an opportunity to make rational use of budgeted funds by combining treatment and nursing, especially for pension-age people, and offering quality palliative help and rehabilitation.

While forming hospital districts, it may be necessary to create such medical-social centres based on some secondary-level inpatient care institutions in district centres or neighbourhood hospitals. It is important to legally define a separate status because these are not purely medical facilities but social-medical institutions. This will allow them to involve budgetary funding allocated to ensure the exercise of authority by the Social Policy Ministry, especially since the Constitution does not impose strict conditions on the free delivery of social services. In this case, it is possible to build a well-founded system of multi-channel financing and co-payment. Medical services can be financed based on the agreed capitation rates per day of stay while similar per-person rates per day can be used for social services. Some expenses can be paid by patients or from local budgets. Approving these changes improves the chances of receiving non-budget financing and strengthening care through social security agencies.

When one tries to define the status of these institutions, one is often misled by the stereotype that inpatient care is a secondary-level institution. This division at the level of medical aid delivery is rather conditional, and relevant centres can become institutions of a separate type where patients can be sent both by family doctors and inpatient care facilities. The creation of medical-social centres should not rule out the delivery of these services by specialised wards in polyclinics or ambulatory wards in hospitals. It is up to every community to decide on an organisational form.

The second part of this route concerns urgent cases if a chronic disease worsens or flares up and requires intensive treatment. The above-mentioned plan can be used here — insurance will cover the cost of a specific treatment course except for the so-called hotel and administrative expenses.

The budget and insurance systems can be combined at the level of united territorial communities. Therefore, relevant budgets must reserve funding for the programme of" financing the cost of medical services in accordance with the list of diseases by using the system of medical insurance." According to our estimates, to ensure financing through insurance at the level of 50 billion UAH per year, every resident of a united territorial community would need to pay an insurance contribution of up to 200 UAH per year, or 18 UAH per month. For a united territorial community with 15,000 residents, the total funding reserved in the local budget for this programme would not exceed 240,000 UAH per year. The money can be paid to an insurance company on a quarterly or even monthly basis. These are absolutely affordable costs considering what united territorial communities are earning today.

3.5. Additional Steps for Reform

Since it is important to ensure state guarantees of the effective and targeted use of money at the initial stage of the introduction of compulsory health insurance, it might be reasonable to establish a state health insurance company with self-sustained subsidiaries in every region. Moldova has been successfully operating a similar approach for almost 10 years now. The creation of a state insurance company does not contradict current legislation in of Ukraine. This organisational-legal form is provided for by Law No. 85/96-VR "On Insurance" adopted in 1996[19]. The company may offer insurance products that would guarantee payment for the most

19. Law of Ukraine «On Insurance» No. 85/96-VR, 7 March 1996 (Vidomosti Verkhovnoyi Rady Ukrayiny, 1996, No. 18, Article 78).

difficult and expensive diseases — oncological, acute and difficult cases of cardiovascular, urological, gastrological and other illnesses — to the amount that is not covered by the National Healthcare Service. There is also a need for insurance products to cover the cost of treatment of diseases not included in the Programme of Medical Guarantees. Private insurance companies can also take part through the system of co-insurance and re-insurance by signing agreements with the state company.

Another important direction in reform would be a stronger focus on doctors rather than institutions. This approach has long been a subject of debate among experts and recently attracted the attention of the Health Ministry. It is a common practice in many countries that doctors receive individual licenses for medical practice and carry personal professional responsibility for the services they deliver. At the primary level, the lack of focus on doctors has already been slowing the pace of reform because it does not make the new funding system more effective. The introduction of this approach is also possible at the tertiary level: for a difficult and highly professional treatment programme (especially a surgical one), a patient would have the right to choose a specific doctor and sign a contract; the doctor would then be able to choose an institution to lease as an equipped space, hire assistants, junior staff and anaesthesiologists, sort of a medical brigade approach. A number of conditions must be guaranteed to introduce this system. If compulsory insurance is introduced, doctors must have a legal right to receive insurance payouts.

In the absence of compulsory health insurance, it is possible to develop a system of financing rates by specific types of highly qualified assistance the recipients of which, apart from doctors, could be patients or patients' primary doctors. At the least, it is worth considering such approaches and maybe running pilot projects.

The introduction of paid services is a separate and not fully settled issue. As noted, while developing the mechanism of reform implementation, its authors did not use a tip from the Constitutional Court embedded in its 2002 decision on defining the list of paid medical services in the law.[20] If such a step were taken, it would immediately guarantee a legitimate ground for relieving pressure on the budget by expanding the list. It could be expanded to include assistance that does not require a doctor's prescription; social and utility services (so-called hotel services), especially if there is a demand for a higher-quality and a broader range of services compared with those offered by an institution; consultations by experts specially requested by patients; diagnostics, treatment or rehabilitation not foreseen by protocols and standards; medical services out of schedule set by a doctor or institution during off hours or outside the premises of an institution and so on.

Also, it is necessary to develop more clear criteria for selecting the services in the guaranteed package. For every nosology, it should be decided whether it is reasonable to include it and whether the budget should cover such stages as preparation, treatment and rehabilitation. For example, in the case of an appendectomy, it is enough to include only the surgery in the package while a coronary artery bypass surgery would also require preparation and rehabilitation. For a number of nosologies, for example pneumonia, it is necessary to cover the entire course of treatment until full recovery. In other cases, for example, an apoplectic attack, it is enough to trigger a positive trend. In some cases, a guaranteed share of costs may not depend on results, for example, in the case of palliative patients.

As one can see, healthcare reform still has a long list of tasks to fulfil. Ukraine has a professional community to help it settle the outstanding issues. At the moment, organisational efforts to ensure experts' effective involvement in this process are lacking, but it is hoped that positive developments in this regard are forthcoming.

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20. Decision of the Constitutional Court of Ukraine's No. 10-rp/2002, 29 May 2002 (Visnyk Konstytutsiynogo Sudu Ukrayiny, 2002, No. 3, p. 19).

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