



OVERVIEW

Ukraine Health Financing Reform

Progress and Future Directions

Caryn Bredenkamp, Elina Dale, Olena Doroshenko,
Yuriy Dzhygyr, Jarno Habicht, Loraine Hawkins,
Aleksandr Katsaga, Kateryna Maynzyuk,
Khrystyna Pak, and Olga Zeus

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INTERNATIONAL DEVELOPMENT IN FOCUS

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Abbreviations

| | |
|--------|--|
| ALOS | average length of stay |
| AMP | Affordable Medicines Program |
| CabMin | Cabinet of Ministers |
| DRG | diagnosis-related group |
| EML | Essential Medicines List |
| EU | European Union |
| GDP | Gross Domestic Product |
| HTA | Health Technology Assessment |
| INN | international nonproprietary name |
| IT | information technology |
| MoF | Ministry of Finance |
| MoH | Ministry of Health |
| NHSU | National Health Services of Ukraine |
| OECD | Organisation for Economic Co-operation and Development |
| OOP | out-of-pocket |
| PCC | Public Control Council |
| PHC | primary health care |
| PMG | Program of Medical Guarantees |
| SNG | subnational government |
| TB | tuberculosis |
| UDRG | Ukrainian diagnosis-related group |
| WHO | World Health Organization |

Overview

UKRAINE HEALTH FINANCING REFORM: PROGRESS AND FUTURE DIRECTIONS

EXECUTIVE SUMMARY

This report reviews the progress of the implementation of the health financing reform in Ukraine, in particular the funding, purchasing, and governance of the Program of Medical Guarantees (PMG). The health care reforms initiated in 2015 culminated in the Law on Financial Guarantees for Health Care Services, which define a guaranteed benefit package—the PMG—for all Ukrainians and created the National Health Services of Ukraine (NHSU) to serve as the strategic purchaser for this program. The vision was that the PMG would expand over time to eventually cover all types of health care and that financing would evolve from input-based to output-based modalities to better align the provision of care with patient needs. In 2019, a joint World Health Organization (WHO)–World Bank review took stock of reform progress since 2017. Many important developments, including the COVID-19 shock, have taken place since then, warranting a new assessment of where things stand and what the future directions should be.

Tremendous progress has been made in consolidating previously fragmented sources of government health financing into one program—the PMG. By end-2020, 68 percent of total government health spending had been consolidated within the PMG. Subnational governments (SNGs) still play an important role in financing, however, as they are responsible for financing the utility costs of the communal health facilities that they own and may also provide supplemental resources for current and capital costs. As resources—and willingness to use them for health care—vary across localities, SNG financing is also a source of inequity. To reduce it, the government could consider including facility utility costs in the PMG. In addition, the funding of quaternary health facilities could be integrated into the PMG.

The PMG has the potential to reduce “catastrophic” out-of-pocket spending on health, but refinement of the benefit package and additional resources to deliver it are needed. Catastrophic health spending—which occurs when a household devotes more than 10 percent of its consumption to health care—is usually associated with the use of inpatient care. Since 2020, inpatient care has been included in the PMG, which, in principle, means that it is provided free of

charge at contracted facilities. However, the political and technical process for the design, expansion, budgeting, and approval of the PMG benefit package is too broadly defined and not fully transparent. As a result, the PMG cannot realistically be delivered within current budget constraints. In 2021, for example, the Ministry of Health (MoH) and the NHSU requested three times more financing than what was eventually allocated to the PMG.

Because the benefit package that is guaranteed to the population is not yet fully funded, services are rationed at the point of care (or paid for informally). Of the six options for expanding financing for the PMG discussed in the report—increasing taxes, reprioritizing government spending toward health, reprioritizing spending within the health sector, increasing the efficiency of the health sector, pooling some local government spending with the PMG, and introducing cost-sharing—the one that has the greatest potential is reforms that enhance the efficiency of the health sector. Efficiency-enhancing reforms include reducing the excessive reliance on costly hospital care, strengthening primary health care (PHC), and shifting to payment approaches that better incentivize the effective use of resources.

In 2020, the PMG was expanded to include 31 packages of services, including 4 new packages designed to provide COVID-19-specific care. New, specialized care packages included care provided by hospitals (inpatient and outpatient), clinical-diagnostic centers, specialized mono-profile outpatient clinics, and emergency medical services. In response to the COVID-19 pandemic, four packages—covering testing by mobile brigades, pre-hospital emergency care, hospitalization, and a COVID-related salary top-up—were added to the PMG in mid-2020. In 2021, a COVID-19 vaccination package was added. Although the scope and tariff of packages are more clearly defined than in 2020, some packages are still not as clearly defined as they need to be.

The purchasing of PHC, which is based on age-adjusted capitation payments to contracted providers, has proven to be effective and sustainable. It continues to evolve. Enrollment with contracted PHC providers has expanded to cover over 70 percent of the population. The participation of private providers has also increased; they now account for almost a third of the 1,696 providers of PHC in Ukraine. Digital technologies have been exploited to introduce e-referrals for patients requiring nonemergency specialized care, and e-prescriptions are used within the Affordable Medicines Program (AMP). In 2021, additional services (covering tuberculosis, mental health, and COVID-19 vaccination) were added to the PHC package, and performance-based payments for select quality indicators were introduced. The AMP, which is now integrated into the PMG and administered by the NHSU, gives 2.8 million Ukrainians access to medicines with no or a small copayment (through direct reimbursement of contracted pharmacies within the PMG). There is room to expand the types of medicines included in the AMP, but the first priority should be to address the geographic inequities in access caused by the small number of participating pharmacies in some localities.

The introduction of new payment approaches for inpatient care has generated a wealth of experience on which Ukraine should continue to build. Like PHC providers, providers of hospital care are now contracted, which means that funding is available only to facilities that meet contractual requirements (staffing, equipment, infrastructure, and willingness to provide care according to the protocols defined for each package within the PMG). Global budget financing (linked to performance indicators, morbidity, and capacity of providers) was

used to purchase 81 percent of the specialized care in the PMG in 2020 (67 percent of the total PMG budget). Fee-for-service is used for select diagnostic and treatment procedures. Since March 2020, case-based payments (specifically diagnosis-related groups [DRGs]) have been used to pay for four types of care: strokes, myocardial infarction, childbirth, and complex neonatal care. These payments accounted for 8.1 percent of PMG financing in 2020. Case-based payments were intended to be introduced for all inpatient care in March 2020, but under the pressures and uncertainties of the COVID-19 pandemic, full implementation was postponed; implementation commenced in April 2021. Before it was implemented, hospitals reported cases to the NHSU using DRGs, an important building block for DRG implementation.

The governance arrangements of the PMG need strengthening. Five aspects of governance—autonomy of the purchasing agency, clarity in roles and methodologies, effective interagency coordination, external accountability, and internal control—are essential. The roles and processes of all agencies involved in implementing the PMG, at both the national level (the MoH, the NHSU, the Ministry of Finance [MoF], and the Cabinet of Ministers [CabMin]) and the regional level (the NHSU subnational offices, subnational administrations, and hospital district councils) need to be better defined if all agencies are to function and cooperate effectively. In addition, it is important that the recent transformation of health facilities into autonomous enterprises be supported with additional regulations to improve their internal governance and external accountability. A prerequisite for better governance is adequate capacity of the MoH and the NHSU, as well as the agencies to which they are accountable, in terms of personnel, information technology (IT), and other resources.

Concurrent developments in the health sector have bolstered implementation of the PMG. The “hub hospitals” that will form part of the Capable Network,¹ where service delivery reforms will be concentrated, have been identified, laying the foundation for greater efficiency in service delivery. The e-health system has become more sophisticated and now includes electronic health records and referrals, creating potential for better coordination of patient pathways. A stronger e-health and claims reporting system would also enable the NHSU to better understand provider and patient behaviors and monitor records for potential fraud. The continued complementarity of health financing reform and other sectoral policies will be important as Ukraine develops its new long-term strategic vision for universal health care. A clearly defined service delivery model and benefit package is needed that is responsive to people’s needs, with financing and purchasing arrangements to support this vision.

This report makes recommendations in three areas, which can be summarized as follows:

1. Improving the Funding of the PMG Benefit Package

- Clarify the political and technical process for the design, expansion, and approval of the PMG benefit package to make it explicit, more transparent, and participatory.
- Increase public spending on health in line with economic growth and increases in general government spending, in order to realize the coverage and financial protection goals of the PMG.
- Ensure full commitment to current tax reform roadmaps, in particular the tobacco tax roadmap, which envisions a gradual increase in line with the EU–Ukraine Association Agreement.

- Increase spending efficiency by accelerating hospital right-sizing and network rationalization, gradually introducing case-rate payments, and strengthening and better integrating PHC.
- Consider shifting financing responsibilities for utilities from SNGs to the PMG budget in order to reduce inefficiencies, help “money-follow-the-patient,” and reduce inequities across providers.
- Prepare a long-term health financing strategy that includes a vision for expanding the PMG program and its financing, as well as complementary policies, over a 10-year period

2. Improving the Purchasing of PMG Services

Primary Health Care

- Articulate and approve a long-term strategic vision for PHC, with a clearly defined service delivery model that is responsive to people’s needs and purchasing arrangements to support it
- Introduce and mandate the use of standardized clinical protocols within the PMG at the PHC level, starting with priority conditions (such as major non-communicable diseases).
- Accelerate the use of digital technologies in health care delivery across a broad range of functions, from further development of the e-health architecture to implementation of telemedicine.
- Introduce a performance monitoring framework for PHC to measure performance across facilities and within facilities over time, in order to improve accountability for the delivery of quality care.

The Affordable Medicines Program

- Update the Essential Medicines List (EML), on which the AMP draws, to ensure that the medicines included are aligned with modern clinical guidelines and cost-effective.
- Assess the trade-offs between including more conditions and medicines in the AMP and ensuring sufficient funding for less costly and cost-effective medicines (with the latter as priority).
- Encourage the expansion of AMP-contracted pharmacies in underserved regions and underserved areas within each region, to help reduce geographic imbalances.
- Explore the potential for the NHSU to monitor prescribing behavior, using the e-prescription and e-health system, not only to detect fraud but also to improve the clinical appropriateness of care.

Specialized Outpatient, Pre-Hospital Emergency, and Hospital Care

- Define more explicitly the PMG packages and further unbundle the 131 Ukrainian Diagnosis-Related Groups (UDRGs) used to pay for them, in order to increase clinical and cost homogeneity, thus reducing the financial risk to providers.
- Lay out a clear transition pathway toward DRG payments that provides facilities time to adjust and gives protection against excessive financial risk.
- Replace annual and selective contracting (in which providers choose which packages they deliver) with multiyear, comprehensive contracts in order to guarantee equitable access to all PMG services.

- Review the Capable Network Plan to ensure a more transparent hospital selection methodology in which inclusion criteria are aligned with policy principles.
- Continue to strengthen the use of NHSU data for decision making, not only for claims review and fraud detection but also for policy development.

3. Improving the Governance of PMG Services

- Create a CabMin committee to facilitate coordination and consensus across the MoF, the MoH, the NHSU, and other ministries on PMG scope, budget, and tariffs.
- As part of broader public sector governance reform toward performance-based monitoring, consider piloting a mechanism for results-reporting to the CabMin on NHSU performance.
- Develop an NHSU organizational strategy, aligned with the health financing strategy, with performance objectives and indicators.
- Establish a small permanent unit in the MoH with technical expertise in health financing policy, to enable the MoH to better perform its stewardship and governance roles with respect to the NHSU.
- Further specify the role and procedures of the Public Control Council (PCC) with respect to NHSU governance, including the information and reports the NHSU should provide to the PCC.

CHAPTER 1: INTRODUCTION

In 2015, the government of Ukraine initiated fundamental reform of its health system, with the goals of improving the health outcomes of the population and providing financial protection from excessive out-of-pocket healthcare payments. The reforms were to be implemented by modernizing and integrating the service delivery system, introducing changes to provider payment arrangements that incentivize efficiency, and improving the quality of care. They culminated in the passage of a new health financing law—the Law on Financial Guarantees for Health Care Services 2017—which established a health benefit package called the Program of Medical Guarantees (PMG) and created the National Health Services of Ukraine (NHSU) to serve as strategic purchaser for this program. The vision was that the PMG would expand over time to eventually cover all types of care and that financing would evolve from input-based to output-based modalities to better align the provision of care with patient need.

In 2019, the World Health Organization (WHO) and the World Bank published a review of the reforms. It took stock of reform progress since 2017, highlighting achievements, identifying challenges, and providing recommendations on how to overcome them. The report examined five areas: governance; financing (fiscal space, revenue collection, pooling arrangements); strategic purchasing of primary health care (PHC); preparation for strategic purchasing at the hospital level; and the design of the benefit package.

Two years later, implementation of the health financing reforms has progressed substantially, and it is time to again review where things stand and what the future directions should be. There have been many important

accomplishments over the last two years, in terms of both institutional reform and expansion of access to care. Primary care enrollment has increased to include more than 70 percent of the population. The Affordable Medicines Program (AMP) has been integrated into the PMG and is now administered by the NHSU; some 2.8 million Ukrainians have already accessed medicines through it. In mid-2021, the government expanded the scope of the PMG to include specialized and emergency care, tuberculosis (TB) and mental health care, and COVID vaccination. Reform of the hospital payment system has also been initiated and reporting of hospital cases by diagnosis-related group (DRG) in preparation for payment by DRGs has begun. The e-health system has become more sophisticated and now includes electronic health records and referrals. The “hub hospitals” that will form part of the Capable Network, where service delivery reforms will be concentrated, have been identified.

The COVID-19 pandemic precipitated adjustments to existing health financing levels and arrangements. These adjustments included the introduction of new services packages for treatment, testing, COVID-related emergency care, and vaccination, as well as short-term salary top-ups for staff working at facilities designated for COVID-19 care. The pandemic also delayed implementation of some aspects of the health financing reforms, such as the anticipated transition to case-based payments.

This report provides a comprehensive description and assessment of the development and implementation of policies associated with the PMG reform from the start of the reform in 2017 through mid-2021. It examines (a) how the PMG is financed (levels, trends, budgetary processes, and options for increasing its financing); (b) the governance arrangements of the PMG; and (iii) strategic purchasing of the different components of the PMG benefit package (PHC, medicines, and specialized [emergency, inpatient, and outpatient] care). It positions these developments within broader contextual discussions of the financing and organization of health care in Ukraine, in order to make the key features of the financing reforms and their importance accessible to domestic and international audiences. Adjustment by the health sector to cope with the COVID-19 pandemic is a common thread. Each section concludes with a set of recommendations.

CHAPTER 2: FUNDING THE PMG BENEFIT PACKAGE

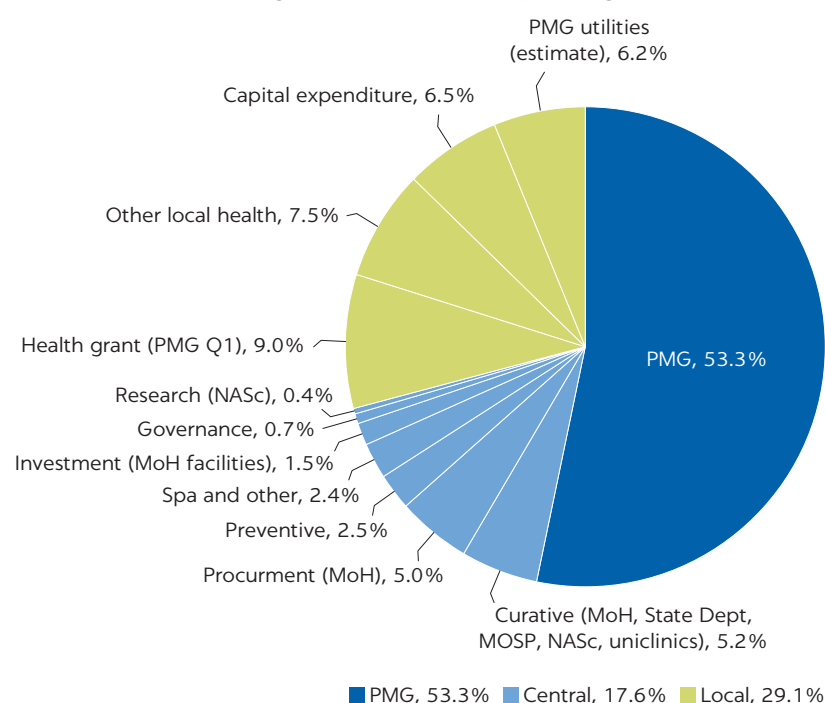
The 2017 health reform pooled most of government health care spending into a single central program—the PMG, which is administered by the NHSU and is provided free of charge to the population through contracted health facilities. The PMG transformed the previous vague constitutional commitment to free health care for all into an entitlement to a defined package of health services. It reduced the fragmentation of health financing and shifted responsibility for government spending from hundreds of subnational governments (SNGs), which were previously responsible for most operational costs, to the national government. SNGs retain responsibility for the utility costs of local health facilities. They also have the option to supplement the operational budget of their facilities. This option provides facilities with a buffer against potential revenue shortfalls, but it weakens the incentive for them to become more efficient, contributing to horizontal inequities in health care financing.

PMG funding: levels, trends, and budgetary process

By the end of 2020, the PMG accounted for 68 percent of consolidated government health spending. About 53 percent of total spending was pooled in the PMG and financed by the central government; 9 percent was paid by SNGs to cover specialized and emergency care services during the first quarter of 2020 before these services were included in the PMG; 6 percent was spent by SNGs on capital investments; and 6 percent was spent by SNGs to cover the utility costs associated with the PMG (figure O.1). The PMG will grow further as more specialized curative services are absorbed into it, leaving mainly preventive, administrative, and research activities funded by the central and subnational governments.²

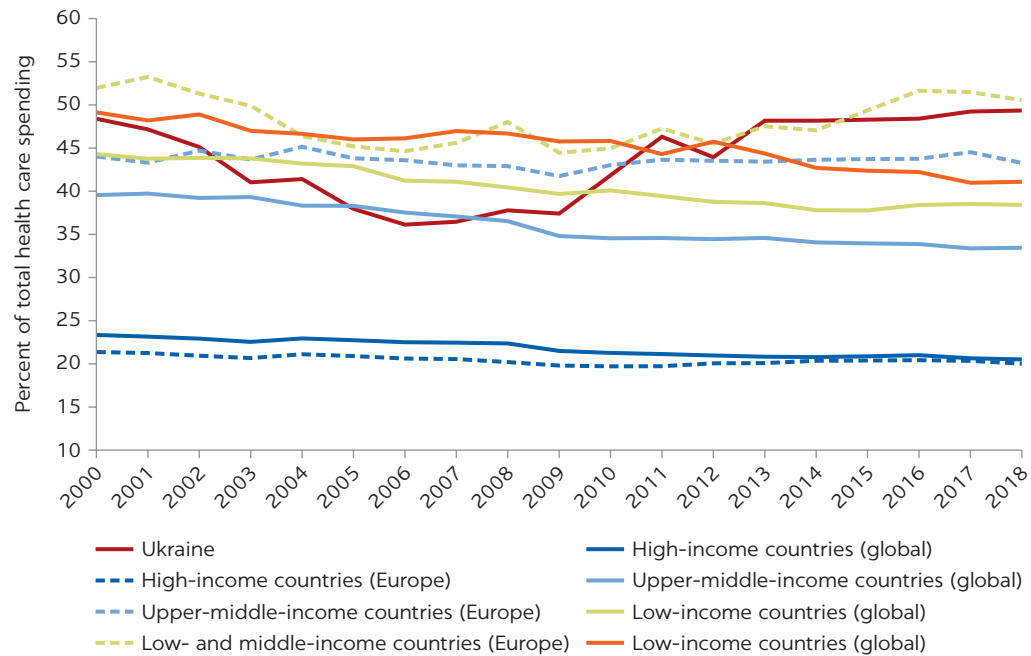
The PMG was introduced in order to ensure equitable access to care and provide financial protection from the costs associated with seeking care, which have historically been high in Ukraine. Ukrainians face high out-of-pocket (OOP) spending on health, which increased from 38.0 percent of total health spending in 2005 to 49.3 percent in 2018. This share is much larger than the average for other lower-middle-income countries (38.4 percent), although it is similar to the average for lower-middle-income countries in the European region (50.6 percent) (figure O.2).³ With the roll-out of the PMG to specialized curative care (mainly hospitals) in April 2020, it is still too early to assess its full effect on OOP. However, as most OOP is spent on medicines and medical goods (74.9 percent in 2018, according to the Ukraine National Health Accounts, prepared by the State Statistical Services of Ukraine), the 2020 expansion of the PMG is unlikely to have a significant impact on aggregate OOP spending, except to the extent that pharmaceuticals are included in the inpatient curative care packages or can be purchased at pharmacies through the AMP.

FIGURE O.1
Planned consolidated government health spending, 2020



Source: State Treasury Service of Ukraine.
Note: MOSP = Ministry of Social Policy; NASc = National Academy of Sciences.

FIGURE O.2

Out-of-pocket spending as share of total current health spending in Ukraine and selected country groups, 2000–18

Source: State Statistics Service of Ukraine (for Ukraine); World Development Indicators database; and Global Health Expenditure Database.

Note: Regional averages are population-weighted.

The PMG could help reduce the incidence of catastrophic health care spending, which tends to be associated with unpredictable and extended use of inpatient care. The incidence of catastrophic spending in Ukraine rose over the last decade. Between 2010 and 2019, the share of the population spending more than 10 percent of its total consumption on health care grew from 6.9 percent to 7.8 percent, and the share of households whose health care spending exceeded WHO Europe’s “capacity to pay” threshold increased from 11.5 percent to 16.7 percent.⁴ Catastrophic spending is heavily concentrated in the bottom consumption quintile. The PMG can also potentially address the large unmet need for health care, which has grown by a factor of 1.4 since 2009, to affect an average of 24.5 percent of households in 2017 and 2018, according to the State Statistics Service of Ukraine’s Household Living Conditions Surveys.

In recent years, the political and technical processes for determining, updating, and budgeting the PMG have been marked by increasing discretion and decreasing transparency. In 2020, the Law on Financial Guarantees for Health Care Services 2017 was revised such that the PMG benefit package specification (including service pricing) is no longer voted on by the parliament (*Verkhona Rada*) and approved as part of the annual Budget Law but is instead approved at the discretion of the Cabinet of Ministers (CabMin). The rules for the technical development of the PMG are very broad and the methodology of the Ministry of Health (MoH) for defining and updating the National Health Priorities on which the PMG is based is not made public, giving the MoH wide discretion in defining the scope of the PMG and preventing scrutiny of its decisions. In particular, PMG costing and pricing processes lack clear and transparent methodologies.

A compounding challenge is the government-wide medium-term budgeting process. This process was introduced in 2018 but suspended in 2020. As result, the CabMin did not approve the planned three-year horizon for PMG development. It could be argued that this decision was an appropriate pandemic response, providing the government with flexibility in a rapidly changing environment. But it also created uncertainty about the future of PMG package development.

For the 2021 budget, the MoH and the NHSU requested funding equivalent to 6 percent of Gross Domestic Product (GDP), almost three times as much as was budgeted for the PMG in the 2020 amended budget. Although not a realistic budget expectation, this request was indicative of the intention to continue to implement the shift from supply-side to demand-side financing that “follows the patient” and provides an increasingly more generous benefit package over time. In the approved 2021 budget, NHSU expenditures on the PMG were approved at a level that represents a 2.3 percent increase over the amount approved in 2020.

Options for increasing the funding allocated to the PMG

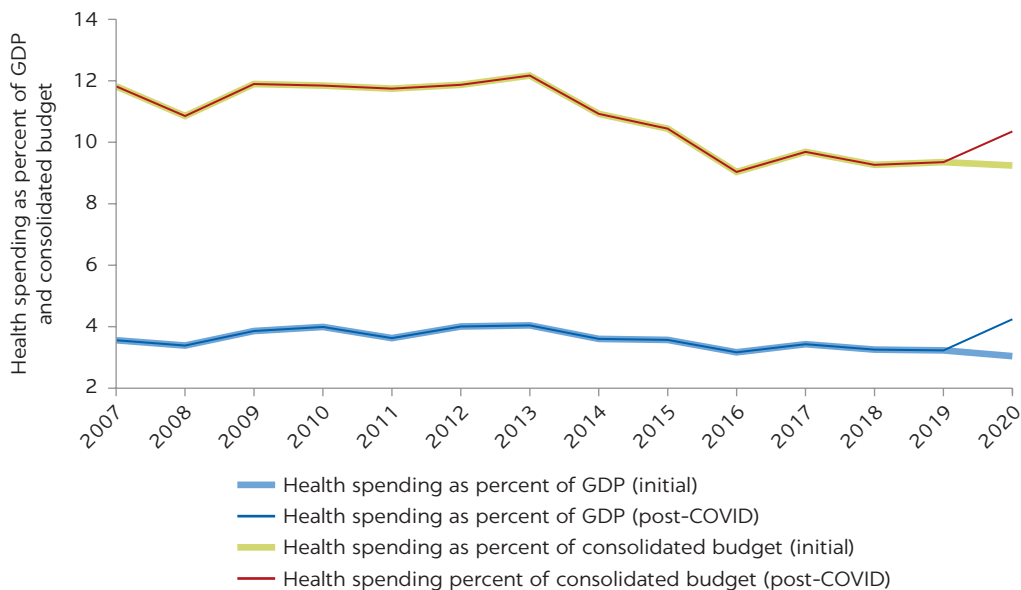
It is vital that the annual budget allocations to the PMG be sufficient to cover the provision of services included by law in the PMG benefit package; if they are not, service rationing will be necessary, undermining the guarantee to care provided by the government to the Ukrainian people. Six options could be considered for finding the resources to expand the PMG, as envisaged as part of the reform process. Not all of them are likely to be equally effective in terms of revenue generation prospects, and some (such as cost-sharing) may entail risks for health sector goals of access and financial protection.

1. *Expanding the fiscal envelope through higher growth and increased tax revenues.* Stronger growth and higher revenues could be a potential source of additional resources for the health sector. Prospects for this option appear limited, however. In the past, procyclical fiscal policies in Ukraine led to the accumulation of large macroeconomic imbalances, requiring a debt restructuring in 2015. Following a sustained period of fiscal consolidation, the fiscal deficit increased to 6 percent of GDP in 2020, in large part because of COVID-related outlays, including for medical procurement, higher wages to health workers, and pension top-ups. Fiscal financing needs are estimated at 16 percent of GDP in 2021 (up from 15 percent in 2020), partly because large debt repayments on past borrowing are coming due. Ukraine’s external public debt service burden is expected to average about US\$10 billion a year during 2020–25, up from less than US\$6 billion a year over 2015–19.⁵ Medium-term spending pressures, related to large minimum wage increases and pension spending, are also increasing. Fiscal contingent liabilities are large, particularly in the energy sector, and will eventually have to be recognized. In addition, new sources of fiscal risk have emerged, related to GDP-linked guarantees that may potentially lead to large fiscal costs and exceed the initial debt write-off when certain growth thresholds are exceeded. There is some scope for additional revenue mobilization measures—through better tax and customs collection or pro-health taxes on sugar and tobacco, for example. However, Ukraine already collects significantly more taxes than its regional peers, with total tax collection averaging 35 percent of GDP over the last five years,

compared with a 22 percent regional average. This rate of tax collection is higher than the average for upper-middle-income countries and some high-income countries in the region. Together, these factors point to constrained fiscal space in the medium term. They will require strong control over expenditure pressures and fiscal deficits to keep Ukraine on a sustainable macro-fiscal path.

2. *Reprioritizing across sectors within the existing fiscal envelope.* Within a constrained fiscal envelope, another opportunity for finding resources to expand the PMG would be to reprioritize government spending toward health. Since 2014, the share of health in the government budget has been falling. After remaining at about 12 percent between 2007 and 2013, it fell to 9 percent in 2016, remaining there through 2020. Combined with the reduction in general government spending, the decline meant that health expenditure decreased to 3.2 percent of GDP in 2016 and remained at about 3 percent in subsequent years, including in the initial 2020 budget allocation (figure O.3). The 2020 COVID-19 budget amendments increased the share of the government budget allocated to health to 10.4 percent (4.2 percent of GDP)—the largest share since 2007. On top of this, the 2021 budget plan⁶ increased central spending on health, including transfers to local governments, to 12.1 percent of total government spending (3.6 percent of GDP).⁷ Comparisons with countries in the Organisation for Economic Co-operation and Development (OECD) and European Union (EU) suggest that there may still be room to increase the share of government budget going to health, as the health spending share in Ukraine as of early 2020 was only about 40 percent the 2019 OECD average (partly because Ukraine allocates a much larger budgetary share to internal security, social protection, and education than the OECD average). The health spending share in Ukraine is relatively high for countries at a similar level of income globally, however (8.9 percent in Ukraine compared with an average of 5.0 percent for all lower-middle-income countries), and it is in line with

FIGURE O.3
Health spending in Ukraine as a share of total spending and GDP, 2007–20



Source: State Treasury Service of Ukraine; State Statistics Service of Ukraine.

lower-middle-income countries in the European region (9.3 percent). The way to determine whether there is room to further prioritize health in the government budget would be to conduct a whole-of-government spending review that identifies spending needs across functions, detects inefficiencies, and evaluates possibilities for resource allocation, taking into consideration the medium-term macro-fiscal outlook.

3. *Reprioritizing within the health sector.* The health sector needs to decide what priority to give to the PMG versus other health programs. It is highly unlikely that other health programs can be substantially cut back without adverse consequences for population health. Therefore, expanding the PMG beyond the current 68 percent of consolidated health budget spent on the services it covers, including utility and capital costs paid by the SNGs and not pooled within the NHSU, does not seem possible. However, it is possible that detailed sectoral spending reviews could identify potential savings within the health budget that could free up resources for other areas of health spending, such as the PMG. The MoH should therefore regularly conduct such reviews. Looking ahead, there is likely to be an apparent increase in the PMG's share of the consolidated health spending, as a further 5 percent of the health budget currently spent on highly specialized (quaternary) curative services is intended to be migrated to the PMG at some point as part of the envisioned reform. This change will merely reclassify some expenditures, though; it will not increase the PMG budget.
4. *Introducing sectoral reforms that enable more efficient use of the existing PMG budget.* Ukraine can achieve significantly better health outcomes by removing inefficiencies in the way the government spends the PMG budget. These inefficiencies are not related to the PMG itself but to broader health sector policies on the organization of the health services the PMG funds. This issue is discussed in detail in the section on Purchasing PMG Services and chapter 3. One such inefficiency is the excessive reliance on costly hospital care and the resulting problem of redundant and inefficient hospital networks. For example, there is scope for efficiency gains in reforming rural hospitals and obstetric care, where low occupancy has not yet triggered the needed reorganization, and in inpatient TB care, which accommodates patients well beyond the intensive care period, including inactive TB. Hospitals in Ukraine are also very poorly equipped, and doctors perform fewer services and procedures than they do in comparator countries. The share of auxiliary personnel is larger in Ukraine than in EU countries, and no task-shifting strategy is in place to optimize workloads. Ukraine could also increase value-for-money in the PMG by further strengthening the role of PHC and effectively integrating care levels to prevent noncommunicable diseases and treat them earlier. Moving ahead with the provider payment reforms, including the introduction of case rates for specialized care, would enhance the efficiency of the hospital system by providing a financial incentive to provide care at the most appropriate level and in the most cost-effective way (by, for example, reducing unnecessary admissions, shortening length of stay, and shifting care to the most appropriate level).
5. *Shifting spending from local governments to pooled spending through the NHSU.* Shifting the cost of utilities, which SNGs currently bear, to the central health budget would reduce some of the inefficiencies of the current arrangement, including the lack of managerial flexibility at the facility level in the use of the budget arising from line-item budgeting for utilities and complications

in the costing of case rates when some components of the cost of care are paid from the PMG and others by SNGs. Shifting these costs would also address the uneven playing field for private providers who cover their own utility costs and public providers that vary in the extent of support they receive from their SNGs for utility costs. This measure would not expand the financing envelope available for PMG services; it would merely shift financing responsibility from local governments and private providers to the national government.

6. *Introducing patient cost-sharing.* The government is considering introducing copayments for services covered by the PMG and supplementary payments for noncovered services in order to permit an expanded range of services and choice of amenities for people who can afford to pay more. Cost-sharing entails considerable risk of adverse consequences: it could increase Ukraine's already heavy reliance on OOPs through formal and informal payments, significantly increase administrative costs, and weaken strategic purchasing if not strictly regulated. It is not realistic to expect that the introduction of cost-sharing will permit the PMG to expand the range of services it covers without undermining the PMG's objective of ensuring equitable access to services. If cost-sharing is introduced it should be in the form of small, flat copayments that are subject to annual caps and be limited to selected services (excluding preventive care, in order to promote its utilization); poor households should be exempt from all copayments; and percentage copayments should be avoided. The design of any copayment policy should be as simple as possible, to ensure that people can easily navigate the health system and do not face administrative barriers to benefiting from protective measures. In addition to copayments for covered services, the government is considering allowing supplementary payments as a means of encouraging private providers to supply PMG services. If implemented, supplementary payments should be limited to aspects of service delivery that are not directly associated with the clinical quality of care, such as a single room in a hospital ("extra billing"). Health care providers should not be allowed to ask patients to pay a supplement in addition to copayments for covered services (also called "balance billing"). Implementation of copayments for covered services and supplementary payments for noncovered services requires careful regulation and active monitoring to avoid creating inequities (including potential discrimination against people who are exempt from copayments or do not make supplementary payments). If introduced, they will need to be accompanied by measures to reduce these risks.

Table O.1 summarizes the prospects for revenue-raising through the six options.

Recommendations for improving the funding of the PMG benefit package

The analysis leads to the following recommendations:

- Clarify the political and technical process for the design, expansion, and approval of the PMG benefit package to make it explicit, more transparent, and participatory.
- Increase public spending on health in line with economic growth and increases in general government spending while also ensuring that in times of

TABLE O.1 Prospects for increasing the resources allocated to fund the PMG

| OPTION | PROSPECTS | JUSTIFICATION FOR RATING |
|---|-----------|--|
| 1. Expanding the fiscal envelope through economic growth and revenue collection | Low | Growth is low and the scope for introducing new taxes limited. |
| 2. Reprioritizing spending across sectors within the existing fiscal envelope | Medium | COVID-related adjustments aside, the health share of government spending and GDP is historically low. It is also low by OECD standards, although it is similar to spending in many middle-income countries in Europe and globally. |
| 3. Reprioritizing spending within the health sector | Low | Cutting back funding on other health programs could have a detrimental effect on population health. |
| 4. Introducing sectoral reforms that enable the existing PMG budget to be used more efficiently | High | Broader health sector policies on the organization and financing of services that are included in the PMG do not sufficiently incentivize efficient service delivery. |
| 5. Shifting spending on components of cost of care from local governments to pooled spending through the NHSU | Low | Shifting spending would not increase fiscal resources, but it could contribute to greater equity in financing. |
| 6. Increasing the patient's share of spending | Low | Once exemptions for poor people and priority services are in place, copayments would be small and potentially inequitable and inefficient. |

Source: Original compilation.

economic contraction the current levels of public spending on health are protected in real per capita terms, in order to realize the coverage and financial protection goals to which the government committed when it passed the Law on the Program of Medical Guarantees.

- Ensure full commitment to current tax reform roadmaps, in particular the tobacco tax roadmap, which envisions a gradual increase in tobacco rates, in line with the EU–Ukraine Association Agreement, as well as broader revenue administration reform.
- Increase spending efficiency by accelerating hospital right-sizing and network rationalization, gradually introducing case-rate payments for inpatient care, and crafting a clear strategy for strengthening the role of PHC and integrated service provision.
- Consider shifting financing responsibilities for utilities from SNGs to the central budget—to be paid by the NHSU via the PMG budget to facilities—in order to reduce inefficiencies, strengthen the principle of “money-follows-the-patient,” and help level the playing field across providers.
- Prepare a long-term health financing strategy that can be politically endorsed and would include a vision for expanding the PMG program and financing it over a 10-year period; complementary plans for associated programs, such as the gradual expansion of the AMP to replace OOP spending on medicines; and policies such as stronger regulations to prevent over-prescribing and improve health care quality.

CHAPTER 3: PURCHASING THE PMG BENEFIT PACKAGE

The NHSU purchases PMG services through service packages defined annually but adjusted throughout the year. In 2020, the PMG expanded from covering only PHC services to covering all types of care, including hospital and specialized outpatient care. It included 29 specialized care packages, 4 of which were developed in response to the COVID-19 pandemic, in addition to

the PHC package and the AMP, for a total of 31 packages (figure O.4). As of May 2021, there were 35 packages, but further changes were implemented in June, including the absorption of COVID-19-specific packages into other packages. Some PMG packages are very specifically defined (such as the packages for hemodialysis, colonoscopy, and acute stroke); others are very broadly defined (such as the single package for “all other types of secondary and tertiary outpatient care”).

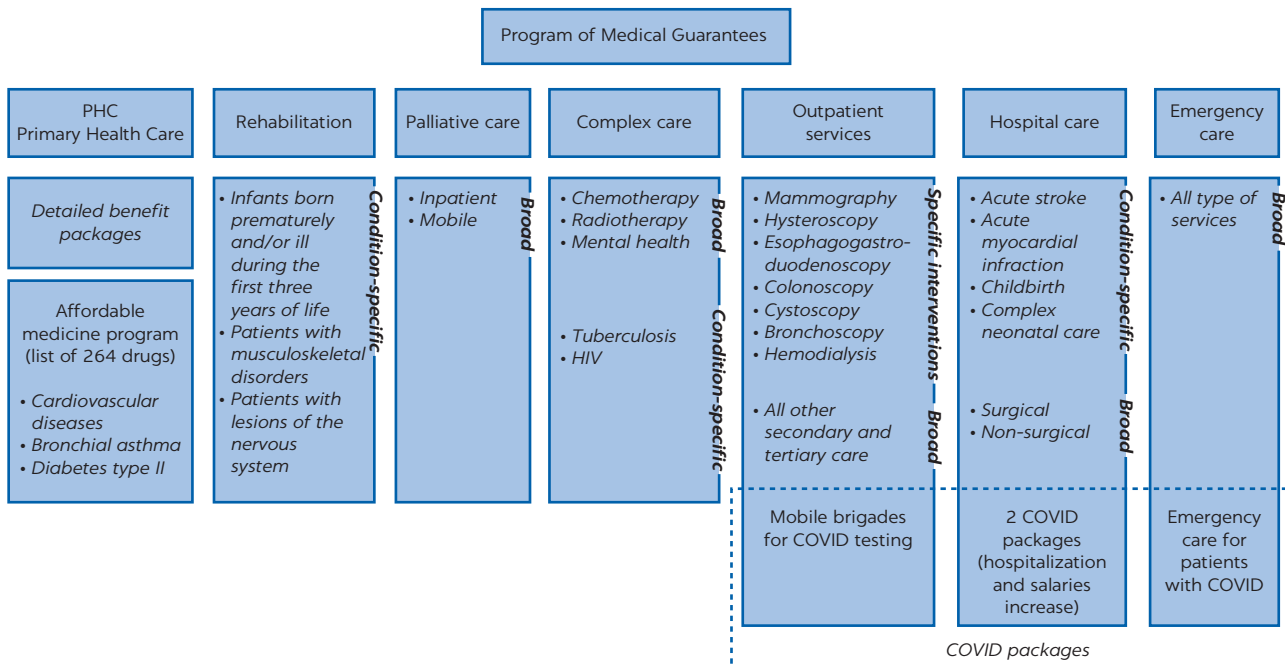
The NHSU purchases services from providers using contracts that include a range of service specifications related to service organization, equipment, and personnel. A provider can apply to provide any one of the service packages, a practice that risks potential inequity in geographical access to services, with overconcentration in some areas and gaps in others. As contracting is not subject to a masterplan for a network of services, strategic purchasing through the NHSU can improve efficiency at the level of the individual provider but cannot make the provider network more efficient.

Services are purchased using different types of payment methods, including global budgets, case-based payments, fee-for-service for hospital care, and capitation for PHC. The parallel development of an e-health system, starting in 2018, has been a critical support to the purchasing function.

Primary health care

The scope and purchasing modalities for the PHC package have not changed substantially since the launch of the PHC reform in 2018, except for an upward adjustment of capitation rates in late 2020 to compensate for sample collection

FIGURE O.4
Service packages purchased under the PMG



Source: Original compilation.

for testing and teleconsultations related to COVID-19. PHC services included in the PMG are explicitly defined. The 17 service types include common diagnostics and treatments for acute and chronic conditions, preventive screening, vaccination, pregnancy and child health check-ups, and certain types of emergency and palliative care. By March 2021, the NHSU had contracted PMG services from 1,696 providers, 77 percent of which were PHC centers that consolidate multiple doctors and service delivery locations under one legal entity. Thirty-five percent of contracted PHC providers are privately owned. All residents of Ukraine who have actively enrolled with a PHC physician contracted by the NHSU are eligible to receive care, and patients can change their provider at any time. By end-March 2021, 31.2 million people—70.3 percent of the population—had enrolled with a PHC provider. Providers are paid based on a national capitation rate adjusted for age and terrain that includes a penalty for providers that exceed the recommended number of people enrolled. In November 2020, the base capitation rate was increased by 8.5 percent as a COVID-19 adjustment, and PHC facilities became responsible for collecting samples for COVID-19 testing (but not the testing of the sample itself), which had previously been a separate COVID-19 package delivered through mobile teams operating from specialized outpatient care departments or PHC centers. In 2021, PHC providers became eligible to apply to deliver the COVID-19 vaccination package, which could be a source of additional revenue for them. For patients, PHC services are free at the point of care, but patients might still make informal payments to providers.

PHC providers are beginning to play an important gatekeeping role in the Ukrainian health system. Patients wishing to access specialized care free of charge need a referral—provided electronically as an e-referral—from a PHC provider. To access medicines provided at pharmacies through the AMP, they need an e-prescription from a PHC provider. The NHSU monitors PHC providers for contractual compliance and potential fraud, but there is no monitoring of performance or quality, and clinical audits are not conducted. The NHSU intends to introduce contract conditionalities related to performance in 2021, focusing on preventive care, risk group screening, and access to outpatient medicines for target groups of patients with chronic conditions. Although there is a requirement that care should be compliant with clinical guidelines, Ukraine does not yet have a standardized set of clinical guidelines in place, and providers can follow clinical guidelines of their choice from other countries.

PHC delivery in Ukraine is increasingly embracing digital technology. Beyond e-referrals and e-prescriptions, the use of electronic medical records enables providers to access patient histories and track care provided. It also enables the NHSU to monitor providers and patients for potential fraud and to learn about patterns of behavior that could inform policy making. The law makes provision for telemedicine, and there have been several telemedicine pilots related to PHC provision. The COVID-19 pandemic accelerated the use of digital technologies for consultations, including via social media.

Starting in 2021, the MoH and the NHSU introduced a gradual expansion of the PHC services covered by the PMG. The expansion includes mental and behavioral disorders, additional laboratory tests, COVID-19 vaccination, and services related to the management of patients with chronic diseases and TB. In 2021, the NHSU will also introduce a pay-for-performance top-up to reward attainment of measles vaccination coverage goals, which may set a precedent for future pay-for-performance incentives. What is not yet in place is a clear and

comprehensive vision for the expansion of PHC services and the changing role of PHC in the wider health system. The *White Paper on the Health Service Delivery Model in Ukraine*, drafted by the WHO and the MoH, has informed ongoing discussions on PHC and its relationship with hospital services but has not yet been formally adopted. The MoH is also drafting a *Concept of Primary Health Care Development in Ukraine to 2031*.

The affordable medicines program

The AMP—managed by the NSHU since 2019 and previously by SNGs through an earmarked grant from the central government—aims to provide affordable access to outpatient prescription medicines. It covers outpatient medicines for a few priority conditions—mainly cardiovascular diseases, bronchial asthma, and Type 2 diabetes—provided that a prescription is provided by a PHC provider and filled at an NHSU–contracted pharmacy. The NHSU reimburses contracted pharmacies directly for AMP prescriptions, using the e-prescription part of the e-health system.

The list of eligible medicines in the AMP is defined using international nonproprietary names (INNs) and then specified by brands through a call to companies whose medicines are included in the EML. The AMP currently includes 297 medicines, based on 27 INNs. To date, the selection of medicines for inclusion in the AMP, and the EML on which the AMP draws, has not been informed by a clear methodology or updated regularly. However, in December 2020, the CabMin approved the introduction of a Health Technology Assessment (HTA) for the purpose of EML updating (CabMin Resolution 1300), with the detailed regulations to be completed in 2021. The use of an HTA promises to improve the clinical appropriateness and efficiency of the AMP.

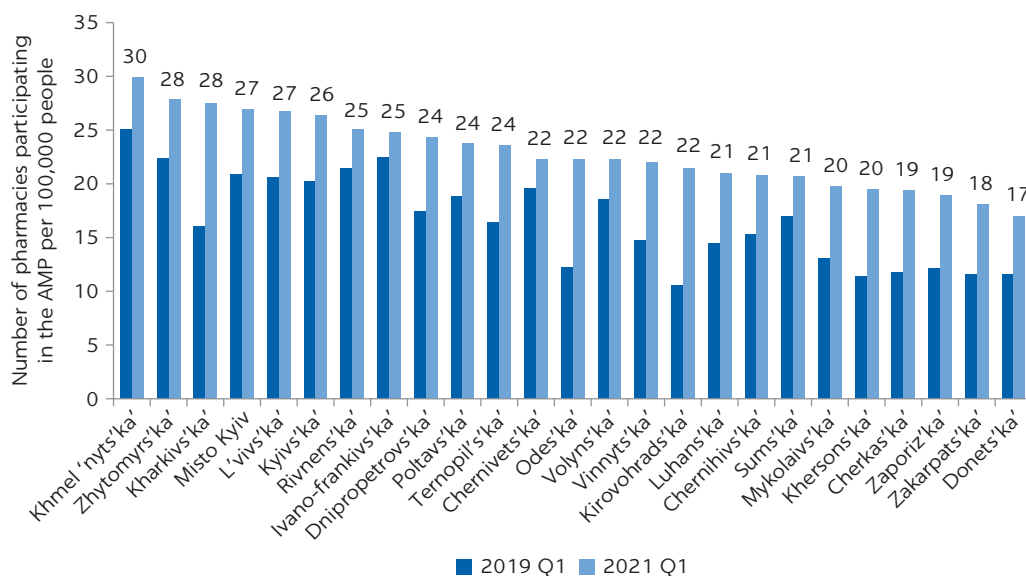
The MoH sets the reimbursement policy using a combination of international and domestic price referencing. Data from five Eastern European countries—the Czech Republic, Hungary, Latvia, Poland and Slovakia—are used to define a median reference price for each INN. Brand-name generics in the local market that are priced above the reference/international price are not reimbursed. For each reimbursed INN, the cheapest brand-name generic price in the local market becomes the reimbursement reference tariff. Brand-name generics in the local market that are priced below the reimbursement (international) price but above the reimbursement reference tariff (domestic) are reimbursed, but the patient has to pay the difference. Patients can thus obtain the cheapest generic free of charge. This approach to price-setting is considered good practice.

The number of pharmacies contracted and the number of patients covered by the AMP continues to grow. As of March 2021, 9,295 pharmacies or drug-dispensing points operating under 1,136 legal entities had participated in the AMP. National coverage increased from 16.1 to 22.9 pharmacies per 100,000 population between 2019 and 2021, and the number of patients who had used AMP benefits stood at 2.8 million as of March 2021.⁸ Equity in access remains a challenge: although all *oblasts* saw increases in the number of AMP–contracted pharmacies between 2019 and 2021, coverage across *oblasts* ranged from 17 to 30 pharmacies per 100,000 population (figure O.5).⁹

Another potential challenge to access is that a fixed monthly budget is set aside for the AMP at the national level, with the monthly spending limit defined based on trends in prescriptions by disease groups. Once that limit is reached,

FIGURE O.5

Number of pharmacies participating in the AMP per 100,000 people, by *oblast*, 2019 and 2021



Source: Data from the National Health Services of Ukraine.

prescriptions eligible for reimbursement are halted until the following month. In practice, this limit has not yet been exceeded.

In 2021, the AMP was expanded to include insulin (starting in July) and 10 additional INNs for mental and neurological disorders (starting in October).¹⁰ The first prescription needs to be provided by a specialist, such as an endocrinologist, psychiatrist, or neurologist; PHC physicians can then write prescriptions for refills.

Specialized outpatient, pre-hospital emergency, and hospital inpatient care

The PMG for specialized outpatient, pre-hospital emergency, and hospital inpatient care was introduced at a point when health care system was still highly hospital-centric. Despite a reduction in hospitalization rates since the hospital right-sizing initiatives of 2015, which brought hospitalization rates for curative care in Ukraine to levels similar to those in its EU13 neighbors, the average length of stay (ALOS) remains substantially higher for Ukraine (10.3 days) than its neighbors (6.6 days).¹¹ Ukraine also maintains a segregated system of general and disease-specific hospitals, which treat many patients who could potentially be treated on an outpatient basis. For example, 4.1 percent of hospital beds in Ukraine are used to treat TB patients, with an ALOS of 85.6 days in 2019, and a large network of psychiatric hospitals accounts for 11.4 percent of all hospital beds.

Specialized outpatient care is delivered by outpatient units in hospitals, clinical-diagnostic centers (reformed former polyclinics), specialized mono-profile outpatient clinics, and private solo practices. There is not yet sufficient coordination between PHC and specialized outpatient care or adequately comprehensive attempts to shift ambulatory-sensitive conditions out of the hospital setting, although some progress has been made on mental health. The new

e-referral system provides an opportunity to analyze the flow of different types of referrals and improve the right-sizing of care.

In early 2020, the government approved a list of 212 “hub hospitals” to constitute the network of providers—the “Capable Network”—to be developed in the future. The move represents an important step toward a more rational and efficient approach to investment in the hospital sector, but care needs to be taken to ensure that the list of hospitals is optimal. Still lacking is an approved formal strategy that lays out the vision for an integrated model of service delivery across all types of care, potentially building on the (draft) *White Paper on Health Service Delivery Model in Ukraine*.

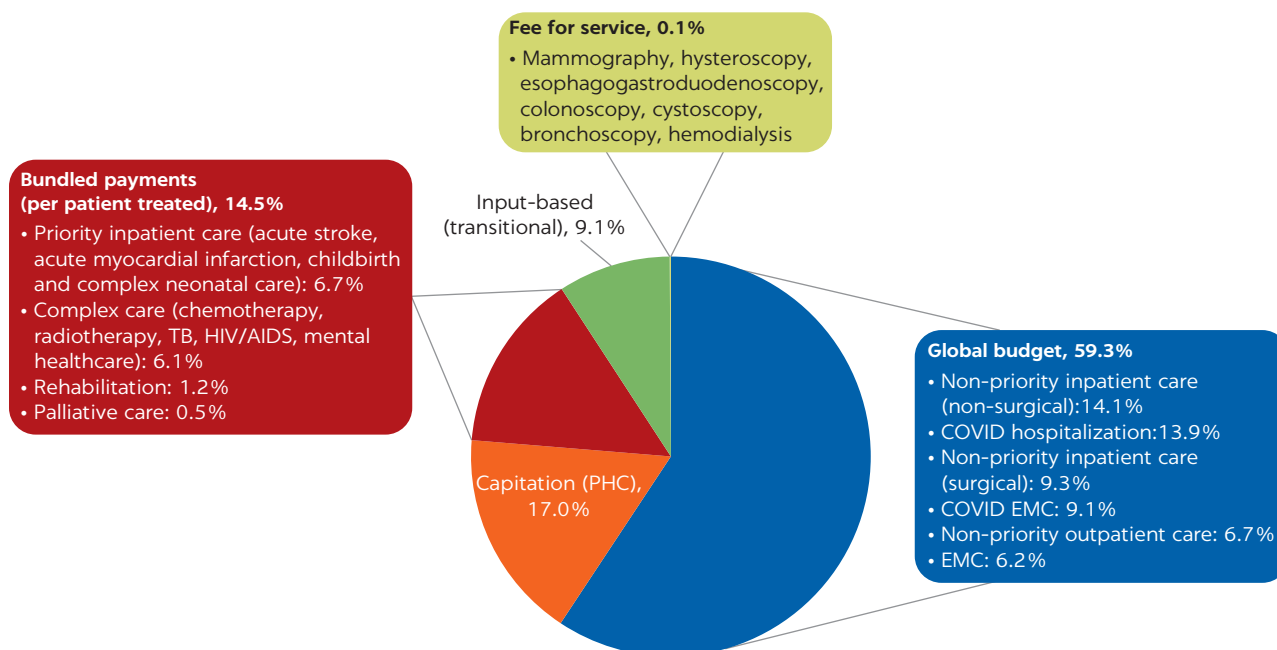
Specialized care services within the PMG are divided into service packages, each contracted separately with providers. As of 2020, there were 29 specialized care packages. They include four COVID-19 packages for testing by mobile brigades, pre-hospital emergency care, hospitalization, and a COVID-related salary top-up, which were added in response to the pandemic. Sixteen packages relate to medical conditions, such as acute stroke, childbirth, mental health, TB, HIV, and COVID-19; they cover a comprehensive set of services to treat them. Nine packages are defined as service inputs (colonoscopy, hemodialysis, radiotherapy), which can be used to treat a variety of conditions. Four packages are broad packages defined by the provider setting—inpatient surgical, inpatient nonsurgical, outpatient, and emergency care—to cover all care that does not fall into the other groups. All specialized care packages in the PMG except outpatient care explicitly cover medicines. In practice, many medicines are purchased out-of-pocket by inpatients. In 2020, a new referral requirement was adopted, to improve the integration of specialized care and primary care within the PMG. In order to receive specialized treatment free of charge, the patient requires an electronic referral from a primary care or other specialized care provider. Contracting is optional; providers can pick and choose which packages to apply. This system exacerbates existing inefficiencies, as providers apply only for packages that are most economically attractive. It also contributes to geographic inequities in access to care.

To be contracted by the NHSU, providers must meet a range of service delivery requirements. They include universal requirements, including those related to legal status, licensing, and e-health functionalities; package-specific requirements, related to facility characteristics, medical personnel, and equipment; and additional relevant licenses (for nuclear medicine or narcotics, for example). Services provided outside the contracted packages are not necessarily reported. Contracted facilities are required to be legally autonomous from the state, to create a purchaser-provider split, and to remove potential conflicts of interest. As part of the reform, hospitals may also open bank accounts at commercial banks rather than the Treasury. This new autonomy requires new governance and accountability arrangements, and new regulations are needed to strengthen it. Between April and December 2020, the NHSU contracted and made payments to 1,681 specialized providers, including 59 private facilities and 25 *oblast*-level emergency medical care centers for its specialized care packages.

In 2020, most of the specialized care in the PMG—81 percent of specialized care and 67 percent of the total PMG budget—was purchased using global budgets. These purchases included all emergency care, all surgical care, all nonsurgical hospital care not paid for using DRG-based payments, and select procedures that are by fee-for-service (figure O.6). For each PMG package contracted on a

FIGURE O.6

Provider payment arrangements for the PMG in the second and third quarters of 2020



Source: National Health Services of Ukraine dashboard.

Note: EMC = emergency medical care; PHC = primary health care.

global budget, the NHSU has defined a “base rate” per service unit, which is adjusted to account for variation in service costs. For example, the outpatient base rate is multiplied by 9.713 for surgical procedures and 0.186 for a dental care intervention and then multiplied by the number services that the contractor provided the previous year to obtain the global budget paid to each contracted facility. A global budget is also used for the new COVID-19 packages, because of the lack of predictability of case numbers.

Since April 2020, case-based payments have been used for four inpatient conditions: acute strokes (one case for all types), acute myocardial infarction, childbirth (one case for all types), and complex neonatal care. Bottom-up costing was used to ensure that these rates cover the full cost of care. Together, these four conditions account for 8.1 percent of all specialized care contracts. Fee-for-service payments are used for seven outpatient services, including endoscopy, mammography, and hemodialysis, to incentivize provision and investment in equipment for these services. Fee-for-service payments accounted for only 0.1 percent of specialized care in the PMG in 2020.

The MoH and the NHSU had intended to gradually introduce more DRG-based payments for hospitals, starting in May 2020; these efforts were postponed because of the COVID-19 pandemic. The original plan was to split hospital payment into a global budget and a case-based amount, with the case-based amount gradually increasing from 10 percent to 40 percent by July 2020. In parallel, providers would be required to start coding and reporting their cases using the Ukrainian DRGs (UDRGs), which are based on the Australian Refined DRGs (AR-DRGs) but aggregated into a larger number of groups (131, in addition to the 4 case-based payments).

The introduction of DRGs was initially postponed from May until June; in June it was postponed until October; in September it was cancelled for 2020. The decision was made for several reasons. First, the UDRG grouping of 131 categories was evaluated as excessively broad, leaving a high degree of cost heterogeneity within individual groups, thereby creating considerable financial risk for providers. Second, these financial risks would be exacerbated by the COVID-19 pandemic, which was expected to depress the use of essential services and, therefore, hospital revenues. Instead, payment for specialized care was based on the historical number of services provided, recalculated using the average tariff to determine the amount to be reimbursed. Thus, in 2020, the NHSU exclusively used global budgets and fee-for-service as the payment method for hospital care, with the exception of the four case-based packages mentioned above and some COVID-related top-ups described below. Although hospitals did not transition to DRG payments in 2020, hospitals started reporting cases using DRGs in June 2020.

In 2020, the government provided select hospitals with two forms of substantial additional financial support to offset potential losses associated with the health financing reform and COVID-19. In June 2020, the government introduced transitional lump-sum top-ups to ensure that providers do not bear excessive losses as a result of the payment reform, raising their budgets to at least 90 percent of the amount they had historically received through central government grants. These payments were made to 519 communal facilities and amounted to 1.6 percent of the 2020 PMG contract value of UAH 2.1 billion. In September 2020, the government provided additional subsidies to SNGs to increase the salaries of medical staff who treated COVID-19 cases, to compensate them for the additional workload and risk. In addition, starting in September 2020, salary increases of 30–70 percent over base salaries were provided to all medical personnel except those working in primary care via NHSU contracts.¹² These measures were extended through the end of the first quarter of 2021 and then discontinued in April 2021. Together, these two top-ups amounted to 9.1 percent of 2020 PMG spending.

Recommendations for improving the purchasing of PMG services

Primary health care

The PHC component of the health financing reform is well-designed and is being implemented effectively. Some actions that could further improve it include the following:

- Articulate and approve a long-term strategic vision for PHC, with a clearly defined service delivery model that is responsive to people’s needs, and align purchasing arrangements to support this vision.
- Introduce standardized clinical protocols and mandate them for use within the PMG at the PHC level, starting with priority conditions (such as major noncommunicable diseases). Doing so would not only help ensure clinical care quality, it would also guide providers on the most cost-effective care they can provide within their capitation budget.
- Accelerate the use of digital technologies in health care delivery, from further development of the e-health architecture to implementation of telemedicine, supported by a strategy and action plan that will ensure the appropriate investment, regulations, and skills.

- Introduce a performance monitoring framework for PHC to measure performance across and within facilities over time, and improve accountability for the delivery of quality care.

The affordable medicines program

The AMP is playing an important role in providing the population with free or low-cost medicines for conditions that affect a large share of the population and can be effectively managed. The following measures could improve its clinical appropriateness, cost-effectiveness, and equity:

- Update the EML, on which the AMP draws, to ensure that the medicines included are aligned with modern clinical guidelines and cost-effective. To ensure timely updates of the EML, finalize the regulations governing the new HTA process (which will be used to update the EML), per the schedule established by the December 2020 CabMin Resolution.
- Assess the trade-offs between including more conditions and medicines in the AMP and ensuring sufficient funding for less costly, cost-effective medicines that treat conditions that affect a large number of people (with the latter a priority). The HTA can also play a role in this effort.
- Ensure that as the AMP expands, it does so equitably across regions and socioeconomic areas within each region, in order to reduce geographic imbalances in population access to AMP-contracted pharmacies. The NHSU and the MoH could approach pharmacies in underserved areas for potential contracting.
- Explore the potential for the NHSU to play a role in monitoring prescribing behavior, through the e-prescription system and the recently strengthened e-health system. Doing so would enable the NHSU to identify potential fraud by providers or patients and improve the clinical quality of care, by assessing whether prescriptions are needed and suitable for the diagnosed condition.

Specialized outpatient, pre-hospital emergency, and hospital care

The specialized care component of the PMG is where most policy attention is needed—understandably, as contracting for these services began only last year, in the midst of the COVID-19 pandemic. Policy needs to ensure access to care and efficiency while managing the financial risk of patients and providers. Recommendations for improving this component include the following:

- Refine the grouping of PMG service packages and the UDRGs intended to pay for them by (a) unbundling the broadly defined packages—outpatient, inpatient surgical, inpatient nonsurgical, and emergency care packages—into more explicitly defined packages of care and specifying more clearly the remaining services in the four packages; (b) regrouping packages that represent inputs into other services (for example, chemotherapy and radiotherapy) as part of packages to treat specific conditions (such as breast cancer); and (c) further unbundling the UDRGs, as the original 131 groups are not clinically similar or cost-homogenous enough, leading to significant cost variation across cases and possible financial risk.
- Lay out a clear transition pathway toward DRG payments that provides facilities with protection against excessive financial risk and gives facilities time to adjust (to develop their coding capacities and adjusting clinical practice,

for example). Options include creating risk corridors, paying partially by DRG and partially by global budget, and providing feedback to providers on how to improve service delivery for greater efficiency and deal with unexpected threats, such as the COVID-19 pandemic.

- Replace selective contracting of providers, in which providers get to choose which packages they want to deliver, with comprehensive contracts that guarantee patients equitable access to all services packages in the PMG. Providers in the Capable Network should be required to provide all services appropriate to their level. Signing multiyear, rather than annual, contracts would give providers the incentive to invest in the inputs needed to provide new services.
- Review the Capable Network Plan to ensure a more transparent hospital selection methodology in which inclusion criteria are aligned with policy principles, such as ensuring sufficient service volumes, avoiding fragmentation, and ensuring equity of geographic access.
- Continue to strengthen use of NHSU data for decision making. These data can be used not only to identify miscoding, upcoding, and abuse by providers or patients but also to support policy decisions within the health sector on issues such as selection of hub hospitals for the Capable Network, the optimization of care pathways, the content of benefit packages, and the evaluation of the effects of provider payment reform.

CHAPTER 4: ESTABLISHING GOVERNANCE ARRANGEMENTS FOR THE PMG

The creation of a health service purchasing agency such as the NHSU, along with the introduction into the health system of the strategic purchasing function, requires changes in governance structures. The key functions of these governance structures should be to set the strategic direction for the purchasing agency and to hold it accountable for resource use and results. Five aspects of governance are essential: the autonomy of the purchasing agency, clarity in roles and methodologies, effective interagency coordination, external accountability, and internal control. Adequate capacity of all agencies involved in governance arrangements, especially the NHSU and the MoH, in terms of personnel and other resources is also critical. This chapter provides a detailed discussion of governance arrangements for the PMG.

The NHSU is autonomous in law, but to ensure that it can effectively function as an autonomous purchasing agency, the NHSU, the MoH, and the MoF all need to further adapt to their new institutional roles. The NHSU was established as a Central Executive Agency. This means that it has autonomy in technical and operational matters but not policy decisions, which the government makes. The MoH remains responsible for overall health sector policies. The MoF is responsible for fiscal policy, which affects the NHSU budget allocation; under the law, it also has a joint role, with the MoH, in approving major policy decisions that affect the NHSU's budget. This new arrangement somewhat modifies the traditional institutional roles of the MoH and the MoF, which need to transition to arms' length stewardship of the NHSU without getting involved in technical and operational matters. The NHSU needs to fully assume the role of an implementing agency that provides neutral technical advice and faithfully implements the political choices made by the government. As in other countries, agencies may

take time to adapt to their new roles. Frequent dialogue between the leadership of the three entities and strengthening of the capacity of their staff can accelerate adaptation.

For all entities to function and cooperate effectively under the new arrangement, their roles and related processes need to be better defined. The law defines the overall institutional architecture of the new system and the roles of the CabMin, the MoH, the MoF, and the NHSU in decision making related to the PMG, but regulatory gaps persist pertaining to the rules for defining and financing the PMG. In particular, there is no systematic methodology for establishing PMG priorities or designing the benefit package, weighing the cost and benefits of the services, or determining the contract specifications to be used by the NHSU. These processes need to be transparent, evidence-informed, and mindful of NHSU budget constraints. They also need to incorporate a medium-term perspective in planning and priority-setting, coordinated with the budget cycle. It is also important to develop a clear framework for consultations with the general public and the medical community on issues related to the PMG, which would strengthen transparency and lend legitimacy to the choices the government makes.

Interagency cooperation would benefit from stronger planning and more constructive transitions after changes of leadership. Coordination and cooperation by the NHSU, the MoH, the MoF, and the CabMin is also critical to strategic health purchasing. Good processes for meetings, decisions, and communications are needed, as well as a shared strategic plan and policy frameworks to guide the contributions of the MoH, the NHSU, healthcare providers, and SNGs. The Ukrainian health sector lacks a strategic plan developed and agreed to by the MoH, the NHSU, and key health sector stakeholders that is aligned with a multiyear health financing strategy and endorsed by the government. A strategic vision would help accelerate the process of building constructive relationships across agencies after transitions of the government or ministers. Transitions, which are frequent in Ukraine, are often challenging. Conflict and lack of alignment between the NHSU and the MoH can inappropriately push the responsibility for health sector stewardship onto the MoF; lack of cooperation between the MoH and the MoF may weaken their roles in strategic stewardship and NHSU governance.

Successful interagency cooperation also requires better alignment between central and subnational levels, especially in policies related to rationalizing the facility network. A significant share of financing still flows through the subnational budgets, and SNGs are responsible for developing and maintaining their network of health facilities, in compliance with the contractual requirements of the NHSU. In particular, SNGs are responsible for the deficits and debts of their facilities and have the option of bailing out ineffective and loss-making healthcare providers. Although this mechanism is useful for coping during a health financing transition and the COVID-19 crisis, it creates risks to system efficiency and accountability. In the medium and longer term, the NHSU and the MoH will need to strengthen their coordination with the SNGs and hospital districts to rationalize the facility network and make it more efficient. These measures should also include stronger accountability of the newly autonomous healthcare facilities, in terms of both contractual accountability to the NHSU and accountability to their owners, the SNGs.

A critical governance requirement is for the NHSU, as the newly created strategic purchaser, to be accountable to the CabMin, the government's audit

authorities, and the Public Control Council (PPC). External accountability is central to building trust in the NHSU as a capable purchaser, as well as in the health reform in general. As a Central Executive Agency, the NHSU reports via the MoH to the CabMin, with the MoH and the MoF having joint authority over key policy decisions governing health financing and NHSU purchasing, including approval of the PMG, tariffs, and budget proposals. Lack of an effective forum for the MoH and the MoF to engage with each other on health financing impedes development of a shared strategic vision and effective oversight of the NHSU. This issue could be addressed by creating an NHSU oversight committee involving the MoH and the MoF, perhaps chaired by a representative of the Prime Minister's Office. Ideally, the NHSU also needs to have a set of annual and medium-term performance objectives, which would become the basis of its accountability to the government. The NHSU is responsive to recommendations from the mandatory audits by the State Audit Authority, the National Anti-Corruption Committee, and the Accounting Chamber of Ukraine, but not all reports are publicly available; it would be good practice to publish all of them. The NHSU also reports to a PCC, made up of patients and civil society members. The PCC's role is only advisory, however; it does not have the governance powers or responsibilities of a supervisory board. Accountability could be strengthened by providing formal oversight of the PCC by the MoH and CabMin and better defining its role.

In addition to external accountability, the NHSU needs an impeccable system of internal control to ensure that it extracts best value from its resources and does not tolerate fraud. The NHSU is responsible for ensuring spending discipline by preventing breaches of the budget and the inappropriate use of resources by the NHSU or the facilities it contracts. Managing its responsibility within its approved budget requires that the NHSU use appropriate data and methods in forecasting demand, costing the PMG, and formulating its budget proposal and that the government (on the advice of the MOF and the MOH) ensures that the approved budget is realistic. The NHSU developed, and continues to strengthen, internal control measures to prevent mistakes and fraud in claims. These measures include independent checks and balances, an operational internal audit unit, and an antifraud program that uses automated monitoring based on algorithms to detect potentially fraudulent claims. The automated monitoring is supposed to be followed up by monitoring visits to investigate cases; the frequency of these visits should be increased. Doing so requires strengthening the NHSU's five subnational offices, as well as adopting and implementing draft by-laws (already prepared) to create the basis for imposing sanctions and penalties on providers. It would also be good practice for the NHSU executive to develop a risk register documenting strategic, financial, operational, and reputational risks and corresponding risk management measures, which the internal audit unit would regularly review.

To successfully assume the complex new role of strategic purchaser, the NHSU needs to become a highly capable organization, with stronger staffing and IT capacities. Its level of staffing (266 central and 53 subnational staff in February 2021) and the size of its administrative budget relative to its program budget for purchasing services (0.23 percent) are lean, constraining the full development of its strategic purchasing function. Issues that need to be addressed include the shortage of analytical staff at the NHSU, particularly its five subnational offices, and the MoH; a shortage that is driven in part by low salaries in segments such as IT. The MoH should consider (i) increasing NHSU staff numbers within the

total limit already approved, with flexibility to reallocate posts between central and subnational offices, and (ii) developing the analytical skills NHSU staff to support the development of strategic purchasing. In addition to human resources, the NHSU needs to significantly expand and enhance its IT systems. It relies on external funding from development partners for most of its software and lacks resources for upgrades and licenses. In the medium term, as the e-health system for healthcare providers is developed further, it will be important to invest in the coordinated development of NHSU's IT and data management systems, to ensure integration with the wider e-health system and avoid duplicative systems.

Recommendations for improving the governance of the PMG include the following:

- Create a CabMin committee to act as an oversight committee for the NHSU, and facilitate better interagency coordination by the MoF, the MoH, the NHSU, and other ministries in setting the strategic directions for the NHSU and reaching consensus on issues such as health financing strategy and PMG budget and tariffs.
- As part of Ukraine's new developments in performance-based oversight of policy implementation by the CabMin, consider piloting a mechanism through which the MoH would facilitate NHSU's accountability to the CabMin for relevant aspects of the sector policy implementation, clearly defining responsibilities for agreeing and reviewing performance objectives.
- Develop an NHSU organizational strategy that is aligned with the health financing strategy and with the performance objectives and indicators proposed above by which NHSU can be held accountable to the CabMin.
- Establish a small permanent unit in the MoH with technical expertise in health financing policy, to enable the MoH to better perform its stewardship and governance roles with respect to the NHSU, including its roles on the CabMin committee overseeing the NHSU.
- Further specify the role and procedures of the PCC with respect to NHSU governance in a CabMin order, including the information and reports the NHSU should provide to the PCC, and formalize a mechanism by which the PCC can share its findings and recommendations with the MoH and the CabMin committee proposed above.

NOTES

1. The MoH identified 212 hospitals that are included in the Capable Network for inpatient care. The Capable Network Plan was approved by the Cabinet of Ministers of Ukraine in January 2020.
2. Still excluded from the PMG are highly specialized and experimental procedures, which are provided mainly by facilities reporting to Ukraine's National Academy of Medical Sciences rather than the MoH and which might be considered "quaternary care." It is envisaged that all of these advanced services will eventually be absorbed by the PMG, which currently covers up to tertiary care. The legal mandate of the PMG covers tertiary care; it does not delineate quaternary care from tertiary care.
3. The European region in this report refers to the WHO European region. It includes Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, the Kyrgyz Republic, Latvia, Lithuania, Luxembourg, Malta, Moldova, Monaco, Montenegro, the Netherlands,

North Macedonia, Norway, Poland, Portugal, Romania, the Russian Federation, San Marino, Serbia, the Slovak Republic, Slovenia, Spain, Sweden, Switzerland, Tajikistan, Turkey, Turkmenistan, Ukraine, the United Kingdom, and Uzbekistan.

4. Out-of-pocket payments greater than 10 percent of total household consumption is the global metric used to monitor catastrophic health spending as part of Sustainable Development Goal (SDG) 3.8 on Universal Health Coverage. Member States in the WHO European Region also monitor catastrophic spending using a “capacity to pay” approach, which is more sensitive to financial hardship among poorer households than the SDG approach. Capacity to pay for health care is country specific and measured as a household’s total consumption minus a standard amount to cover basic needs, such as food, housing, and utilities.
5. Total debt repayment needs in 2021 alone are projected to be 10 percent of GDP.
6. Subnational budget plans for 2021 were not yet approved at the time of writing, so the consolidated health spending figure was not available.
7. Government spending on health in Ukraine now meets the minimum (12 percent) that WHO Europe recommends to its Member States.
8. Despite the increase in the number of patients, the number of prescriptions dropped significantly during the COVID-19 pandemic. In November 2020, for example, the number of prescriptions was down by almost a quarter year-on-year, according to data from the NHSU.
9. Figures were calculated using the NHSU dashboard (for data on number of pharmacies) and the State Statistics Service of Ukraine (for data on population).
10. See <https://zakon.rada.gov.ua/laws/show/133-2021-%D0%BF#Text>.
11. Ukraine data are for 2019 (MoH Center of Medical Statistics); EU13 data are for 2018 (<https://stats.oecd.org/>).
12. The value of the top-ups to existing NHSU contracts through the PMG was calculated based on actual personnel numbers. The salary increases were 70 percent for doctors, 50 percent for nurses, and 30 percent for junior medical staff.

ECO-AUDIT

Environmental Benefits Statement

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In 2015, the government of Ukraine initiated fundamental reform of its health system with the goals of improving the health outcomes of the population and providing financial protection from excessive out-of-pocket health care payments. This was to be implemented through modernizing and integrating the service delivery system, introducing changes to provider payment arrangements that incentivize efficiency, and improving the quality of care. It culminated in the passage of a new health financing law—the Law on Financial Guarantees for Health Care Services 2017—which established a health benefit package called the Program of Medical Guarantees (PMG), and also created the National Health Services of Ukraine (NHSU) to serve as strategic purchaser for this program.

This report provides a comprehensive description and assessment of the development and implementation of policies associated with the PMG reform from the start of the reform in 2017 through mid-2021. It examines (1) how the PMG is financed, (2) strategic purchasing of the different components of the PMG benefit package, and (3) the governance arrangements of the PMG. The report also positions these developments within broader contextual discussions of the financing and organization of health care in Ukraine in order to make the key features of the financing reforms and their importance accessible to domestic and international audiences.