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Co-payment policy: considerations for Ukraine

Ukraine

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Document number: WHO/EURO:2021-2671-42427-58855

Suggested citation. Co-payment policy: considerations for Ukraine. Copenhagen: WHO Regional Office for Europe; 2021. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.
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Design and cover design: Aleix Artigal, Familia

Abstract & keywords

Ukraine's constitution states that all citizens are entitled to free health care in public facilities, but low levels of public spending on health and an inefficient provider network have created favourable conditions for informal payments, contributing to high levels of out-of-pocket spending on health. Comprehensive health financing reforms have been under way since 2016, aiming to improve population health outcomes and ensure financial protection from excessive out-of-pocket payments. Alongside this reform process, discussion is ongoing about introducing co-payments for services covered by the Programme of Medical Guarantees. Co-payments may create additional financial barriers to access and increase financial hardship for the people most in need of health services. Any decision-making on their potential role in the health system should therefore involve public consultation and technical discussion reflecting international experience and the current context in Ukraine. This policy brief aims to contribute to these discussions, detailing the ways in which people currently already pay out of pocket for health care, looking at international evidence on co-payments as a policy instrument, and highlighting policy considerations for Ukraine.

CO-PAYMENT POLICY
FINANCIAL PROTECTION
HEALTH FINANCING
OUT-OF-POCKET PAYMENTS
UKRAINE

Contents

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The authors are grateful to Alexandr Katsaga (WHO Consultant) and Olga Zues (WHO Consultant) for their technical input provided during the process of developing the document, building on their earlier unpublished policy brief on the same topic from September 2019. Thanks are also extended to Tomas Roubal (Health Policy Adviser, WHO Country Office in Ukraine) for reviewing the report and providing valuable feedback, as well as to Ben Zinner (United States Agency for International Development) and Olena Doroshenko (World Bank) for their technical feedback on the draft.

Overall leadership and guidance for producing this policy brief was provided by Tamás Evetovits (Head of the WHO Barcelona Office for Health Systems Financing) and Jarno Habicht (WHO Representative and Head of the WHO Country Office in Ukraine).

This work was prepared in the context of the Bilateral Cooperation Agreement between the Ministry of Health of Ukraine and the WHO Regional Office for Europe. It was made possible thanks to the financial contribution of the Grand Duchy of Luxembourg and the European Union within the EU-Luxembourg-WHO Universal Health Coverage Partnership.

Abbreviations

COVID-19	novel coronavirus disease (2019-nCoV virus)
NHSU	National Health Service of Ukraine
OOP	out-of-pocket
PMG	Program of Medical Guarantees
VHI	voluntary health insurance
WHO	World Health Organization

1. Background

Since 2016 Ukraine has been implementing a comprehensive health financing reform, which envisions: explicit and transparent government guarantees for health care that is free at the point of use; better financial protection in case of illness; effective and equitable distribution of public spending on health; a reduction in informal payments; and the introduction of incentives to improve the quality and efficiency of health care provided by public providers *(1)*.

The health financing reforms focus on four key elements:

1. pooling general government revenues at the national level to overcome inefficiencies and inequities created by previous decentralized financing arrangements;

2. establishing the National Health Service of Ukraine (NHSU) as a single-payer public entity to contract public and private providers in order to deliver the Programme of Medical Guarantees (PMG);

3. developing and implementing (in phases) the PMG *(2)* to introduce an explicit benefits package defining the health services and medicines covered by the NHSU;

4. introducing new financial mechanisms and provider payment methods to ensure a more efficient and equitable use of resources.

The overall design of Ukraine's health financing reforms follows international best practice – as concluded by a joint WHO–World Bank review in 2019 – improving access to and the quality and efficiency of health services *(3)*. A more recent United Nations policy paper from 2020 also confirmed that the overall reform design is in line with global evidence on universal health coverage and well aligned with Ukraine's development objectives *(4)*.

Transition to an explicitly defined benefits package is under way. Considering the complexity of designing an explicit PMG and its implementation in the Ukrainian context, the Ministry of Health and NHSU agreed on a phased transition. The agreement was to start with priority services that should be explicitly defined and available free of charge for the whole population, while other services would continue to be subject to implicit rationing. The explicitly defined list of services will be expanded over time within the given fiscal space[1]. For the priority services, the explicit scope and specific organizational requirements are defined, and the provider payment rate is set to ensure those services are provided free of charge to all patients.

The recent health financing reforms in Ukraine have been carried out in spite of the challenging macro-fiscal environment and relatively low level of public spending on health. In 2018 public spending on health as a share of gross domestic product was 3.7%, which is low compared to the WHO European Region and European Union averages (4.9% and 5.9%, respectively). The priority given to health in government spending remains

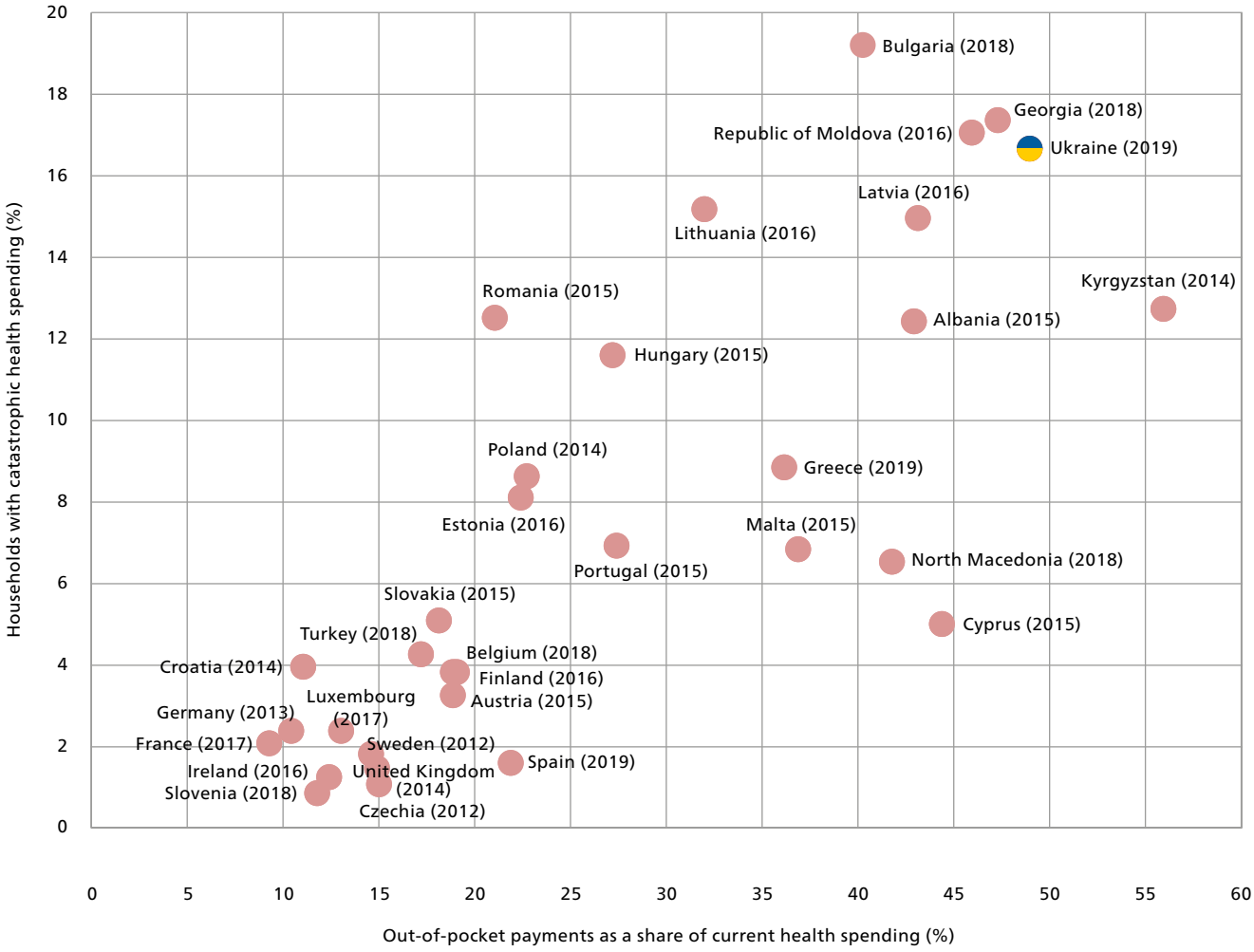
1. The transition started with primary health-care services (2018), followed by prescribed outpatient medicines for patients with cardiovascular diseases, bronchial asthma and diabetes mellitus type 2 (2019), rheumatic disorders (2020), diabetes mellitus (insulins) and diabetes insipidus (1 July 2021), and mental and behavioural disorders and epilepsy (1 October 2021). In the year 2020 priority service packages were updated, including: inpatient services (for stroke, acute myocardial infarction, maternity and neonatal care), diagnostic procedures (six procedures related to early detection of cancer), and extracorporeal haemodialysis in outpatient settings.

low in Ukraine (8.8% in 2018) (*5*). However, the budget amendments carried out in 2020 as a result of the impact of the COVID-19 pandemic increased the share of the government budget allocated to health to 11.0% (*6*). The budget plan for 2021 envisions a further increase in the health share to 11.2% of the government budget (*7*).

Out-of-pocket (OOP) payments are the single largest source of health spending in Ukraine, reaching 49% of current spending on health in 2018; this is one of the highest levels in Europe *(5).* High OOP spending weakens financial protection and limits access to care. The incidence of catastrophic OOP payments was 16.7% in 2019, among the highest in Europe (Fig 1.1). In the same year, 10.8% of households were pushed – or pushed further – into poverty due to OOP spending on health (*8*).[2]

2. The impact of recent health financing reforms on OOP payments has not yet been measured.

Fig 1.1. Incidence of catastrophic health spending and OOP payments as a share of current spending on health in the European Region (latest year available)



Note. Data on OOP payments are for the same year as data on catastrophic incidence.

Source: authors' compilation based on WHO Regional Office for Europe, 2019 (*9*) and updated unpublished data.

The existing regulatory framework already defines the services for which providers can charge extra payments from patients. Patients have to pay the full price of services if they bypass referrals. All providers can charge extra for so-called hospitality services considered to be over and above the standard provided (such as a private room, access to a TV, or certain food). In addition, a resolution of the Cabinet of Ministers defines the list of services that are not covered by the PMG, for which people have to pay the full price *(10)*. However, providers are seeking additional ways to charge patients extra. For example, public providers have a so-called charitable donations fund, which in practice mostly serves to collect money from patients for services provided, constituting about 5% of providers' revenue *(11)*. Informal payments continue to be an important source of revenue for health professionals. According to a recent study, the health professionals that most frequently ask for informal payments are attending physicians and their nurses, as a result of direct and close contact with the patients or their relatives (*12*).

The *Likarniana kasa* (health insurance fund) system plays a complementary voluntary health insurance (VHI) role, covering health services and medicines not covered by the NHSU. The Likarniana kasa is a regional, nongovernmental, voluntary and non-profit-making organization that receives revenues through targeted personalized contributions from legal entities and individuals. In total, 206 organizations of this kind were functioning in Ukraine in 2019 *(13)*. The Likarniana kasa concludes agreements with the pharmacies and health care providers within its territory to cover the cost of medicines and health services for enrolled people. The population covered with this form of VHI varies by region. For example, in Zhytomyr Region 17% of population was enrolled as of 1 January 2021 *(14)*. About 5–6% of the population are covered by other types of VHI, mainly through their employers (*15*).

2. Co-payments as a policy instrument: international evidence[3]

Co-payments create barriers to accessing health care, resulting in unmet need (see Box 2.1). They can also lead to financial hardship.
A large body of evidence on the impact of user charges is remarkably consistent in concluding that they:

- are not an effective instrument for directing people to use health services more efficiently because people are just as likely to reduce the use of essential and non-essential health services;
- are not a good instrument for rationing because most decisions about health-care use and costs are made by health-care providers; and
- are likely to lead to adverse health outcomes among poor people, older people and people with chronic conditions, partly through reduced adherence to essential medicines, which undermines efficiency.

3. This section draws on research findings on financial protection in Europe from the WHO Regional Office for Europe, published in 2019 (*9*).

Box 2.1. Types of co-payments

Co-payments (user charges or user fees), are money that people are required to pay at the point of using health services covered by a third party, such as the government, a health insurance fund or a private insurance company.

Most common types of co-payments

Fixed co-payments are a flat amount per good or service.

Percentage co-payments (also referred to as co-insurance) require the user to pay a share of the good or service price.

Deductibles require users to pay up to a fixed amount first, before the third party will cover any costs.

Other types of user charges

Balance billing is a system in which providers are allowed to charge patients more than the price or tariff determined by the third-party payer.

Extra billing allows charging extra for services that are not included in the benefits package.

Reference pricing is a system in which people are required to pay any difference between the price or tariff determined by the third-party payer (the reference price) and the retail price.

Source: WHO Regional Office for Europe, 2019 (*9*).

Co-payments are not an efficient way of solving health system performance issues; rather the opposite. There is ample evidence that co-payments:

- increase administrative complexity and cost at the provider and purchaser levels;
- reduce transparency and increase cost-related uncertainty for patients;
- may not actually raise much money for providers; and
- are not enough to reduce informal payments.

Co-payment design is a key factor influencing financial protection, largely determining the extent and distribution of OOP payments for covered services. It can protect people from or expose them to health system inefficiencies and financial risk.

- **Exemptions** for poor people and regular users of health services are the single most effective design feature in terms of access and financial protection.
- **Caps** also protect people if they are applied to all co-payments over time, rather than narrowly focused on specific items or types of service – and if they are low enough. Ideally, they should be set as a very low share of household income. However, caps alone are unlikely to be sufficient to protect poor people and they are challenging to implement where administrative capacity is weak and the necessary information is not available.
- **Low fixed co-payments create less financial risk and uncertainty for households.** Percentage co-payments shift financial risk from the purchasing agency to households and expose people to health system inefficiencies, as well as causing uncertainty about the amount of the co-payment. This is particularly problematic in contexts where pricing, prescribing and dispensing are not adequately controlled. It is also unfair if people with illnesses that require more expensive treatment have to pay more out of pocket than those with illnesses that can be treated more cheaply.
- **Co-payment policy should be designed around people** rather than around items, services or diseases.
- **Co-payment design should** be as simple as possible to minimize confusion and enhance transparency.

Balance billing and extra billing increase inequalities in access to services, weaken the role of the purchasing agency and worsen financial protection. Allowing providers to charge patients extra on top of the standard tariffs set by the purchaser may seem like a desirable way of increasing provider revenues while keeping public spending under control. In practice, the situation is more complicated. This approach creates a two-tiered system in which quality services are available to those who are able to pay extra. If providers are interested in charging additional fees to increase their revenues, this creates an incentive to keep publicly paid services at a so-called basic standard (that is, lower quality). In the longer term this will seriously undermine the publicly financed system. Moreover, allowing providers to introduce additional supplementary fees reduces the effectiveness of the purchaser's role in setting tariffs and using its purchasing power to support effective service delivery. It adds administrative complexity and reduces the transparency of tariffs. It is also likely that introducing additional fees would increase OOP payments and weaken financial protection. Balance billing and extra billing will have a disproportionately negative affect on poor people, who will pay proportionally more in relation to their income.

International evidence shows that VHI is not an effective way of reducing OOP payments. VHI generally exacerbates inequities in access to health services. International experience shows that VHI is protective at health system level only when it explicitly covers user charges, covers all those who have to pay user charges and is heavily subsidized[4] by the state for poor households. Only three countries in Europe and globally – Croatia, France and Slovenia – have been able to meet these conditions, through extensive government involvement in and oversight of VHI, and their experience is not easily generalizable to other contexts (*9, 16*). In other countries that have tried to foster VHI covering user charges, such as Latvia, uptake of VHI is limited and heavily skewed towards richer households (*16*). More widely, VHI is not effective in reducing OOP payments, in contrast to public spending on health (*9,16,17*).

4. General tax relief for VHI premiums does not serve this purpose, as richer people benefit from it most.

3. Policy considerations for Ukraine

The introduction of additional co-payments is not a panacea for solving the complex large-scale challenges that the Ukrainian health system is facing. Transformative health system reform needs consistency, time, resources, smart phasing and continuous effort to achieve the expected results.

Any decision to introduce additional co-payments should be well informed and based on clear policy objectives, underpinned by realistic expectations. Policy-makers should carefully assess the potential benefits and risks of introducing co-payments given the current health reform context, the weaknesses of the health system and the already very high OOP payment levels in Ukraine. If co-payments are nevertheless introduced, they should be carefully designed to be limited, simple, transparent and to protect poorer households. Percentage co-payments should be avoided, for the reasons discussed in the previous section. Policy dialogue around co-payment policy has a significant opportunity cost, however, and the time spent on it could be used more efficiently to solve Ukraine's health system challenges.

The rapid introduction and poor design of co-payment policy could lead to multiple risks and unfulfilled expectations. In the current context, with excessive OOP payments and a high incidence of catastrophic spending, additional co-payments are likely to compound existing problems and disadvantage even further those who already experience difficulties in affording health care. The introduction of co-payments will also significantly increase administrative costs at both provider and NHSU level.

The existing regulatory framework already permits providers to charge patients extra without compromising clinical aspects of care. Allowing additional supplementary fees that are related to clinical aspects of care (e.g. choice of doctor, higher costs for medicines or medical devices) could lead to a situation in which NHSU coverage is seen as poorly funded care for poor people.

Co-payments are not a feasible way to increase budgetary space for health in Ukraine. It is not likely that people could afford more OOP payments (which already accounted for 49% of current health spending in 2018). Policy-makers should look at more efficient and equitable alternative methods of raising health revenue in the Ukrainian context. These include: public funding and potential reinvestments of savings generated through optimization of excess infrastructure; improvement of price regulation for medicines; and wider use of evidence-based clinical practices. Ukraine increased the government budget allocation for the health sector in 2020 and 2021 in response to the COVID-19 pandemic. This prioritization of health within the government budget will need to be sustained in the years ahead.

Formalizing informal payments requires a comprehensive and long-term strategy; the introduction of co-payments alone is not enough. This is because co-payment design is not usually based on an understanding of the motivations behind or root causes of informal payments, and co-payments therefore add to, rather than replace, the burden of informal payments. Ideally, addressing informal payments should combine a long-term comprehensive health system strategy (e.g. phased revision of the PMG with the aim of having explicitly defined benefits, adequate tariffs and scaling up enforcement capacity in the health sector and beyond) with short-term, targeted so-called quick fixes (e.g. raising population awareness about their entitlements) *(18)*. The introduction of co-payments would increase population expectations for a quick reduction of informal payments; however, this would be unlikely to happen without rapid and radical changes in other areas of the health system and beyond.

NHSU tariff-setting – combined with provider payment design and a contracting strategy – is a powerful tool to drive broader health system reforms. Tariffs set by the NHSU should be seen as much more powerful than just an instrument to cover the cost of providing care and should be used to provide the right incentives. NHSU tariffs should approximate the cost of delivering services in the most efficient way that enables an acceptable level of quality and health outcomes. This has been one of the policy objectives in revising service packages and tariffs for priority services, but more can be done to address existing inefficiencies in service delivery[5]. Allowing supplementary top-up fees would seriously hinder this power.

5. For example, a recent study found that over one third (37.6%) of hospitalizations in Ukraine were inapproriate admissions (*19*).

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