

ALIGNING HEALTH AND DECENTRALIZATION REFORM IN UKRAINE

Health policy paper series





**World Health
Organization**

REGIONAL OFFICE FOR **Europe**

ALIGNING HEALTH AND DECENTRALIZATION REFORM IN UKRAINE

Health policy paper series

KEYWORDS

DECENTRALIZATION

LOCAL SELF-GOVERNMENT

TERRITORIAL HROMADA

HEALTH REFORM

INDIVIDUAL HEALTH SERVICES

PUBLIC HEALTH SERVICES

HEALTH FINANCING

Document number: WHO/EURO:2021-2593-42349-58635

© World Health Organization 2021

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: "This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition: Aligning health and decentralization reform in Ukraine. Copenhagen: WHO Regional Office for Europe; 2021".

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization. (<http://www.wipo.int/amc/en/mediation/rules/>)

Suggested citation. Aligning health and decentralization reform in Ukraine. Copenhagen: WHO Regional Office for Europe; 2021. Licence: [CC BY-NC-SA 3.0 IGO](https://creativecommons.org/licenses/by-nc-sa/3.0/igo).

Cataloguing-in-Publication (CIP) data. CIP data are available at <http://apps.who.int/iris>.

Sales, rights and licensing. To purchase WHO publications, see <http://apps.who.int/bookorders>. To submit requests for commercial use and queries on rights and licensing, see <http://www.who.int/about/licensing>.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.

Design and cover design: Yulia Madinova

All photos: © WHO

CONTENTS

List of illustrations	iv
Acknowledgements	v
List of abbreviations	vi
Key messages	vii

1. Introduction	1
-----------------------	---

2. Definitions, principles and features of optimal decentralization	3
2.1 Definitions	3
2.2 Decentralization principles, design features and health system challenges ...	4

3. Decentralization reform since independence	8
3.1 Reform history	8

4. Challenges, trade-offs and implications of decentralization in the health sector	12
4.1 Financing of individual health care services	12
4.2 Delivery of individual health care services	16
4.3 Decentralization reform in public health financing and service delivery	21

5. Conclusions and policy recommendations	25
5.1 Financing of individual health care services	25
5.2 Delivery of individual health care services	26
5.3 Decentralization of financing and delivery of public health services	28

6. References	29
---------------------	----

7. Annex 1. Case study of Voznesensk hospital	33
7.1 Health service delivery	33
7.2 Health service financing	34

LIST OF ILLUSTRATIONS

Figures

Fig. 1. Delivery of individual health services in specialized health care facilities (Khmelnysk city TH)	18
Fig. 2. National and decentralized public health institutions (2020).....	22

Tables

Table 1. Configuration of local administration types at each level (2020).....	10
Table 2. Health financing trends by government tier, 2015–2020	14

ACKNOWLEDGEMENTS

This document was written by Loraine Hawkins (WHO Consultant, Governor, The Health Foundation – UK), Elina Dale (Health Policy Adviser, WHO Country Office in Ukraine), Olga Demeshko (Health Financing Officer, WHO Country Office in Ukraine), Yuriy Dzhygyr (WHO Consultant, formerly Deputy Minister of Finance of Ukraine), Nataiia Piven (Public Health Expert, WHO Country Office in Ukraine) and Matviy Khrenov (WHO Consultant, formerly Deputy Mayor, Zhytomyr City Council).

Internal review of the current document was provided by Susan Sparkes (Economist, WHO – Geneva) and Triin Habicht (Senior Health Economist, WHO Regional Office for Europe).

Overall leadership and technical guidance have been provided by Jarno Habicht (WHO Representative and Head of Country Office in Ukraine) and Tamás Evetovits (Head of the WHO Barcelona Office for Health Systems Strengthening).

The authors would like to express their gratitude to all the participants of the Health Transformation Forum and the Delegation of the European Union to Ukraine (in particular, Tomasz Ostropolski), for discussions and input provided during the development process. Technical input from Benedikt Herrmann (former First Secretary, Policy Officer for Decentralization and Sectoral Reform, Delegation of the European Union to Ukraine) is also gratefully acknowledged.

This publication forms part of the series of work in the area of health policy, launched in 2020 to enhance the development of health system of Ukraine, under the leadership of Jarno Habicht and Natasha Azzopardi-Muscat (Director of the Division of Country Health Policies and Systems, WHO Regional Office for Europe), coordinated by Elina Dale.

This work was prepared in the context of the Biennial Collaborative 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.

LIST OF ABBREVIATIONS

ATH	amalgamated territorial hromada
COS	cities of oblast significance
COVID-19	novel coronavirus disease 2019-nCoV (COVID-19 virus)
GDP	gross domestic product
LSG	local self-government
NHSU	National Health Service of Ukraine
OLC	Oblast Laboratory Centre
PMG	Programme of Medical Guarantees
rPHC	regional public health centre
SES	Sanitary Epidemiological Service
TH	territorial hromada
UAH	Ukrainian hryvnia (currency)
UPHC	Ukrainian Public Health Centre

KEY MESSAGES

Key message 1. Inherent health systems characteristics create challenges to the implementation of principal design features for effective decentralization, as well as subjecting it to trade-offs. Constructive relationships and formal coordination mechanisms can help to overcome these challenges.

Key message 2. Decentralization reform in Ukraine since the country's independence in 1991 has successively introduced more local democratic accountability in territorial hromada (THs; one type of local administration), which are now responsible for primary and secondary health care facilities. More direct and transparent fiscal relations and clearly delineated responsibilities have been established, along with more closely aligned financing and performance accountability.

Key message 3. Health care financing and budget pooling at central level in a single purchaser (the National Health Service of Ukraine (NHSU)), established in late 2017, reduced fragmentation and made entitlements through the Programme of Medical Guarantees (PMG) more portable, and resource allocation more equitable.

Key message 4. Still, important health care financing responsibilities remain fragmented, functional assignments of central and local governments overlap, and inequity in health expenditure between richer and poorer local self-governments (LSGs) continues. The aim over time should be to pool most or all current expenditures on individual health care services within the NHSU. Targeted, conditional grants to LSGs can also be useful for capital expenditure, to address inequities in health care infrastructure and to create incentives for optimization of the health facilities network. Adaptation of the criteria and processes for health sector grants from the existing State Fund for Regional Development could be considered, for this purpose.

Key message 5. Decentralization of health care service delivery in Ukraine created overlaps of responsibilities among different levels and types of local administration (THs, rayons and oblasts). Hospitals owned by other sectors (e.g. railways, police) add to overlaps and fragmentation in some localities. Lack of pooling of capital expenditure and fragmentation of health facility ownership make it difficult for the central Ukrainian Government to use financing and planning levers to address health facility inefficiencies.



Key message 6. Hospital districts provide a structure for coordinating planning and investment across neighbouring THs, but these districts have not yet been resourced and developed to become operational. The governance of hospital districts needs careful consideration. While giving oblast authorities a leadership role may expedite decision-making, oblasts lack democratic accountability to the communities affected. An alternative governance model would be a council, made up of representatives of THs as well the oblast; this option may face difficulties in building consensus, though it would have better capacity for consultation and communication with affected communities. It is always challenging to build local political consensus for decisions on consolidation of hospital networks because the interests of citizens differ among and within THs. The hospital districts need strong governance structures, along with the authority to oversee network optimization and the coordination of investment decisions in a way that attempts to build local consensus while avoiding decision-paralysis, based on judgements about what would best work in Ukraine's context. A legal basis for formalizing inter-LSG cooperation already exists (1), and a draft order on the management of districts is under discussion.

Key message 7. The Ukrainian central Government will need to use multiple policy levers to create incentives for hospital districts to agree on and take up the challenge of building local support for facilities optimization, as well as providing technical support. In addition to conditional capital grants, the NHSU should align its contracting with approved Hospital District Development Plans. The Ministry of Health's regulatory powers and instruments for setting standards for licensing hospitals of different levels (of volume of care) will need to be developed in order to ensure adequate scale and concentration of services to meet quality standards. It is also helpful to coordinate hospital rationalization with planning of primary health care development and integrated care (see key message 8), which will provide some services that were formerly hospital-provided services in primary care settings, locally, to maintain access to such care for local communities.

Key message 8. To develop the envisaged broader role of primary health care and integrated care, capacitated primary care networks need to be created. In rural areas where THs have small populations, some with less than 10 000 people, some primary care networks would need to serve more people than a single urban TH, in order to provide enhanced quality services. This also requires a coordinated,



policy-drive approach across neighbouring THs. Development of integrated care also requires coordination with the nearest high-capacity secondary care hospital, to plan and facilitate investment by all THs, as well as technical support for development of new and improved primary health care functions and integration of primary and other health care services. This too could be supported by central government use of conditional grants, along with technical support to THs and primary health care networks from larger, more urban THs and oblasts.

Key message 9. Reforms of public health services (in terms of disease prevention, health promotion, and health protection) have initiated partial decentralization of responsibility for financial and service delivery. However, aspects of legislation and implementation remain incomplete. Local government responsibility for public health services is currently unclear and linkages of coordination and accountability to the Ministry of Health and the central Ukrainian Public Health Centre (UPHC) for centrally financed and regulated public health functions still need to be defined. There are good policy reasons and practical arguments for using a combination of devolution, delegation and centralization of public health services. The benefits of decentralization can be combined with the need for greater scale and central technical expertise as long as there is a clear functional assignment and clear definition in law of which level of administration has decision-making authority, together with effective coordination.



1 | INTRODUCTION

Ukrainian decentralization reform has increased and democratized local government responsibility for health care at the level of local government closest to communities and has increased regional and local government responsibility for public health. Decentralization affects health system reform in three important areas: health financing, individual health services and public health. Decentralization reforms changed local government organization, functions and financing, directly affecting delivery of **(individual) health care services**. However, the national PMG has re-centralized most **health care financing** since 2017, while most health facilities remain under local government ownership. Financing and delivery of **public health services** (encompassing disease prevention, health promotion and health protection) are now a mix of central and local government responsibility. The novel coronavirus disease 2019-nCoV (COVID-19 virus) pandemic outbreak presents national and local authorities with unparalleled public health challenges, with reforms ongoing and incomplete.



АПТЕКА

ФАРМАЦИЯ



2 | DEFINITIONS, PRINCIPLES AND FEATURES OF OPTIMAL DECENTRALIZATION

2.1 | Definitions

This policy brief uses the World Bank definition of administrative decentralization as central government redistribution of authority, functions and financing for public service delivery to different government levels and in three distinctive forms (2). The Government can deconcentrate some authority, functions and financing to supervised government agency field units at oblast, city or rayon levels, or to other newly created entities. The regional and district laboratory network of the former Sanitary Epidemiological Service (SES) serves as an example prior to recent reforms. The Government could delegate authority, functions and financing to semi-autonomous organizations – such as public enterprises and health districts¹ – which it creates without relinquishing ultimate control. Recently autonomized health care facilities are an example found in Ukraine. Thirdly, the Government can devolve authority, functions and financing to local administrations (e.g. to local self-governments (LSGs))² and to legally recognized territorial regional and municipal authorities with separate corporate status (which are representative elected bodies). They enjoy considerable autonomy, the right to raise all or part of their own revenues and to elect their own governors, mayors or councils. In Ukraine, devolution is now found only in cities with special status (Kyiv and Sevastopol) and in THs; these are referred to as LSG authorities.

1 There is no such phenomenon in Ukraine, but this approach is widely spread in the United States and Australia, for example. Health districts serve the health needs of a community and are governed by a selected board, representing the interests of all territorial units covered by the health district.

2 This paper uses “local administration” as a generic term to refer to all forms of local government – both those with administrative decentralization and those with political decentralization, including oblasts, rayons, THs, and cities with special status (Kyiv and Sevastopol). It uses the term LSGs to refer to local governments with elected leaders and councils.

2.2 | Decentralization principles, design features and health system challenges

Seven principles and design features underpin effective decentralization in both theory and evidence. Inherent health systems characteristics make their implementation challenging and subject to trade-offs. Clear and constructive relationships and coordination between different decentralized levels and neighbouring LSGs can help to overcome many of these challenges.

1. **Any legislative mandate and authority should be clearly assigned**, without functional overlap with other territorial or government units. Clearly outlined responsibility and accountability help to prevent cost- and responsibility-shifting.

Challenge: Responsibility for the various health care levels (primary, secondary and tertiary care) is assigned to different levels of national and local government in Ukraine but these are linked through upward referral, downward logistical and technical support, and joint and shared responsibilities. Patients need to be enabled to use health care in other territories' facilities.

Implication: Inter-local coordination mechanisms and structures across territorial boundaries are needed, to link health system levels and coordination mechanisms with central state technical and logistical support provided by the Ministry of Health and its agencies. The hospital districts (described in Section 2.1) being established in Ukraine are intended to play this role. The central purchaser (the NHSU) can also facilitate coordination.

2. **Functions should be assigned to the lowest governance level** able to internalize costs and benefits, achieve economies of scale and scope, and manage functions effectively and with local input.

Challenge: Health programmes and functions in Ukraine, as elsewhere, are often made up of components with different economies of scale. Health externalities (e.g. infectious disease spread) often affect other territories and require consistent responses across all affected areas.

Implication: Inter-local coordination structures and special financing mechanisms for cross-boundary functions are needed, with clear regulation for tackling health externalities, in order to optimize decentralization.

3. National power over national allocative goals and principles should be retained.

Challenge: Equity and human rights goals and health priorities affect almost all health functions.

Implication: National regulation and national funding mechanisms are needed to ensure equal access, equal dignity, fair treatment and protection of the vulnerable in health services.

4. Cost and financing accountability should be aligned with performance accountability for efficient, patient-responsive service delivery by LSGs. Ideally, a single government administration should be accountable for trade-offs between public services provided and the associated cost to tax payers.

Challenge: In Ukraine, national financial pooling is combined with locally managed health facilities, which de-links performance accountability, because of the benefits of national pooling noted here under challenges 3 and 5. Specific solutions are needed to foster accountability for trade-offs.

Implication: The NHSU as the national health financing agency tasked with pooling and purchasing needs specific structures, expertise, information resources and enforcement powers to ensure the services it purchases are efficient and patient-responsive. Both the NHSU and local governments need to clarify to citizens who is accountable for what – the NHSU for monitoring quality and patient-responsiveness of services under its contracts; and local governments for investing in facilities and ensuring they are run efficiently.

5. LSG financing should be vertically and horizontally balanced. Assigned and/or locally raised financial resources should be (vertically) balanced with estimated costs. Financial resources are equitably (horizontally) balanced in line with local population needs and local costs.

Challenge: Health needs correlate with old age and poverty, which inversely affect the revenue-generating capacities of local governments.

Implication: National pooling or equalization funds are needed to pool risks and for equitable redistribution of resources across rich and poor areas. This was a key rationale for re-centralizing health care financing within the NHSU. But the NHSU needs to be monitored and held accountable for the horizontal equity of its resource allocation.

6. **Congruent or synergistic functions should be grouped together at same level of governance** to the fullest extent possible.

Challenge: Social determinants of health are affected by policy and services in many other sectors – e.g. education, housing, social welfare and social care – much of which is the responsibility of local government in Ukraine.

Implication: There are major potential health benefits to be gained from the **devolution** of some public health responsibility (e.g. health promotion) and community health care responsibility to local government, due to synergistic local functions, such as social care, education and housing.

7. **Specific or performance-related grants should be considered** to address externalities and to align national and local priorities, when functions also benefit from decentralized management. That is, centralized management is not the only nor the preferred response to externalities.

Challenge: Externalities create trade-offs as well as benefits. Local voters or politicians may not prioritize less visible or long-term health care aspects.

Implication: The Ministry of Finance, the Ministry of Health and the NHSU should consider using specific or performance-based grants to address externalities, and performance-based or matching grants to incentivize investment in national health priorities.





3 | DECENTRALIZATION REFORM SINCE INDEPENDENCE

3.1 | Reform history

Post-independence Ukraine inherited a form of decentralization that delegated most health care services to oblasts, cities and rayons, with centrally appointed governors and mayors. Under the *matryoshka* (nested doll) principle, all central government health funds were allocated – without vertical or horizontal balancing, a clear mandate or managerial authority – to oblasts, which divided the funds between cities and rayons that allocated funds to towns and villages. Over the subsequent 30 years, successive governments have carried out a series of reforms which have been to a substantial extent in line with the above principles, although some reforms are not yet fully implemented, while health sector reforms have recently re-centralized some responsibility (for reasons also based on the above principles).

The country's new constitution of 1996 retained the presidential right to appoint oblast governors but introduced the election of local councils at all LSG levels, as well as city mayors with executive authority, strengthening local democratic accountability for primary and secondary health care services. However, oblast power over budgets and mandated reporting structures continued to undermine LSG authority in cities. Reporting obligations of the oblasts to elected local councils and the central Government created a so-called dual subordination. Reporting obligations of heads of rayons – appointed by means of a Cabinet of Ministers proposal, with presidential approval – to elected local councils, oblasts and the central Government created a triple subordination.

The 2001 reform established direct a fiscal relationship between cities and rayons and the central government funding, as well as more clearly delineated LSG responsibilities for local administrations, creating more scope for LSGs, rayons and oblasts to increase spending on health care from local revenues. Shared taxes and formula-based grants made intergovernmental finances more transparent and incentivized the development administrations' own tax base. The most specialized tertiary health services and research functions remained assigned to the central Government, while other specialized tertiary services were assigned to oblast level. Primary and secondary health care remained the responsibility of cities of oblast significance (COS) and rayons. LSGs' new responsibility for social care, education, culture and sport created the possibility of synergistic functions.

The 2014–2015 decentralization reform reassigned the primary and secondary health care responsibilities of rayons to COS, cities with special status (Kyiv and Sevastopol) and amalgamated rural THs (ATHs). Villages, rural settlements and small towns were encouraged to group into larger ATHs to create economies of scale, but rural ATHs were still too small to manage secondary care and some were even too small to manage larger scale modern multidisciplinary primary care centres. The intergovernmental finance system more closely aligned financing and performance accountability by allocating a larger share of revenue to all LSG levels, and by successfully incentivizing increased local revenue collection. The central budget-earmarked grant – the “medical subvention” – was based on a per-capita formula and thus introduced more horizontal equity in financing for local health services, reflecting the differences in LSGs' ability to raise revenue.

The recent health financing reform re-centralized most financing for individual health care services; public health reform is still under discussion. In October 2017, Parliament adopted a new health financing law; the Law on Government Financial Guarantees of Health Care Services (3) and a package of related by-laws. This provided a legal basis for the development of a PMG to be funded through general taxes pooled at the national level. It also established the NHSU as a public entity to contract public and private providers to deliver the PMG. Around the same time, under parallel public health reforms, some public health functions³ were decentralized to oblasts, and to a lesser extent to other LSGs.

A new wave of decentralization reform took place in 2020 with implications for health care financing and service delivery. The 2020 decentralization reform amalgamated the 490 rayons into 136 rayons, with reduced functions. The Government is also in the process of completing the amalgamation of small rural communities and COS into THs to enable full transfer of primary and secondary health care from rayons to THs, with a deadline of mid-2021. The term TH now encompasses the former ATHs and COS and the newly amalgamated territories, all of which now have the same health responsibilities for primary and secondary care. Oblasts and rayons continue to have either dual or triple subordination and so are not fully self-governing. Table 1 sets out the local administration configuration in 2020.

3 Public health functions encompass disease prevention, health promotion, health protection services provided to whole communities or populations.

Table 1. Configuration of local administration types at each level (2020)

Level of administration (LSG/not)	Type	Number	Average population per unit (estimate)
Higher tier (cities are self-governing; oblasts are not fully self-governing)	Autonomous Republic of Crimea	1	1 967 259
	Oblasts	24	1 600 000
	Cities with special status (Kyiv, Sevastopol)	2	Kyiv: 2 967 360 Sevastopol: 385 870
Second tier (not fully self-governing)	Rayons	136 (including 17 in Non-Government controlled areas)	300 000
Third tier (self-governing)	THs (including former COS and ATHs which have now all become THs)	1 469 (including 31 in Non-Government controlled areas)	26 500
Lower tier (not fully self-governing; limited functions)	Smaller cities, urban and rural settlements, villages	Approximately 30 000	

Sources: authors' own compilation based on data extracted from the Geoportal "Administrative-territorial structure of Ukraine" (4,5); and from information and analytical materials of the State Statistics Service of Ukraine (6,7).





4 | CHALLENGES, TRADE-OFFS AND IMPLICATIONS OF DECENTRALIZATION IN THE HEALTH SECTOR

The current situation and issues in the health sector arising from decentralization reforms differ in three areas: health financing, individual health services, and public health.

4.1 | Financing of individual health care services

In addition to the aforementioned new health financing law (3), two main laws define intergovernmental health financing responsibilities. The Law on Local Self-Government describes broad definitions without disaggregation between different types of medical care (8). The Budget Code of Ukraine (9) provides, but does not impose, some specifications on funding responsibilities by level of government, by type of care and in many instances by type of health care facility. It thereby defines what types of expenditure may be legally funded by each level of government.

Between 2018 and 2020 the Government re-centralized medical subvention financing and introduced national pooling and purchasing of individual health care services via the newly established NHSU. The 2017 health financing reform was accompanied by amendments to the Budget Code. Primary health care financing was centralized within the NHSU in July 2018, and 97% of public primary health care providers and 123 private providers were contracted by April 2019 (10). Capitation-based payments from the NHSU have addressed the mismatch between health financing and their service delivery responsibility, and primary health care centre ownership has become more attractive for THs.

In 2020 the NHSU started contracting secondary and tertiary health facilities to provide extended service packages in the specialized medical care field and is phasing in case-based payment for these services. The NHSU also began contracting providers of emergency medical services, palliative care and rehabilitation. The amended Budget Code retained LSG and oblast financing responsibilities for local public health programmes and selected public health services, capital and utility costs of communal health facilities, supplementary primary health care or specialized care services not covered by the PMG, and unspecified additional spending on primary care or specialized care.

Both policy reasons and practical arguments exist for pooling of the health care budget at central level. Social values of equity and comprehensive and universal social protection for health are better achieved with national pooling, in line with strong widely shared values. Health care coverage becomes portable and benefits packages more consistent. On the other hand, the pre-reform medical subvention, combined with LSGs' ability to supplement these grants from local health budgets, aligned local financing and performance accountability and had the potential to make services more responsive to local needs (at least for health facilities owned by LSGs).

Certain issues remain, including continued fragmentation of health care financing responsibilities across LSGs for capital expenditure and utilities for health facilities that provide PMG services. Local responsibility for capital expenditure makes sense, given the local ownership of facilities. The intention is for the responsibility for utilities expenditure to be transferred back to the NHSU, but there is a case for deferring this until after some facilities have been consolidated, to reduce utilities costs. The Budget Code also permits LSGs to supplement NHSU payments to health facilities from local budgets, contrary to the original policy intent. This provision in the Budget Code thus creates the kind of overlap of functional assignment and fragmentation that – according to the seven key design principles outlined in Section 2.2 – should be avoided. This is because it leads to an unclear LSG financing role, blurs and dilutes accountability for financing gaps between health facility costs and NHSU payments, and encourages responsibility shifting. It can also erode willingness of both Government and Parliament to allocate funds to the PMG in the long term. Many LSGs do provide supplementary financing for PMG services⁴ (see Table 2), because the current fiscal situation and the balance of central and local revenues do not yet permit the NHSU to pay prices that cover the full cost of hospital care. As owners of health facilities that often make a loss, LSGs are in practice obliged to fund the financing gap between facility costs and the NHSU's PMG payments. However, this means that NHSU financing does not have the financing leverage or influence that the reform was designed to provide, while LSGs may have rather weak incentives to improve efficiency of their facilities to eliminate facility deficits, because efficiency can only be maximized by reforming a local network of facilities, which requires coordination with other LSGs.

⁴ There are also some central Ministry of Health programmes that finance components of individual health care services (such as drugs for some rare diseases) along with health care services funded by other sectors that are not yet pooled in the NHSU.

Table 2. Health financing trends by government tier, 2015–2020

	Expenditure on health, UAH billion						Expenditure on health, % of GDP						Expenditure on health, % of total expenditure on health						
	2015	2016	2017	2018	2019	2020 plan	2015	2016	2017	2018	2019	2020 plan	2015	2016	2017	2018	2019	2020 plan	
Consolidated budget	71.0	75.5	102.4	115.9	128.4	138.5	3.57	3.17	3.43	3.26	3.23	3.04	100	100	100	100	100	100	
State budget	11.5	12.5	16.7	22.6	38.6	96.2	0.58	0.52	0.56	0.64	0.97	2.11	16	17	16	20	30	69	
Local budgets	59.6	63.0	85.7	93.2	89.8	42.3	2.99	2.64	2.87	2.62	2.26	0.93	84	83	84	80	70	31	
including:																			
Local expenditure funded by transfers	51.9	44.8	62.0	64.8	59.1	17.7	2.61	1.88	2.08	1.82	1.49	0.39	73	59	61	56	46	13	
Local expenditure funded by local revenue	7.7	18.3	23.7	28.4	30.7	24.6	0.39	0.77	0.79	0.80	0.77	0.54	11	24	23	25	24	18	
Consolidated budget	71.0	75.5	102.4	115.9	128.4	138.5	3.57	3.17	3.43	3.26	3.23	3.04	100	100	100	100	100	100	
Central expenditure including transfers	63.3	57.2	78.7	87.4	97.7	113.9	3.19	2.40	2.64	2.46	2.46	2.50	89	76	77	75	76	82	
Local expenditure without transfers	7.7	18.3	23.7	28.4	30.7	24.6	0.39	0.77	0.79	0.80	0.77	0.54	11	24	23	25	24	18	
Memorandum item: Block grants	7.3	6.8	22.0	25.2	25.9	21.8	0.37	0.29	0.74	0.71	0.65	0.48	10	9	21	22	20	16	

Note. UAH: Ukrainian hryvnia (currency).

Sources: State Treasury Service of Ukraine (11,12).

Continued fragmented LSG financing of health facilities has led to continuing inequity in per-capita health expenditure between richer and poorer LSGs, although to a lesser extent than before health finance reform. Poorer LSGs in particular, who had relied on block grants to bridge financing gaps, are now facing difficulties in recruiting and retaining staff, financing inpatient drugs, paying utilities bills or maintaining facilities. However, some groups of neighbouring LSGs have cooperated in ways that support poorer LSGs; for example, a better resourced urban LSG has met most of the costs of a hospital used by residents of struggling small rural THs nearby, which cannot afford to contribute. The Government has also provided transitional support via the stabilization grant and the additional subvention for health and education, and through a new equalization fund with a protective floor for poorer LSGs.

But this additional funding and TH revenue growth have not been sufficient to enable them to meet their health sector responsibilities. Overall, the equalization system is underfunded, with little government budget contribution at this level of government compared to its growing use of discretionary specific grants available to oblasts and rayons.

As a whole, ambiguity about LSG health financing responsibilities has already led to a reduction of both LSG expenditure and total public health care expenditure, although some providers with good local leadership and relationships benefit from their ability to access local financing as well as NHSU payments, and more progressive local government executives have allocated more funds and improved health service quality and access (see Annex 1). After the 2015 decentralization reform, LSGs substantially increased the amount of local revenue allocated to health, reaching 25% of total spending in 2018, although with significant variations in locally derived co-financing amounts. After the health reform was fully introduced at the primary health care level in 2019, these top-ups slightly contracted to 24% in 2019, while primary health care expenditure increased in absolute terms, but local transfers to primary health care decreased as NHSU financing increased. Since central budget health expenditure remained constant as share of gross domestic product (GDP) in 2019, overall health expenditure as share of GDP only slightly decreased from 3.26% to 3.23% in 2019. As the health reform unfolded in 2020 to cover the entire benefits package, top-ups further decreased to 18% in 2020, which budgeted increases in central spending will not compensate. Together with a cut of central government block grants, partially earmarked for health expenditure including utility costs for poorer LSGs, overall health expenditure was thus projected to decrease to 3.04% of GDP, the sharpest contraction since 2016 (see Table 2). However, COVID-19-related budget amendments in 2020 sharply increased the share of government budget being allocated to health, translating into the highest share of GDP (4.4%) allocated to health in recent times.⁵

Lack of capital expenditure pooling combined with fragmentation of health facility ownership makes it difficult for the Ukrainian central Government to use financing levers to address health facility inefficiencies through consolidation, reorganization or by using assets for other purposes. While responsibility for utility costs has incentivized some LSG investment in more energy-efficient technologies, the overall significance of NHSU payments to LSGs is reduced, and the NHSU's influence on the development and performance of health facilities is weakened accordingly. There is a strong case for pooling responsibility for the utility cost component of services within the NHSU. While decentralization of capital expenditure can provide opportunities, especially when piloting innovation and change in service delivery models – when combined with re-centralized financing for service costs – it requires some medium-term coordination of NHSU contracting with LSG decisions on investment in facilities.

5 This is based on authors' calculations, derived from information on GDP from the appendix "State Budget indicators for 2022–2023" (estimates taken from the Draft Law on the State Budget of Ukraine for 2021 (13)); and on consolidated health spending from the State Treasury Service of Ukraine's report on the implementation of the State Budget for January–December 2020 (14).

The NHSU has scope to motivate and influence local government investment and development of health facilities to be more efficient, adjusted to local circumstances and capacities; for example, by establishing joint steering committees with LSGs, to define and plan what the NHSU needs to purchase from the area over a 3–5 year horizon, to facilitate discussion of how the existing provider network could be reorganized over a multi-year period in order to deliver these services more efficiently, and to guide alignment of LSG decisions. The scope for the NHSU to contract with networks of facilities could also be explored. Central Government could use conditional capital grants to LSGs to influence local capital investment decisions for health facilities in line with coordinated Hospital District Development Plans. It could also continue to target capital grants to reduce inequity in the quality of health infrastructure. It would be useful to explore adapting the allocation of grants for health sector investment from the existing State Fund for Regional Development of the Ministry of Regional Development, Building and Housing and Communal Services, to support these objectives.

4.2 | Delivery of individual health care services

Ukraine's health system assigns different levels of health care to different levels of administration, as do many countries with decentralized systems. The advantages of decentralization for small-scale services like primary health care can be combined with the need for a larger scale and the greater technical expertise that often only regional or central authorities can provide for more specialized tertiary health care. The challenge is to produce clear functional assignments with distinct responsibilities that do not overlap. Where this is not possible, it can be difficult to address issues affecting multiple LSGs, such as the need to redistribute services across territories to rationalize excess infrastructure. It can also create burdens of multilayered administration. Effective decentralization therefore requires institutionalized coordination and cooperation mechanisms across neighbouring LSGs and between different levels of local government, as well as inter-local joint service delivery structures to manage larger scale service delivery in cases of more comprehensive decentralization. Health reform in Ukraine now allows private providers to contract with the NHSU to deliver PMG services. Public providers have been given autonomy, and their managers may have greater freedom to decide what services to provide or cease to provide. There is a need to clarify who is responsible for organizing service delivery in order to ensure there are no gaps in availability of providers of adequate-quality PMG services throughout the country for the NHSU to contract with.

Decentralization has also allocated responsibility for primary and secondary health care in ways that create overlaps or duplication of responsibility for service delivery to the same population. Oblasts and the largest cities have tertiary health care facilities covering the whole population within their territory, but commonly patients use these tertiary facilities to address health problems that could be dealt with in primary or secondary health care. Health care facilities in THs – particularly hospitals – often treat patients from other neighbouring LSGs, while some small rural THs are lacking a fully capable primary or secondary care facility in their territory.

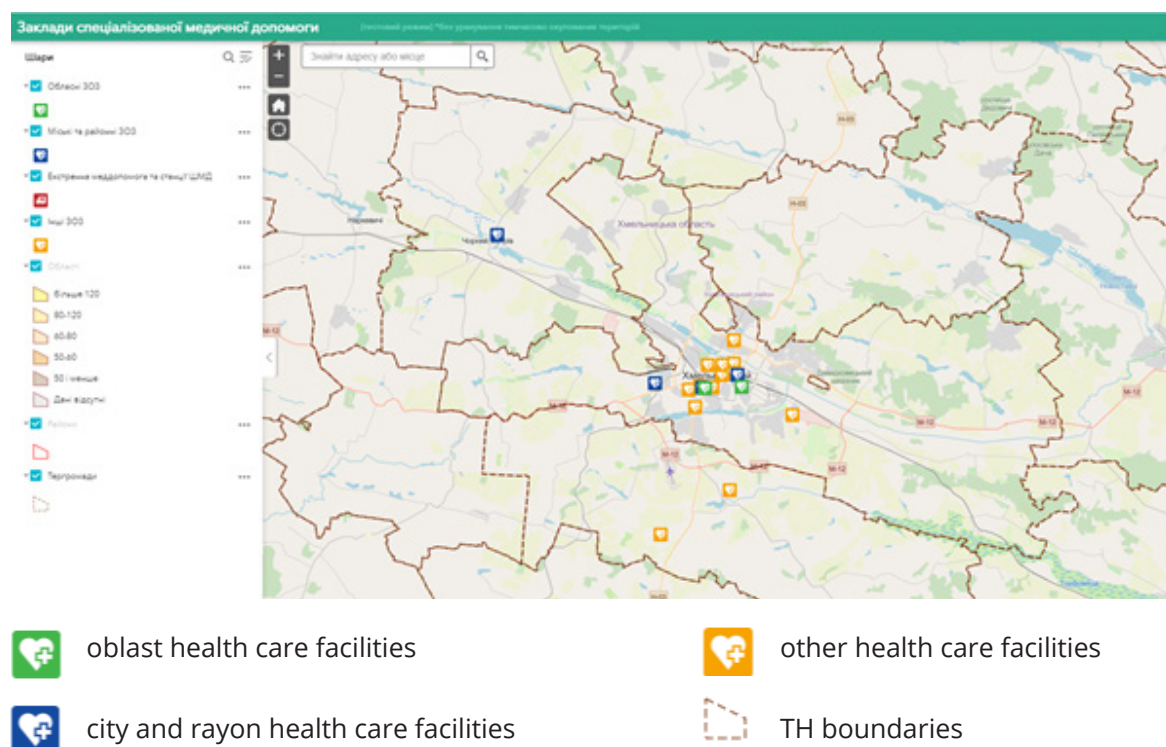
Re-centralization of financing into the NHSU has mitigated this problem of overlap, but not fully eliminated it. The NHSU can now choose what services it contracts from various providers. NHSU contracts allow “money to follow patients” to providers in other territories. Health financing reform has mitigated the problems of overlapping responsibility for primary and hospital care in the decentralized system by paying health facilities for the number of patients they treat, regardless of the patient’s territory of origin. This is important progress. Primary health care providers and hospitals that ensure the highest quality services (and are credible, nurturing trust and relationships) can attract patients and the associated revenues from the territory of other communities by offering better customer satisfaction and building on patient loyalty. However, responsibility for utilities, capital investment and development of services, as well as for tackling the inefficiency of loss-making providers remains with local government and this local funding is not necessarily allocated in line with the NHSU’s purchasing plans. In addition, LSGs are permitted to provide supplementary financing to facilities for PMG services and are free to do this in ways that may work against the NHSU purchasing approach – for example, funding services in substandard or inefficient local facility, while the NHSU has chosen to purchase from another provider that is better able to meet its contractual requirements.

In Ukraine, small LSGs lack economies of scale and expertise to manage modern hospitals. Current decentralization reforms have allocated responsibility for secondary care to LSGs, with considerable variations in size, from small rural THs to the largest city of special status (Kyiv). The recommended catchment populations for standard secondary care hospitals are at least 100 000 for sparsely populated rural areas, particularly in low-income countries, and at least 200 000 for more urbanized areas. Urbanization and health system modernization require fewer but larger hospitals to achieve efficiency and high quality for the most specialized services. These trends mean that Ukraine faces a long-standing and increasingly urgent need to rationalize and consolidate its network of hospitals, particularly at the secondary care level, but the fragmentation and overlap of territorial responsibility for secondary care facilities makes this very challenging.

Many smaller rural THs are not large enough to manage modern hospitals and their territories often do not align with the boundaries required for hospital districts. Underequipped, less-specialized former rayon and district hospitals now transferred to THs are financially unviable, as they struggle to attract staff as well as patients.

THs have been reluctant to take on their statutory responsibility for rayon or municipal hospitals, particularly where the hospital serves neighbouring LSGs, because THs still bear utility and capital costs and are responsible for their facilities' losses. As a coping mechanism, many rayons continued to take responsibility for secondary health care services that should have been transferred to THs. THs also lack political incentives to consolidate health facilities in order to enable elimination of deficits through efficiency gains and better quality services for their population, in particular if this benefits a neighbouring territory while leading to a downgrading of their own facilities to outpatient clinic or health centre status. Meanwhile, THs that include or adjoin the oblast capital typically have a concentration of too many hospitals at both oblast and TH levels, and may also have health facilities formerly or currently owned by ministries of other sectors or state-owned enterprises (see health care facilities network of Khmelnytsk city TH in Fig. 1). Rayons created after the 2020 amalgamation are not envisaged to have health care service delivery functions; as is the case with many rural THs, they are often not large enough to manage modern hospitals; and do not align with the required boundaries.

Fig. 1. Delivery of individual health services in specialized health care facilities (Khmelnytsk city TH)



Sources: unpublished data provided by the Ministry of health of Ukraine on the specialized health care facilities network in 2019; and by the Ministry for Communities and Territories Development of Ukraine on TH boundaries in 2021.

A reform initiative in 2016–2017 approved by a resolution of the Cabinet of Ministers of Ukraine (15) proposed the creation of hospital districts as a mechanism for coordination and joint decision-making by representatives of the LSGs and health care facilities across various administrative units within oblasts. The creation of such districts aimed at overcoming the aforementioned barriers to achieving consolidation and optimization of the fragmented hospital network at the former rayon, city and TH levels. Districts were formed initially from groups of neighbouring LSGs sharing a single high-capacity acute hospital, with a coordinating governance structure. The final size and territorial profile of hospital districts was reviewed in 2020 and the Government now plans to form hospital districts across whole oblasts – to facilitate planning of secondary and tertiary care together and enable facility optimization at oblast and TH levels. Ideally, the health facilities of other sectors, as well as private health facilities should be taken into consideration by hospital districts in the planning of a hospital district and facilities network. The hospital districts reform has not yet been resourced and developed as an active mechanism for rationalizing, consolidating and modernizing the health facilities network.

The governance of hospital districts needs to be clarified. While giving oblast authorities a leadership role would enable higher authority to be brought to bear, oblasts lack democratic accountability to the communities affected by hospital optimization. An alternative governance model would be an inter-LSG council, made up of representatives of TH hospital owners as well the oblast. While this option may face difficulties in building consensus (given that there are 60 THs in an oblast, on average), it may have greater legitimacy and better capacity for crucial consultation and communication with the affected communities. Every country finds it challenging to build local political consensus for decisions on consolidation of hospital networks because the interests of citizens differ among and within THs. A range of options is available to consider, combining elements of top-down strategic direction with bottom-up input from representatives of THs. The hospital districts need strong governance structures and the authority to oversee network optimization and the coordination of investment decisions in a way that attempts to build local consensus while avoiding decision-paralysis, based on judgements about what would best work in Ukraine's context. A legal basis for formalizing inter-LSG cooperation is already provided by the (2014) Law on Cooperation of Territorial Communities (1). A draft order on the management of districts is under discussion.

Central Government will need to use multiple policy levers to create incentives for hospital districts to agree and take up the challenge of building local support for facilities optimization. In addition to conditional capital grants (see Section 4.1), the NHSU should align its contracting with approved Hospital District Development Plans. The Ministry of Health's regulatory powers and instruments for setting standards on the licensing hospitals at different levels will need to be developed, to ensure adequate scale and concentration of services to meet quality standards. It would also be helpful to coordinate hospital rationalization with the planning of primary health care development and integrated care, which will provide some former hospital services in primary health care settings locally in order to maintain access to care for local

communities. Engagement of health experts with the Anti-Monopoly Committee on hospital rationalization will also be important, to try to help the authority to understand that merging and the associated optimization of hospitals across the country are vital steps to improve efficacy and quality of care. In these discussions, health experts can draw on international experience with applying competition law to autonomous public hospitals.

Small LSGs also lack economies of scale and expertise to provide primary care efficiently and develop a broader role for primary health care. Ukraine's draft primary health care strategy envisages a broader primary health care role, which requires a coordinated, policy-driven approach to enable investment in primary care facilities, network formation, staffing, and professional development. Currently, almost 20% of THs do not have any primary health care centres with a full range of primary care functions. Many have only small primary care facilities, such as ambulatory centres, with very low utilization rates, thereby attracting little revenue from the NHSU. This broader primary care role involves greater integration between traditional primary care, outpatient specialist services and social and community services. An expanded primary health care role requires larger scale multidisciplinary facilities, with professional development opportunities and supervision, and greater capacity for diagnosis and treatment, serving populations of between 10 000 and 100 000 people. This can only be achieved through large group practices or networks of smaller practices, serving a population corresponding to the size of larger THs – although they need not be organized along LSG territorial lines. Other countries also provide support to primary health care from a higher administrative level of the health system, for example in the form of community health centres that assist with professional development, supply chain management and quality improvement, or through multidisciplinary community health services provided in re-profiled former district hospitals.

The NHSU cannot on its own bring about reform of the wide variety of primary health care facilities, which all have different diagnostic and treatment capacities and provide a range of different services. Coordination across neighbouring THs – as well as with the growing private primary health care sector – will be needed in order to achieve such reform. In addition, coordination across groups of THs would be desirable, for example to share the task of providing primary health care support to a higher capacity secondary care hospital used by patients from these territories. Consideration could be given to using hospital districts as the forum for this coordination. However, if hospital districts were organized at the oblast level, this would be too large a footprint for effective coordination of THs and primary health care providers. A more local-area coordination structure could be desirable for developing primary health care and integrated care. The same policy levers noted earlier – for motivating THs to cooperate over hospital optimization – are also relevant to inter-territorial primary health care and integrated care development.

4.3 | Decentralization reform in public health financing and service delivery

Between 2017 and 2020 ideas for a new public health system were developed in accordance with the Sustainable Development Strategy “Ukraine 2020”⁶ and the EU-Ukraine Association Agreement (17), with its attendant policy recommendations and obligations⁷. The first stage of the reform established the UPHC as an autonomous public agency (by Order of the Cabinet of Ministers of Ukraine (19) and by Order of the Ministry of Health of Ukraine (20)) and a leading expert institution on public health,⁸ to take over the expert functions of the SES. It also transferred the epidemiological surveillance function to the Ministry of Health, and inspectorate functions⁹ to the State Service on Food Safety and Consumer Protection.

The second stage of the reform,¹⁰ the “public health concept”, transferred certain public health service functions and resources to regional public health centres (rPHCs) under oblast authority, to coordinate public health policy implementation at regional level. The development of rPHCs began in 2017 and they have now been established in all but two oblasts. This decentralization was supported in 2020 by transferring funds from the state budget to local budgets to finance rPHCs and Kyiv city public health centre, which had previously been funded by the state budget under the Ministry of Health, through the medical subvention.

As of the time of writing, there is no clear relationship between the UPHC and the rPHCs, as Fig. 2 demonstrates. The legislation introduced did not clarify the specific public health responsibilities and functions that oblast (and the Kyiv city) administrations **must** fund with these resources, although rPHCs do have a rather general defined range of activities. Also, the public health laboratory network (Oblast Laboratory Centres (OLCs) of the Ministry of Health) continues to be managed centrally by the Ministry of Health in parallel with these new structures. At the same time, services such as routine- and event-based epidemiological surveillance, emergency preparedness, immunoprophylaxis and data collection continue to receive direct state budget funding.

6 The strategy was approved by Decree of the President of Ukraine in 2015 (16).

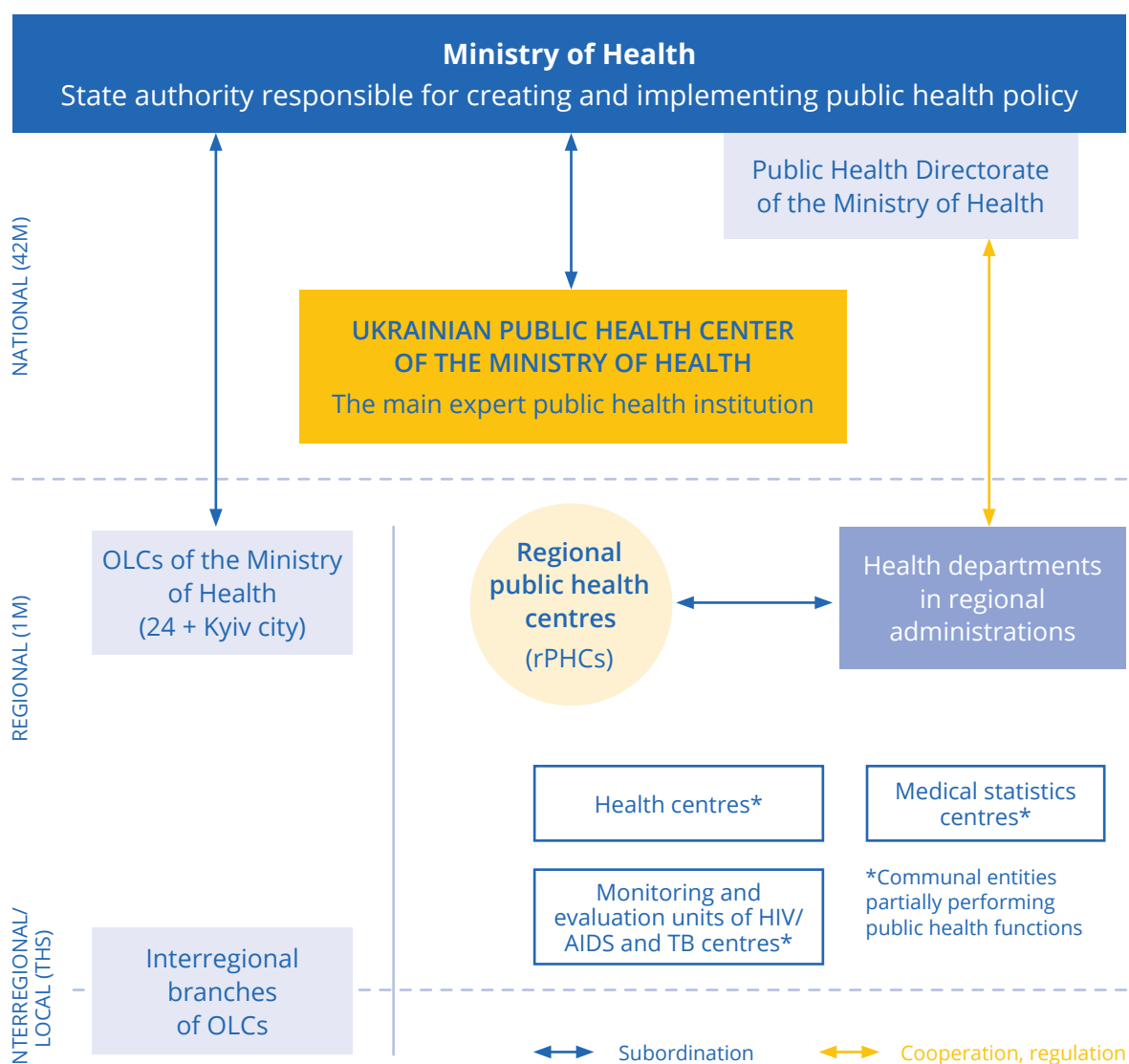
7 The relevant EU documents include Regulation (EC) No. 851/2004 of the European Parliament and of the Council “Establishing a European centre for disease prevention and control” (18).

8 Prior to the reform, the SES was a central executive body responsible for the public health system, characterized by a centralized structure and financing. Its capacity and activities focused on communicable disease prevention and control through regulation of risk factors and carrying out health inspections. The SES did not meet new public health challenges and comply with modern approaches to disease surveillance (including noncommunicable diseases) and health promotion). The UPHC was established with a modern, broader public health mandate; its mission is to ensure quality of life and health of the Ukrainian population through disease prevention, health promotion and protection, counteracting potential health threats, ensuring effective response to public health emergencies, and information and communication policy. Its mandate also includes public health monitoring of diseases, epidemiological surveillance and biosafety, group and population prevention of diseases, response to epidemics, and strategic governance in public health.

9 This encompasses inspection and control (supervision) of the compliance of business operations with the requirements of sanitary legislation.

10 The details of the reform were set out in resolutions of the Cabinet of Ministers of Ukraine (Resolution No. 1002-r of 30 November 2016 (21) and Resolution No. 560-r of 18 August 2017 (22)). This legislation laid the foundation for future public health system development with a vision for health promotion, disease prevention and health protection, aimed at increasing life expectancy and quality, and extending the active working age through concerted societal efforts.

Fig. 2. National and decentralized public health institutions (2020)



Source: authors' own compilation.

There are no coordination mechanisms for the UPHC at TH level, or across regions. The UPHC still needs clearer statutory authority and instruments to coordinate subnational public health institutions. The absence of clearly delineated distribution of public health functions across different levels of government, alongside parallel functioning of public health institutions at the regional level (rPHCs, OLCs) engenders potential fragmentation in public health services delivery and funding.

No developed financing mechanisms exist for decentralized functions, which leaves the rPHCs at risk of being underfunded. The allocation of additional budget subvention to rPHCs (following a resolution in March 2020 of the Cabinet of Ministers of Ukraine¹¹) was in effect an emergency measure, which was prolonged by a further resolution¹² in effect until the end of June 2021.

As a result of recent reforms, Ukraine’s public health system has both national and decentralized institutions and responsibilities. Central public health functions can better create economies of scale, concentrate scarce expertise and provide strategic input and public goods. In Ukraine the national public health laboratory network (the OLCs) concentrates national expertise, the UPHC provides consolidated technical and strategic management know-how through regional and national public health systems, and the Central Procurement Agency supports the national and subnational public health system with bulk procurement of drugs, vaccines and supplies.

Strong policy reasons and practical arguments exist in a country the size of Ukraine for using a combination of delegation and decentralization. Many public health functions – such as management of particular diseases (e.g. cancer or cardiovascular disease), and public health risks (e.g. vector-borne disease control, tobacco control or occupational health) – have components with very different efficiency scales, combining components that are best carried out centrally (e.g. highly specialized technical inputs or production of national public goods, such as mass media campaigns) with very local functions that require working with patients and their carers, communities and local primary care teams.

Central regulation in combination with conditional grants can align national health priorities with local public health functions, as well as aligning costs with financing and budget accountability. Decentralization can strengthen synergies with other sectoral functions at local level and thereby influence the social determinants of health and well-being. Some high-risk public threats and especially low-probability/high-impact public health responsibilities – such as communicable disease outbreaks or natural disasters – require central government coordination. However, delegation is better suited to managing public health externalities and to coordinating rapid local responses. In particular, highly local functions that require working with patients, communities and primary care teams, necessitating local knowledge input and intersectoral cooperation, are best delegated to LSGs, but with defined implementation responsibilities. Such delegation and decentralization of public health functions requires close coordination between different levels of government, clear assignment of functions and responsibilities, close alignment of policy and field-based health service delivery, and funding security.

11 Cabinet of Ministers of Ukraine Resolution No. 250 of 25 March 2020 allocated state budget subvention to oblast budgets to finance rPHCs for implementing certain public health services, namely relating to health promotion and medical statistic data management (23).

12 Cabinet of Ministers of Ukraine Resolution No. 106 of 17 February 2021 amended the procedure for the use of state funds allocated to the budget programme “Public health and measures to combat epidemics” and redirected funds earlier dedicated to rPHC funds to OLCs, from 1 July 2021, with the consequent reorganization of public health centres (rPHCs and Kyiv city) through their merger with health care facilities of the respective administrative-territorial units and transferring their staff to OLCs (24).

The current and intended distribution of functions and responsibilities between the national Government and across various levels of government has yet to be clarified. Because reform of public health structures is recent and aspects of legislation and implementation are not yet complete, many of these requirements present a major challenge, to which complete re-centralization is not an optimal solution. LSG statutory functions in public health are defined rather broadly and with much overlap; the exact relationship between OLCs and rPHCs, and accountability between the UPHC and rPHCs are unclear. Clarification is also needed on the degree of regional government authority in setting public health policy and priorities and the allocation of financial and human resources. The question of the future role and responsibilities of the regional authorities in the public health system is especially acute, as rPHCs are being reorganized and their staff transferred to OLCs by July 2021. The recent proposals for a return to a centralized SES structure raise a different set of concerns, beyond the scope of this brief.

COVID-19 has confronted this new, as yet underdeveloped system with an extremely difficult public health challenge; however, re-centralization of all public health functions is not the optimal solution. Coordination and communication linkages for public health and disease control programmes and functions – such as disease outbreak control – are a major challenge. Early in the pandemic, regions differed considerably in the measures they adopted, at times using different criteria unrelated to the variations of the epidemiological situation. Public health measures were relaxed in areas with the highest number of confirmed cases, while stricter measures were kept in those with similar or lower incidence rates. This reflected a lack of national response standards, legislative gaps in assigning national and local responsibilities and regional capacity variations, in particular their ability to conduct COVID-19 testing. The Ukrainian Ministry of Health's implementation of zoning guidelines in August 2020 helped to set more uniform standards. However, issues around enforcing nationally set standards remain, with some powerful LSGs choosing not to follow national guidelines. In response, during 2020, a new draft Law on the Public Health System has been developed (25). The most recent draft of that regulation at the time of writing appears to propose creating an institution which will combine surveillance, laboratory and investigation functions into a centralized organization, as well as giving the national Government stronger powers.



5 | CONCLUSIONS AND POLICY RECOMMENDATIONS

The Government has taken steps to accelerate the completion of the decentralization reform at TH level and to reduce redundancies and excessive administrative costs at rayon level. The pooling of most funds for health care has mitigated some of the challenges presented by Ukraine's highly decentralized and fragmented health care system. The new payment system has increased equity in primary health care funding, rewarding those able to attract more enrollees and benefiting hospital facilities that are more productive. However, unresolved and incomplete elements of decentralization and financing reform remain, acting as a barrier to better equity, efficiency and quality of health care.

5.1 | Financing of individual health care services

- Structures and systems should be implemented for the NHSU to work more closely with LSGs and hospital districts on needs assessment, along with multi-year planning of purchasing by the NHSU, aligned with LSG investment in consolidating and developing the health facilities network.
- This alignment and planning would be easier if the NHSU were to pool expenditure for the all the current costs of individual health care, including (over time) utilities, maintenance and minor capital expenditure, and other central and local expenditures related to PMG services (such as funding to meet the medicines-related needs of vulnerable population groups and patients requiring orphan drugs for rare diseases). A predictable multi-year pathway for the NHSU's budget and contracts would also facilitate this kind of alignment and planning with LSGs, because facilities network optimization is a multi-year process.

- The assignment of responsibility to the NHSU and to different LSG levels in the Budget Code (8) needs to be reviewed to remove overlapping responsibility and assign it clearly to the appropriate levels of government and funding streams. Where responsibilities involve entitlements to individual health services, inclusion into PMGs and the NHSU pooling should be considered.
- A conditional grant programme to LSGs is needed to cover major capital investment and to direct investment towards agreed plans for optimization and consolidation of the health facilities network at both primary care and hospital levels. Conditional grants could be used to create incentives for hospital districts to make progress in developing, agreeing and implementing coordinated plans for optimizing the facilities network and supporting its development.

5.2 | Delivery of individual health care services

- The fragmentation of health care facility ownership across different levels of government must be resolved. This report recommends combining the several policy measures, as listed here.
 - Hospital districts must become operational and Hospital District Development Plans should be developed and implemented.
 - Similar inter-territorial cooperation bodies need to be established to coordinate primary care (and integrated care) development and support to primary care for the purposes of broadening the role of primary health care and strengthening quality. This will require cooperation among groups of neighbouring LSGs across a wider area than a single TH, in many rural areas, and will require coordination with private sector providers contracted to the NHSU, which are more common in urban areas.
 - Governance structures and processes for the hospital district or primary care development area should be clarified.
 - Central policy instruments are needed to support this process. This should include conditional or matching grants, but also Ministry of Health guidance, regulations and standard-setting, and alignment of NHSU contract awards for various types and levels of services.
 - The NHSU needs a legal and regulatory basis to enter into contracts with integrated care networks for primary health care, as well as inpatient and outpatient care that may be provided by more than one legal entity, working jointly.

- Creating oblast-based hospital districts provides a good option in principle. However, oblast-based and newly consolidated rayon-based hospital districts lack accountability to their locally elected councils, which can be important for fostering legitimacy for the difficult decisions to be made on hospital optimization. Some options exist for deciding how to organize governance for hospital districts. Under any option, all LSG levels with health care responsibility should be involved in planning and decision-making, whether through representation, consultation, or both.
 - One option is to have a top-down model of governance, with the oblast chairing the Hospital District Council, and the oblast having some authority and accountability upwards into the central Government over final decisions (e.g. on hospital master plans). This option may lack democratic legitimacy, however, and may be less able to build local consensus for change.
 - An alternative is a bottom-up model of governance, with THs choosing their Hospital District Council representatives and chair, and with the Council having accountability downwards into local LSGs. This option would provide a governance structure which better represents democratically elected levels of administration, although it may lead to slower decision-making.
 - Other options could be developed, which combine top-down and bottom-up elements (e.g. central guidance and standards to guide the bottom-up process at the beginning, and use of the oblast and central authorities to resolve disagreements where plans cannot be agreed locally).
- Creating inter-territorial structures to coordinate primary care and integrated care development and support could be achieved using the existing Law on Cooperation of Territorial Communities (1) to its full potential to enable horizontal initiatives of groups of THs. These could be put in place across amalgamated rayon footprints, where that makes sense for primary care but, as noted above, in some areas the new rayon territory may not be the most logical footprint for health service planning and development, so alternative options could be considered locally for determining the preferring grouping of THs as a basis for primary health care planning and support and integrated care.

5.3 | Decentralization of financing and delivery of public health services

- The Draft Law on the Public Health System (25) must be finalized to clearly define local government responsibility for financing and delivery of public health services. This includes the following aspects.
 - Centralization of policy and regulation-making for health protection should be considered, as one aspect of public health. This should also include policy-setting, regulations and standards, and mandating requirements for data collection, surveillance and reporting.
 - However, centralization of responsibility for implementation of some aspects of health protection is not optimal in larger, more complex countries. Delegation of local implementation functions is likely to be desirable in the Ukrainian context, subject to central policy guidance, centrally set standards and use of central government financing instruments, such as ring-fenced grant financing or mandated minimum levels of resource allocation from local budgets.
 - Decentralization should be considered for most health promotion and disease prevention activities, other than those with strong economies of scale (such as mass media campaigns or bulk procurement of vaccines and essential supplies), but it should be supported by central expert technical guidance, capacity-building and some centrally set strategic priorities, underpinned by use of central government financing instruments, such as conditional grants or matching grants.
- Local structures for implementation, communication and cross-sectoral coordination need to be established, with clearly mandated types or levels of responsibility and necessary minimum resourcing requirements.
- The new Law on the Public Health System needs to clarify general and overlapping functions. Formal coordination mechanisms between different levels of administration need to be established and supported by standard operating procedures.
- The central Government should support local government-mandated responsibility to develop population health strategies and to invest in local and regional public health programmes through capacity-building, technical support and the use of matching- or performance-based grants.



6 | REFERENCES

1. Verkhovna Rada of Ukraine. ЗАКОН УКРАЇНИ Про співробітництво територіальних громад [Law of Ukraine “On cooperation of territorial communities”] (in Ukrainian). Verdicts of the Ukrainian Parliament (VVR), 2014; No. 34(1508-VII):1167, updated 17 June 2014 (<https://zakon.rada.gov.ua/laws/show/1508-18#Text>, accessed 25 February 2021).
2. Administrative decentralization [website]. Washington (DC): The World Bank Group; 2001 (<http://www1.worldbank.org/publicsector/decentralization/admin.htm>, accessed 25 February 2021).
3. Verkhovna Rada of Ukraine. ЗАКОН УКРАЇНИ Про державні фінансові гарантії медичного обслуговування населення [Law of Ukraine on Government Financial Guarantees of Public Medical Services] (in Ukrainian). Verdicts of the Ukrainian Parliament (VVR) 2018; No. 2168-VIII (<https://zakon.rada.gov.ua/laws/show/2168-19#Text>, accessed 17 March 2021).
4. Research Institute of Geodesy and Cartography. Geoportal of the administrative-territorial structure of Ukraine [website]. Kyiv: Ministry of Development of Communities and Territories of Ukraine; 2020 (<https://atu.gki.com.ua/ua/portal>, accessed 24 February 2021).
5. Administrative-territorial structure of Ukraine [website]. Kyiv: Ministry of Development of Communities and Territories of Ukraine; 2020 (<https://atu.decentralization.gov.ua/#buttons>, accessed 25 February 2021).
6. Information and analytical materials [website] (2014 data). Kyiv: State Statistics Service of Ukraine; 2014 (http://database.ukrcensus.gov.ua/PXWEB2007/ukr/publ_new1/2014/publ2014.asp, accessed 25 February 2021).
7. ЧИСЕЛЬНІСТЬ НАЯВНОГО НАСЕЛЕННЯ УКРАЇНИ на 1 січня 2020 року [Number of existing population of Ukraine as of January 1, 2020]. Kyiv: State Statistics Service of Ukraine; 2020 (http://database.ukrcensus.gov.ua/PXWEB2007/ukr/publ_new1/2020/zb_chuselnist%202019.pdf, accessed 25 February 2021).

8. Verkhovna Rada of Ukraine. ЗАКОН УКРАЇНИ Про місцеве самоврядування в Україні [Law of Ukraine on Local Self-Government in Ukraine] (in Ukrainian). Verdicts of the Ukrainian Parliament (VVR) 1997; No. 24(280/97-BP);170 (<https://zakon.rada.gov.ua/laws/show/280/97-%D0%B2%D1%80#Text>, accessed 25 February 2021).
9. Verkhovna Rada of Ukraine. БЮДЖЕТНИЙ КОДЕКС УКРАЇНИ [Budget Code of Ukraine] (in Ukrainian). Verdicts of the Ukrainian Parliament (VVR) 2010; No. 50 -51:572 (<https://zakon.rada.gov.ua/laws/show/2456-17#Text>, accessed 25 February 2021).
10. 97% комунальних закладів первинної допомоги уклали договори з НСЗУ [97% of municipal primary care facilities have concluded agreements with the National Health Insurance Fund] (in Ukrainian) [website]. Kyiv: National Health Service of Ukraine; 2019 (<https://nszu.gov.ua/novini/97-komunalnih-zakladiv-pervinnoyi-dopomogi-uklali-dogovori-z-11>, accessed 25 February 2021).
11. Місячний звіт про виконання Державного бюджету України за січень-грудень 2020 року [Monthly report on the implementation of the State Budget of Ukraine for January-December 2020] (in Ukrainian). Kyiv: State Treasury Service of Ukraine; 2020 (<https://www.treasury.gov.ua/ua/file-storage/misyachnij-zvit-pro-vikonannya-derzhavnogo-byudzhetu-ukrayini-za-sichen-gruden-2020-roku>, accessed 25 February 2021).
12. Квартальний звіт про виконання Державного бюджету України за I квартал 2020 року [Quarterly report on the execution of the State Budget of Ukraine for Q1 2020] (in Ukrainian). Kyiv: State Treasury Service of Ukraine; 2020 (<https://www.treasury.gov.ua/ua/file-storage/kvartalnij-zvit-pro-vikonannya-derzhavnogo-byudzhetu-ukrayini-za-i-kvartal-2020-roku>, accessed 25 February 2021).
13. Проект Закону про Державний бюджет України на 2021 рік [Draft Law on the State Budget of Ukraine for 2021] (in Ukrainian). No. 1082-IX; 15 December 2020. Kyiv: Verkhovna Rada of Ukraine; 2020 (https://w1.c1.rada.gov.ua/pls/zweb2/webproc4_1?pf3511=69938, accessed 25 February 2021).
14. Підрозділ II.2 «Видатки за функціональною класифікацією видатків та кредитування бюджету» розділу II «Видатки» [Subsection II.2 “Functional classification of budget expenditures and lending” of section II “Expenditures”]. In: Місячний звіт про виконання Державного бюджету України за січень 2020 року [Monthly report on the implementation of the State Budget of Ukraine for January 2020] (in Ukrainian). Kyiv: State Treasury Service of Ukraine; 2020 (<https://www.treasury.gov.ua/ua/file-storage/misyachnij-zvit-pro-vikonannya-derzhavnogo-byudzhetu-ukrayini-za-sichen-2020-roku>, accessed 25 February 2021).

15. Cabinet of Ministers of Ukraine. Деякі питання створення госпітальних округів [Some issues of creating hospital districts] (in Ukrainian). Resolution No. 1074; 27 November 2019. Kyiv: Verkhovna Rada of Ukraine; 2019 (<https://zakon.rada.gov.ua/laws/show/1074-2019-%D0%BF#Text>, accessed 22 March 2021).
16. Cabinet of Ministers of Ukraine. Указ Президента України Про Стратегію сталого розвитку «Україна – 2020» [Decree of the President of Ukraine on the Sustainable Development Strategy “Ukraine 2020”] (in Ukrainian). Decree No. 5/2015; 12 January 2015. Kyiv: Verkhovna Rada of Ukraine; 2015 (<https://zakon.rada.gov.ua/laws/show/5/2015#Text>, accessed 25 February 2021).
17. Verkhovna Rada of Ukraine. ЗАКОН УКРАЇНИ Про ратифікацію Угоди про асоціацію між Україною, з однієї сторони, та Європейським Союзом, Європейським співтовариством з атомної енергії і їхніми державами-членами, з іншої сторони [Law of Ukraine “On ratification of the Association Agreement between Ukraine, on the one hand, and the European Union, the European Atomic Energy Community and their Member States, on the other”] (in Ukrainian). Verdicts of the Ukrainian Parliament (VVR), 2014; No. 40(1678-VII):2021 (<https://zakon.rada.gov.ua/laws/show/1678-18#n2>, accessed 25 February 2021).
18. Regulation (EC) No. 851/2004 of the European Parliament and of the Council of 21 April 2004 establishing a European centre for disease prevention and control. Official Journal of the European Union, L 142/1; 30 April 2004:1–11 (<https://eur-lex.europa.eu/eli/reg/2004/851/oj>, accessed 25 February 2021).
19. Cabinet of Ministers of Ukraine. Питання Міністерства охорони здоров'я [Questions from the Ministry of Health] (in Ukrainian). Order No. 909-r; 2 September 2015. Kyiv: Verkhovna Rada of Ukraine; 2015 (<https://zakon.rada.gov.ua/laws/show/909-2015-%D1%80#Text>, accessed 22 March 2021).
20. Ministry of Health of Ukraine. Про утворення державної установи “Центр громадського здоров'я Міністерства охорони здоров'я України” [On the establishment of the state institution “Public Health Centre of the Ministry of Health of Ukraine”] (in Ukrainian). Order No. 604 of 18 September 2015. Kyiv: Verkhovna Rada of Ukraine; 2015 (<https://zakon.rada.gov.ua/rada/show/v0604282-15#Text>, accessed 22 March 2021).
21. Cabinet of Ministers of Ukraine. Про схвалення Концепції розвитку системи громадського здоров'я [On approval of the public health development system concept] (in Ukrainian). Order No. 1002-r; 30 November 2016. Kyiv: Verkhovna Rada of Ukraine; 2016 (<https://zakon.rada.gov.ua/laws/show/1002-2016-%D1%80#Text>, accessed 22 March 2021).

22. Cabinet of Ministers of Ukraine. Про затвердження плану заходів щодо реалізації Концепції розвитку системи громадського здоров'я [On approval of the action plan for the implementation of the public health system development concept] (in Ukrainian). Order No. 560-r; 18 August 2017. Kyiv: Verkhovna Rada of Ukraine; 2017 (<https://zakon.rada.gov.ua/laws/show/560-2017-%D1%80#Text>, accessed 22 March 2021).
23. Cabinet of Ministers of Ukraine. Деякі питання надання у 2020 році субвенції з державного бюджету місцевим бюджетам на здійснення підтримки окремих закладів та заходів у системі охорони здоров'я [Some issues of providing subventions from the state budget to local budgets in 2020 to support certain facilities and activities in the health care system] (in Ukrainian). Resolution No. 250; 25 March 2020. Kyiv: Verkhovna Rada of Ukraine; 2020 (<https://zakon.rada.gov.ua/laws/show/250-2020-%D0%BF#Text>, accessed 22 March 2021).
24. Cabinet of Ministers of Ukraine. Про внесення змін до постанови Кабінету Міністрів України від 27 листопада 2019 р. № 1121 [On amendments to the Resolution of the Cabinet of Ministers of Ukraine No. 1121 of 27 November 2019] (in Ukrainian). Resolution No. 106; 17 February 2021. Kyiv: Verkhovna Rada of Ukraine; 2021 (<https://zakon.rada.gov.ua/laws/show/106-2021-%D0%BF#Textb>, accessed 22 March 2021).
25. Проект Закону про систему громадського здоров'я [Draft Law on the Public Health System] (in Ukrainian). No. 1164-IX; 2 February 2021. Kyiv: Verkhovna Rada of Ukraine; 2021 (http://w1.c1.rada.gov.ua/pls/zweb2/webproc4_1?pf3511=70025, accessed 25 February 2021).



7 | Annex 1.

Case study of Voznesensk hospital

The hospital of Voznesensk city in Mykolayiv oblast provides a positive example of what can be achieved, while also highlighting the difficulties poorer local self-governments (LSGs) continue to face.

The multi-specialty, autonomous 275-bed hospital serves the Voznesensk hospital district of 180 000 people. The hospital district is composed of the city itself, five amalgamated territorial hromada (ATHs) that constitute the Voznesensk rayon and four neighbouring rayons. Prior to decentralization the hospital was owned by the Voznesensk rayon. Funding was provided through medical subvention from rayon and city budgets and additional funds from the city council's local subvention. These funds did not cover basic operating costs and had to be heavily supplemented from the city budget to at least cover salaries and utilities. This led to an ongoing dispute between city and rayon councils, since the hospital not only served the city itself, but also the Voznesensk rayon and the other four rayons of the Voznesensk hospital district.

7.1 | Health service delivery

Because the Voznesensk rayon lacked sufficient budgetary capacity, hospital ownership was transferred to Voznesensk city by virtue of the flexibility decentralization provides. The hospital director then engaged in a constructive dialogue with the newly elected young and progressive ATH leadership. He successfully advocated the transfer of the ATH subvention directly to the hospital and attracted additional ATH funds for quality improvements by stressing the political capital they could build in their constituencies. The ATHs themselves soon took the initiative to identify other areas for health service improvements. The required burden of investment was shared (if too costly for a single ATH to bear) and the funding provided – under new legislation – only to those ATHs willing to financially contribute.

The hospital was able to use three years' worth of detailed patient data by type of services provided and place of residence to calculate expected costs, prepare monthly reports and to negotiate and advocate patiently inter-LSG budget contributions, also taking into account their actual financial resources. In the case of Voznesensk hospital, local democratic accountability, progressive and proactive leadership, willingness to communicate and clear assignment of responsibility proved critical in securing funding and improving services.

7.2 | Health service financing

The NHS has contracted Voznesensk hospital for a wide range of inpatient and outpatient Programme of Medical Guarantees (PMG) services. The 2020 PMG budget of 44.7 million Ukrainian hryvnia (UAH) for the first nine months of operation represents a nominal 16% increase compared to same period in 2019. In addition, the hospital will receive UAH 13.9 million for services specifically related to coronavirus disease (COVID-19). However, COVID-19 and the attendant economic crisis – together with the as-yet undetermined impact of health financing reform in these conditions – have placed great strain on health facilities and local budgets. No local budget funds have been allocated since April 2020, except for utilities now exclusive covered by the city budget. The share of Voznesensk local budget contribution to the hospital between April and June 2020 dropped from 26.5% to 9.5% when compared to same period in 2019; and those of ATHs from 3.0% to 1.2%. Continuing operation is made possible because the share of state budget/NHSU contributions increased by 13 percentage points to 79%, but also because charity, official development assistance and non-health government contributions more than doubled, reaching over 10%. Voznesensk hospital illustrates the difficulties faced by poorer LSGs, as well as their vulnerabilities to economic and epidemiological shocks. This highly productive hospital aims to attract more patients through service quality improvements but is in funding competition with separate primary health care centres in each small ATH. It must rely on the continuing efforts by the hospital director to secure funding from budgets fragmented across many small LSGs, where even clear financing obligations are difficult to enforce. It highlights the advantages a single large council responsible for hospital expenditure would present, and in particular the need for greater equalization in LSG financing.

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

Member States

Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Croatia
Cyprus
Czechia
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Montenegro
Netherlands
North Macedonia
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
Serbia
Slovakia
Slovenia
Spain
Sweden
Switzerland
Tajikistan
Turkey
Turkmenistan
Ukraine
United Kingdom
Uzbekistan

WHO/EURO:2021-2593-42349-58635

World Health Organization Regional Office for Europe

UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel: +45 45 33 70 00 Fax: +45 45 33 70 01
Email: eurocontact@who.int
Website: www.euro.who.int