Struggling with the inheritance of the Soviet Semashko model:

Primary Health Care policy and practice in Ukraine

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A thesis submitted in partial fulfilment of the requirement for the degree of Master in International Health

By
Suzanne Viveen,
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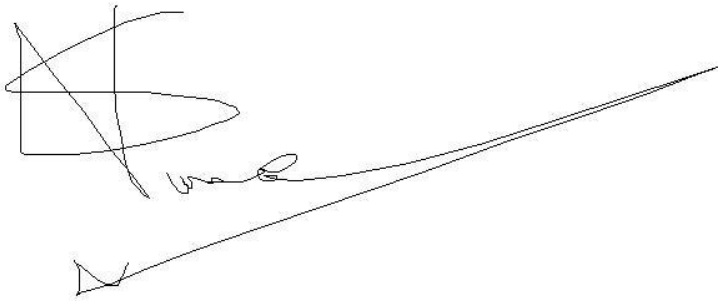

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Abbreviations

AIHA	American International Health Alliance
CEE	Central and Eastern Europe
CIS	Common Wealth of Independent States
DT	District Therapist
GDP	Gross Domestic Product
GP	General Practitioner
EERC	Economics Education Research Consortium
EU	European Union
FM	Family Medicine
FFS	Fee for Service
IMF	International Monetary Fund
MOH	Ministry of Health
NGO	Non Governmental Organization
NIVEL	Netherlands Institute for Health Services Research
PCET	Primary Care Evaluation Tool
PHC	Primary Health Care
USAID	United States Agency for International Development
U.S.S.R	Union of Soviet Socialists Republics
OOP	Out of Pocket
WB	World Bank
WHO	World Health Organization
WHO HFA DB	World Health Organization, Health For All Database

Abstract

Objective and methods
Since its independency (1991) Primary Health Care reform has been a stated priority in Ukraine, aiming to increase the efficiency of its health system and subsequently improve the low health status of its population. However, recent evidence indicates the reform is still in the beginning of its transition. In order to explain the stagnation, in this study a review was made of the former and current state of primary care in Ukraine. The results were compared with the latest governmental plans and two frameworks were used to identify what factors contributed to the differences found.
Results
The results show significant differences between the promising governmental plans and the current state of primary care in Ukraine. As a possible explanation for these differences, the framework of Roberts et al.. (2008) shows that almost none of the five 'control knobs' (funding, finance, organisation, legislation, behaviour) of the system have been changed. The framework of Sondorp and Percival (2011) leads to question the governmental motivation for and dedication to the reform plans. Moreover it identifies political instability and medical professional resistance as other significant hindering factors for the implementation of reforms.
Conclusions
In order to implement an effective primary care reform in Ukraine, the involvement of governmental and regional policymakers, physicians as well as international stakeholders in the development of plans is indispensible. Hopefully, this will strengthen their long term commitment to the reform and enable to institutionalise General Practice in Ukraine and gain the confidence of the population to use it.

Keywords:

Ukraine, Primary Health Care, Health Care Reform, Health Sector.

What led me to choose this subject?

As a general practitioner and tropical doctor, I worked and studied in different countries in Europe, Africa and Latin America. These gave me the opportunity to experience and observe differences in the way primary care was organised in these countries and the effects this had on the health of their populations. In my opinion primary care should be the corner stone of a health system, as it is the most efficient and comprehensive way of providing (at least basic) health care to its population and increasing the overall health of the population.
During my vocational training to become a General Practitioner, I did a three month internship at the Netherlands Institute for Health Services Research (NIVEL) and got fascinated by the reform processes of ex-Soviet and central European countries. From the nineties all of them searched to reform their Soviet health systems, mainly based on specialist-care, into a primary health care based system in order to improve its efficiency. Strikingly, in contrast to many other countries, twenty years later Ukraine still seems to be in the beginning of this process. And as the low health status of its population is demanding a system that can respond to their needs, with this thesis I hope to be able to contribute to a more effective primary health care reform.

Acknowledgement

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Michiel for all of his patience in this seemingly never-ending project

1 Background

1.1 Health care and health care system of the former Soviet Union

Before the fall of communism, the health care system in the Union of Soviet Socialists Republics (U.S.S.R) was based on the centrally planned and state financed Soviet Semashko model, with a strong focus on secondary care. Family medicine, in the form of a single type doctor of first contact to provide longitudinal and coordinated care, did not exist. Primary care physicians, called District Therapists (DTs), were mainly busy with administrative tasks and annual check-ups (Ryan and Stephen, 1996; Platonenko, 1993), while curative services were provided by directly accessible medical specialists, working in polyclinics (Grielen and Boerma, 2000; Rechel and McKee, 2009).
In theory, free access to all health services was available for the entire population. However, in practice the system had many weaknesses. A shortage of pharmaceuticals and medical supplies led to black markets. Medical salaries were kept artificially low, thus stimulating the demand of out of pocket (OOP) payments as compensation. The delivery of care was inefficient, due to disproportional numbers of hospital beds and physicians, working in narrow specialised areas, with rudimentary skill levels by Western standards (Healy and McKee, 1997). And above all, the system was paralyzed by corruption and a 'suffocating bureaucracy and command mentality' (Platonenko, 1993).
The problems in the health care sector were reflected in the health status of its population: U.S.S.R was unique among post-industrial societies, having a declining life expectancy and rising child mortality between 1966 and 1986 (Anderson and Silver, 1986; 1989).

1.2 Independence: start of a transition period and health care reforms

For all former Soviet countries, independency (1991) was the start of a difficult transition period towards a democratic society and market economy. In parallel with this transition, all of them have been struggling to reform the structure of their health care systems in order to improve its performance and cost effectiveness. In these countries, with their historical emphasis on costly hospital based care, strengthening of primary health care (PHC) is generally recognized as an effective instrument to achieve these goals (Marrée and Groenewegen, 1997; Saltman and Figueras, 1997; Delnoij and Klazinga 2003; World Health Organisation, 2008; Starfield 1994).
As the culture, political situation and socio-economic development of the fifteen newly independent states vary widely, so do their approaches of PHC reform.
Not surprisingly, the Baltic states of Estonia, Latvia and Lithuania, who have always been pro-Western and are now all part of the European Union, were forerunners to scale up and institutionalise family medicine centred PHC (Koppel et al.. 2003; Svab et al.., 2004; Tragakes et al., 2008;). In contrast, as I will describe below, the more 'Soviet-leaning' Ukraine had far more difficulty setting up PHC and implementing its intended reform (Lekhan, Rudiy and Richardson, 2010).

1.3 Economy, politics and health indicators of Ukraine

Economy and politics

Ukraine, by geographical size the largest country in Europe, has almost 46 million inhabitants and is dived into 24 'oblasts' (regions), which are again dived into 490 rayons (districts).

Ukraine was an important economic component of the former Soviet Union. Its fertile black plains in the centre generated a high agricultural output, while its diversified heavy industry, mainly situated in the Eastern part of the country, supplied ample equipment and raw materials (Sutela, 2012). After independence (1991), it was expected that it would become a wealthy free market economy and eventually join the European Union.

Unfortunately the country was challenged by a deep economic crisis that included the worst hyper-inflation in the region and a significant decline in production (Lekhan, Rudiy and Nolte, 2004; Sutela, 2012). Ukraine attempted to transform to a democratic market economy, but this was combined with a growth of corruption and the development of a shadow economy, with most of the Soviet power structures remaining intact (Aslund, 1995; Dyczok, 2000).

In this context, the historical division between the eastern and western regions of Ukraine is important: The latter generally favour private ownership and radical economic reforms, while the eastern regions are predominantly Russian oriented and prefer a Soviet-style economy (Pilyavsky and Aaronson, 2006).

Between 2001 and 2008 the Ukrainian economy grew again, mainly due to production of metals by privatised ex-Soviet oligarchs (Sutela, 2012). In the meantime dissatisfaction grew under the population about the semi-authoritarian power of the Soviet-leaning Kuchma-regime, leading to the 'orange revolution' which brought the more Western oriented Viktor Yuschenko to presidency in 2005 (Kubicek, 2009). Unfortunately the new system proved as unstable as the old, with continuous conflicts on unfinished reforms, unclear boundaries between presidential and parliamentary power and increasing corruption (Lekhan, Rudiy and Richardson, 2010). This eventually led Russia-oriented Yanukovich and his 'Party of the Regions' to win the most recent presidential (2010) and parliamentary (2006, 2007 and 2012) elections again.

Economically, Ukraine is suffering severely from the global economic crisis: it has led to more than 15% decline in Gross Domestic Product (GDP) in Ukraine in 2009 (World Bank, 2009) and as its corruption hampers any grow in the private sector, it is not likely these figures will improve soon (Tarantino et al., 2011).

Health status of the population

The economic and political crisis mentioned above led to reduced living standards and a deteriorating health status for large parts of the population. The inefficient health system was not able to respond adequately to the increased need for health care, only aggravated the situation. The birth rate fell by almost 40% between 1990 and 2001, leading to an 7,5% population decline. At the same time, Ukraine experienced a severe mortality crisis, with male life expectancy falling by more than 4 years between 1990 and 1995 (Lekhan, Rudiy and Nolte, 2004).

As shown in table 1, Ukraine's current life expectancy is still more than 10 years below the European average (World Health Organisation, Health for All Database, 2009). Diseases of the circulatory system account for 59% of the deaths. And with almost 50% of men being smokers (WHO HFA DB, 2011), smoking accounts for a considerable part of Ukraine's mortality (Lekhan, Rudiy and Richardson, 2010). High infant and maternal mortality are other worrying indicators. They are not only worse than the European average, but also much higher than in for example neighbouring Belarus. In addition, Ukraine has one of the fastest growing HIV epidemics in the world. TB is another epidemic, which is not under control (Lekhan, Rudiy and Nolte, 2004; Tarantino et al., 2011).

Table 1: Health indicators, demographic indicators and health care resources of Ukraine

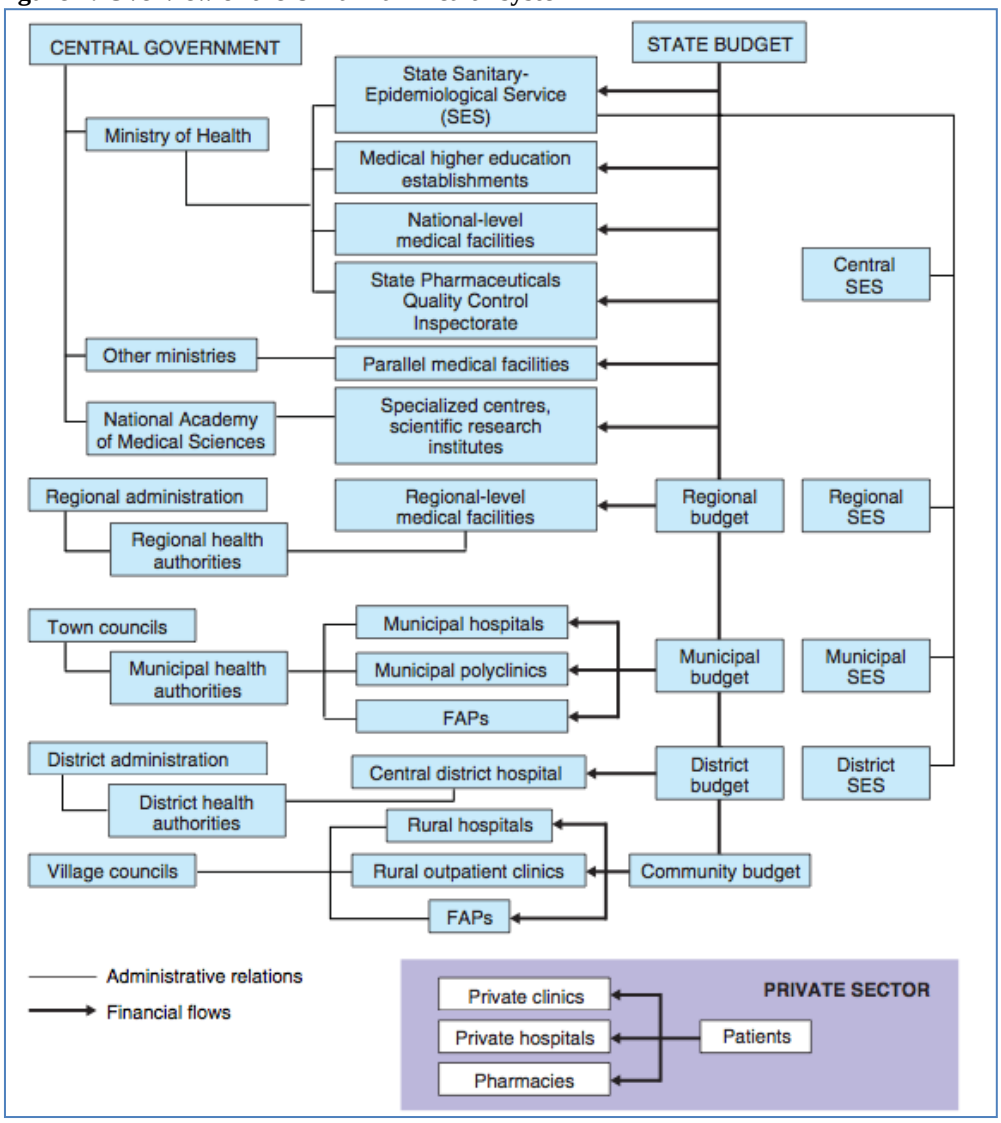
	Indicator	Ukraine	Belarus	CIS average	EU average	Source of data
Demographic Indicators	Population (millions)	45,5	9,5			HFA DB 2011
	Pop density (per km^2)	79	47			WDI 2010
	Population growth	-0,54%	-1,0%	0,49%	0,42%	WDI 2008 Eurostat-2010
	Urban population (% of total pop.)	68%	74%	53%	71%	WDI 2008, Eurostat 2010
	GDP per capita (in US$)	$ 3615	$ 6328	$ 8703	$ 34877	HFA DB 2011
	GDP growth (annual %)	-15%	0,2%	-1%	-4%	WDI 2009
Health indicators	Life expectancy at birth (years) Overall, male (M) female (F)	69,7 M 64,4 F 74,9	70,6 M 64,8 F 76,6	69,5 M 64,5 F 74,7	79,9 M 76,8 F 82,8	HFA DB 2009
	Total fertility rate (children per woman)	1.46	1.51	1.65	1.55	HFA DB 2011
	Standardised Death Rate (/1000 pop)	12,0	11,6	12,0	6,1	HFA DB 2009
	Estimated infant mortality (per 1000 live births)	11	4	17,5	4,1	HFA DB 2010
	Death on diseases of circulatory system (per 1000 pop SDR)	5,9	4,3	5,4	1,8	HFA DB 2009
	Abortions / 1000 live births	224	308	351	221	HFA DB 2010
	Maternal deaths /100.000 live births)	25,2	0,92	27,7	6,7	HFA DB 2009
	TB incidence /100.000	75,2	49,6	76,7	12,2	HFA DB 2011
	HIV incidence/100.000	38,8	12,6	32,1	5,7	HFA DB 2010
	Regular smokers (% of 15+ population) overall, male (M) and female (F)	24,9 M 47,6 F 6,1	27 M 51,2 F 9,8	-	-	HFA DB 2011
Health resources	Expenditure on health care as % of GDP	7,7%	5,6%	5,7%	9,9%	HFA DB 2009
	Out of pocket payments on health, as % of total expenditure on health	42,0%	26,9%	-	-	HFA DB 2009
	Physicians/100.000 population	350	365	380	329	HFA DB 2009
	Hospital beds/100.000 population	869	1107	841	552	HFA DB 2009
	Hospital admissions/100 pop.	22,4	30,0	20,3	17,8	HFA DB 2009
	General Practitioners/100000 pop.	36	45	29	82	HFA DB 2009

Source: WHO Health for all database (HFA DB), World Bank World Development Indicators (WDI), European Commission Eurostat (Eurostat)

Health care system of Ukraine

The organisation of the health care system in Ukraine is still based on the old Soviet-Semashko model. This model was built on the following principles: The health care system was financed entirely through the state budget (general taxation). Health care facilities were all state owned and were funded based on capacity, such as staffing levels and number of beds (Grielen, Boerma and Groenewegen, 2000). Health care was provided free of charge for all. There was no distinction between primary or secondary care. Almost all services were provided by directly accessible specialists and there was an emphasis on hospital based care, with a relatively high number of hospital beds and hospital admissions (Rechel and Mckee, 2006).
The current public health system in Ukraine is officially still financed by general taxation and should (constitutionally prescribed) provide free health care for every citizen. The Ministry of Health (MOH) coordinates the system, although there are many ministries that have their own (paralleling) medical facilities. Ukraine has an almost insignificant private health care sector, which accounts for less than 1% of total health expenditure (Lekhan, Rudiy and Richardson, 2010). In figure 1 an overview is given of the current health system in Ukraine:

figure 1: Overview of the Ukrainian Health system



Source: Lekhan, Rudiy and Richardson, 2010

The main differences between the current health system in practice and the theoretical basis of the Semashko system are:

- As a result of governmental decentralisation reform in the nineties local self governments are now responsible for the management of the health services in their region, although they still have to abide to the strict central regulations. As shown in figure 1, they are now directly funded by the state budget. (Tarantino et al., 2011; Lekhan, Rudiy and Richardson, 2010).
- Patients are obliged to pay OOP costs for the provision of services and these OOP costs make up more than 40% of the total expenditure on health (World Bank, 2009)
- There is a shortage of physicians in rural areas, which impedes the accessibility of health care for these populations (Lekhan, Rudiy and Richardson, 2010)

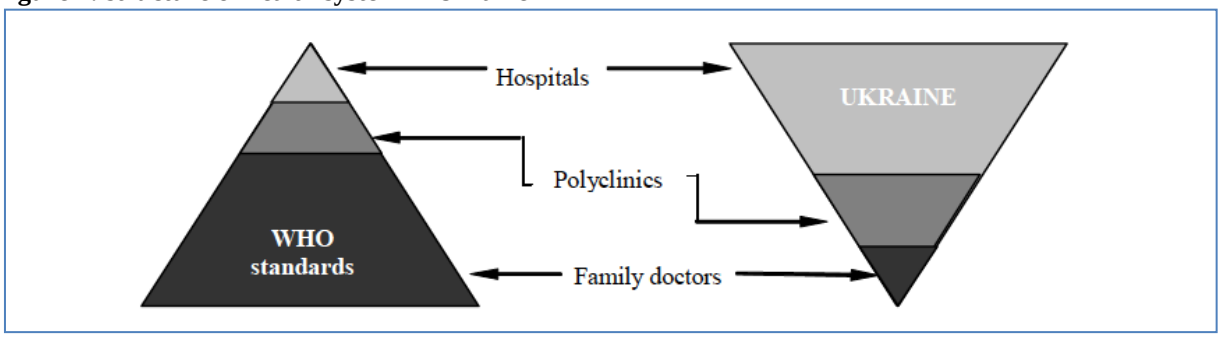
In table 2 the differences and similarities are arranged according to the four main functions of a health system, as defined by the WHO Health system framework (WHO, 2000)

Table 2 differences and similarities between current Ukraine health system and Semashko system

	Theoretical basis of the Semashko Health system	**Current health system in Ukraine (2009-2011)**
Financing	• 100% state financed (general taxation) • Financing of the health system centrally planned • Financing of facilities based on capacity	• Mainly state financed (general taxation), although 40% of expenditure on health is funded through OOP payments • Regional facilities financed through regional budgets • Financing of facilities based on capacity
Stewardship	• Health system centrally planned and governed by MOH • Ministries having their own medical facilities	• Local governments responsible for management of regional health facilities • Ministries having their own medical facilities
Generating resources	• Emphasis on secondary/hospital based care.	• Emphasis on secondary/hospital based care. • Lack of physicians in rural areas
Delivery of services	• Free health care for all	• Affordability and accessibility limited by OOP costs and by the shortage of physicians and facilities in rural areas

The major part of the health care services in Ukraine is still provided at the level of secondary and inpatient care, as is reflected in the high number of hospital beds and hospital admissions, and the low number of general practitioners in table 1. Similarly this is where most of its funding is spent on. Primary care is relatively underdeveloped and underfunded, which leads to an expensive health care structure that is the opposite of the WHO standards, as shown in figure 2 hereunder.

figure 2: structure of health system in Ukraine



Source: Betliy, Kuziakiv and Onishchenko, 2007

Primary health care in Ukraine

Since its independency in 1991, Ukraine went through a long and tedious debate on the best approach to set up PHC, according to the principles of family medicine (FM): a single type doctor (General Practitioner) being the point of first contact to provide longitudinal, comprehensive and coordinated care. Retraining of the district therapists (DTs) into General Practitioners (GPs) with a broader task profile was already initiated on a small scale in the nineties, although lack of a clear national policy impeded the progress of this reform.

Hence, the governmental health policy programme 'Health of the Nation' (2002) was an important step in the intended transformation of PHC. This plan proposed to convert all existing PHC units, staffed by DTs, into a new network of vocationally trained GPs in 2010. Moreover, it aimed to reduce the high workloads of primary care physicians by raising their total number. Since then, the same goals have been repeated in various other policy documents (Boerma and Kringos, 2010; Lekhan, Rudiy and Nolte, 2004).

Despite these ambitions, little actual steps towards implementation of the plans have been taken so far. The training process of GPs is proceeding slowly (Rechel and Mckee, 2009) and the attempt to raise the total number of primary care physicians has not succeeded yet: In 2007, only 10 % of all physicians were working in PHC, which is far below the European average of 30% (WHO HFA DB, 2007).

To get more clarity on the state of primary care in Ukraine, WHO initiated an evaluation of the state of its PHC in 2010. For this evaluation the 'Primary Care Evaluation Tool' (PCET, Kringos et al., 2008) was used, which uses a combination of questionnaires of a random sample of primary care physicians and patients in two different regions, subdivided in rural and urban areas, as well as reports of several governmental and nongovernmental stakeholders. The results of the PCET in Ukraine show that there is a severe shortage of primary care physicians, there are no incentives for professional development, there is a lack of equipment and a lack of training capacity of general practitioners. Furthermore it reveals that the clinical task profile of primary care physicians is narrow: Almost no difference in clinical task profile or performance is found between (re)trained general practitioners (GPs) and the former district therapist (DTs) (Boerma and Kringos, 2010).

2 Problem statement, Objectives, Research Questions and Methods

2.1 Problem statement

After its independence Ukraine suffered a deep economic crisis, which led to reduced living standards and a deteriorating health status for large parts of its population (Sutela, 2012; Lekhan, Rudiy and Nolte, 2004). Twenty years later it still struggles with a low life expectancy, with diseases of the cardiovascular system accounting for most of the deaths, and worrying high incidences of HIV and TB (Lekhan, Rudiy and Richardson, 2010).
As stated before, PHC is internationally acknowledged as an effective way to improve the performance and cost-effectiveness of health care systems (WHO, 2008; World Bank, 2010).
Therefore, since its independency (1991) the Ukrainian government has formulated plans to transform its secondary care based health system and to develop a family medicine based PHC system. The aim of this planned reform is to increase the efficiency of its health care system in order to ensure fairness and equity in health, promote healthy lifestyles, reduce the incidence of socially important diseases and improve the health status of its population (Lekhan, Rudiy and Nolte, 2004). However, in spite of promising governmental plans, a recent evaluation of the current state of PHC in Ukraine reveals that the reform process is still in the beginning of its transition (Boerma and Kringos, 2010).

2.2 Objective

The problem statement lead to the formulation of the following objective for this thesis: To analyse which factors caused the stagnation of the Ukrainian PHC reform, in order to formulate recommendations for future improvements of its PHC, aiming to increase the effectiveness of its health care system and consequently improve the low health status of its population.

2.3 Research questions

To be able to achieve the objective the following research questions need to be answered:

A. What is known on the current state of PHC in Ukraine and to what extent does it differ from PHC in its Soviet episode (before 1991)?
B. What differences are found between the governmental plans for PHC and the current state of PHC in Ukraine?
C. What factors can be identified, that affected the PHC reform and could explain the differences between governmental plans for PHC and the current state of PHC?

2.4 Relevance of this study

The WHO (2008) as well as the World Bank (2005) has stressed repeatedly that information on effectiveness and performance of PHC systems is indispensible to guide and optimize reforms. Unfortunately this information is generally lacking (Rechel and McKee, 2009) and decisions on reforms are still made on politics, rather than evidence.
There have been evaluations of the Ukrainian health system (Tarantino et al.., 2011; Betliy, Kuziakiv and Onishchenko, 2007; Lekhan, Rudiy and Richardson, 2010) and a recent evaluation of its PHC system (Boerma and Kringos, 2010). However, a literature review, combining all available evidence on the state of its PHC, and a specific analysis of its PHC reform process and the factors influencing this process is lacking. Especially at present, while the government is developing new reform plans and aiming to implement them in the coming years (MOH Ukraine, 2011), this analysis of the state of PHC in Ukraine and the factors

impeding the PHC reform process is relevant for local policymakers as well as for international stakeholders such as WHO and World Bank. Hopefully this thesis helps to promote discussion and evidence-informed decisions on further reform plans.

2.5 Methods/ Data collection

The following methods were used to answer the research questions:

1. A directed literature search for currently available evidence on the topic of PHC and its reform in Ukraine was carried out in November 2012.

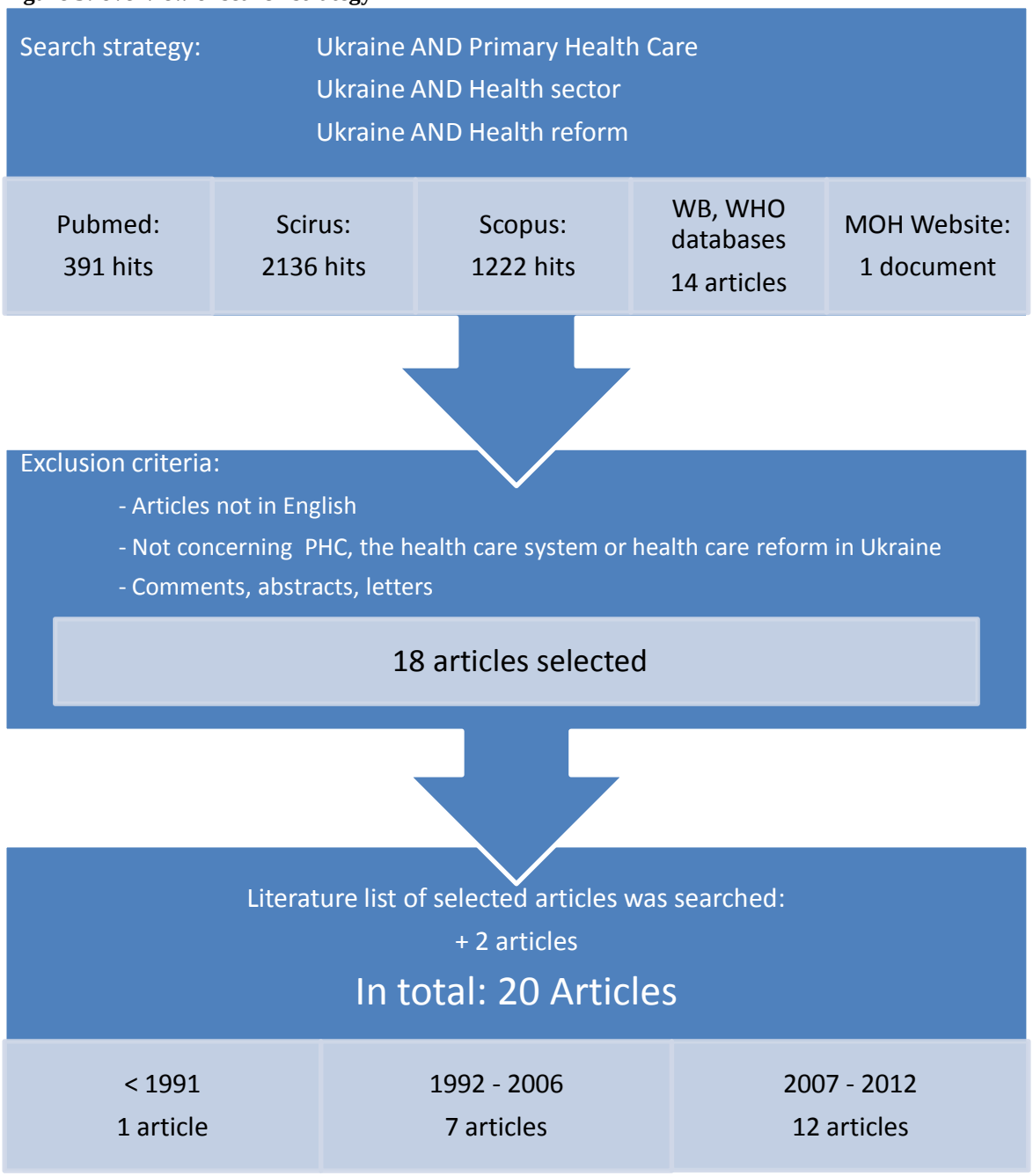
    - ◊ Pubmed, Scirus and Google scholar databases were searched, using the terms 'Ukraine' and 'rimary health care', 'Ukraine' and 'Health care reform' and 'Ukraine' and 'health care sector'.
    - ◊ The databases of WHO and World Bank were searched with the same search terms.
    - ◊ The website of the Ministry of Health of Ukraine was searched for the latest policy plan. In view of the relevancy of this plan, a translator was found prepared to help translating this text.
    - ◊ Reference lists of all selected articles were screened for relevant articles.
    - ◊ When an email-address was available, authors of relevant documents on the Ukrainian PHC system were contacted in order to gain more recent information.

    The following exclusion criteria were applied:
    - ◊ Comments, abstracts and letters were excluded
    - ◊ As no translator was available to translate articles (apart from the governmental reform plan), the search was restricted to English literature.
    - ◊ Articles that did not concern primary health care, health care reform or the health care system in Ukraine, or articles that merely focused on one aspect of its health system (for example how the health system dealt or deals with Tsjernobyl, HIV, TB) were excluded.
    - ◊ Given the scarce evidence available, no time limit was used for this search.

    However, only articles dating from 2007-2012 were considered as representing the current situation. Articles dating from 1992- 2006 were used to describe the evolution of PHC during the years following Ukraine's independence and articles from before 1991 were used to describe PHC during the Soviet episode.

    Twenty relevant articles were identified. Hereunder in figure 3 an overview of the search strategy is given.

figure 3: overview of search strategy



2. In order to give a comprehensive overview of the current state of PHC in Ukraine, the following framework was identified and used, as it allows for a structural description of the aspects and functions of PHC:

   <u>The theoretical framework, which was used for the Primary Care Evaluation Tool (PCET)</u>
   The PCET is a standardised instrument, developed to evaluate the structure and provision of PHC (Kringos et al.., 2008). This tool is based on the WHO Health system framework, which indicates performance of a health system is determined by the way in which its four key characteristics are organized: stewardship, generating resources, financing and service provision (WHO, 2000). In order to describe the delivery of services in more detail, these characteristics were combined with the four main functions of primary care systems:

accessibility, continuity of care, coordination of care and comprehensiveness of services, as described by Barbara Starfield (Starfield, 1976; 1991; 1994; 1998; Kelly and Hurst, 2006; Boerma, 2003; Slibthorpe, 2004; Watson et al., 2004).

Table 3: Aspects of PHC, arranged according to the framework of the PCET (Kringos et al., 2008)

Functions	**Examples**
Stewardship	policy vision; legislation; regulations
Resource generation	human resources; education; facilities and equipment
Financing	mode of payment of service providers; financial incentives for providers
Service provision	
- **Access**	Extent to which the population uses the service; What are the barriers?
- **Continuity**	Do people relate to the same provider over time for all but referred care?
- **Coordination**	Available information system; Collaboration with other health workers
- **Comprehensiveness**	What is the breadth of services provided?

The PCET has been used by the WHO in their evaluation of the state of PHC in several central and eastern European (CEE) and former Soviet (CIS) countries, including Ukraine. As the framework, where the PCET is based on, enables to structurally describe the different aspects of a primary health care system, this framework was used to arrange and analyse all the information that resulted from the literature search, in an accessible way.

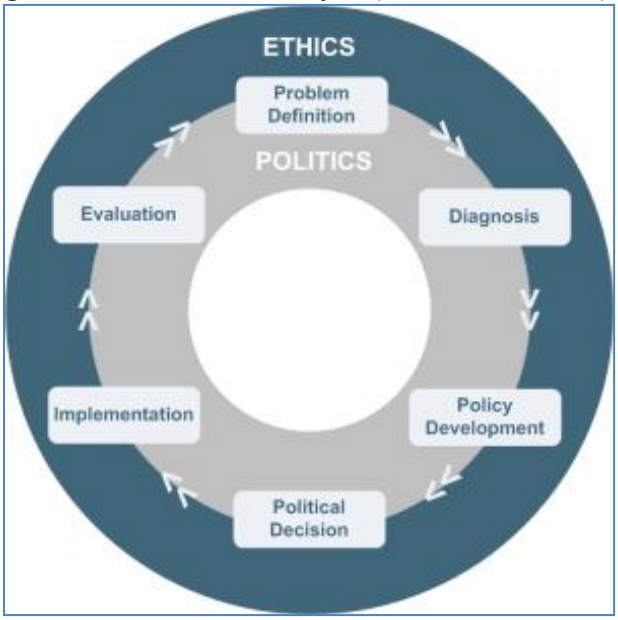
3. Identification of existing frameworks that could be suitable to guide the analysis of Ukraine's PHC reform, the factors influencing this reform and explain possible differences between plans and practice.

Health sector reform can be defined as 'a sustained, purposive change to improve the efficiency, equity and effectiveness of the health sector with the goal of improving health status, obtaining greater equity and greater cost-effectiveness for services provided' (Basch, 1999). Berman and Bossert defined it slightly different: 'Sustained, purposeful and fundamental changes intended to improve the performance of the sector in terms of efficiency, equity and effectiveness.' (2000).

◊ Health reform cycle and the five control knobs (Roberts et al.., 2008) There are many frameworks available to analyse health care reforms. Many of them are aimed at specific health care reforms or specific regions. I have chosen the health reform cycle of Roberts et al.. (2008), as it is comprehensive and broadly applicable. Their cycle consists of 6 steps, in which continuously political as well as ethical issues play a role: It indicates one should start with a problem definition (step 1), then make a good diagnosis of what the causes of the problem are (step 2), consequently develop

an appropriate policy to attack these problems (step 3) and make sure the corresponding political 'will and skill' is available (step 4). And after the final implementation (step 5) of the reform, it is important to evaluate (step 6) the process and its outcomes.

figure 4: The health reform cycle (Roberts et al., 2008)



According to Roberts et al.., to make an accurate diagnosis of the causes of the problem, reformers need to examine the five 'control knobs': the mechanisms that determine a system's health outcomes and can be adjusted by the reformers to improve performance. Health care reform will generally require more than one control knob to be changed, and changes in one of them will produce changes in other knobs as well. The five control knobs are:

i. Financing — How do we collect money?
ii. Payment — How are providers paid?
iii. Organisation — Mechanisms to influence the providers behaviour
iv. Regulation — Rules and coercive measures to change behaviour
v. Behaviour — Measures to influence behaviour (e.g. media campaigns)

This framework provides a comprehensive way to analyse the process of the health reform (the policy cycle) as well as the mechanisms that can/should be adjusted to elicit a (positive) change in health outcomes. Therefore I reckon it will be a useful tool to analyse the health reform process in Ukraine and search for possible causes of the differences found between policy and practice.

◊ Conceptual framework to analyse health reform in post-conflict settings (Percival and Sondorp, 2010)

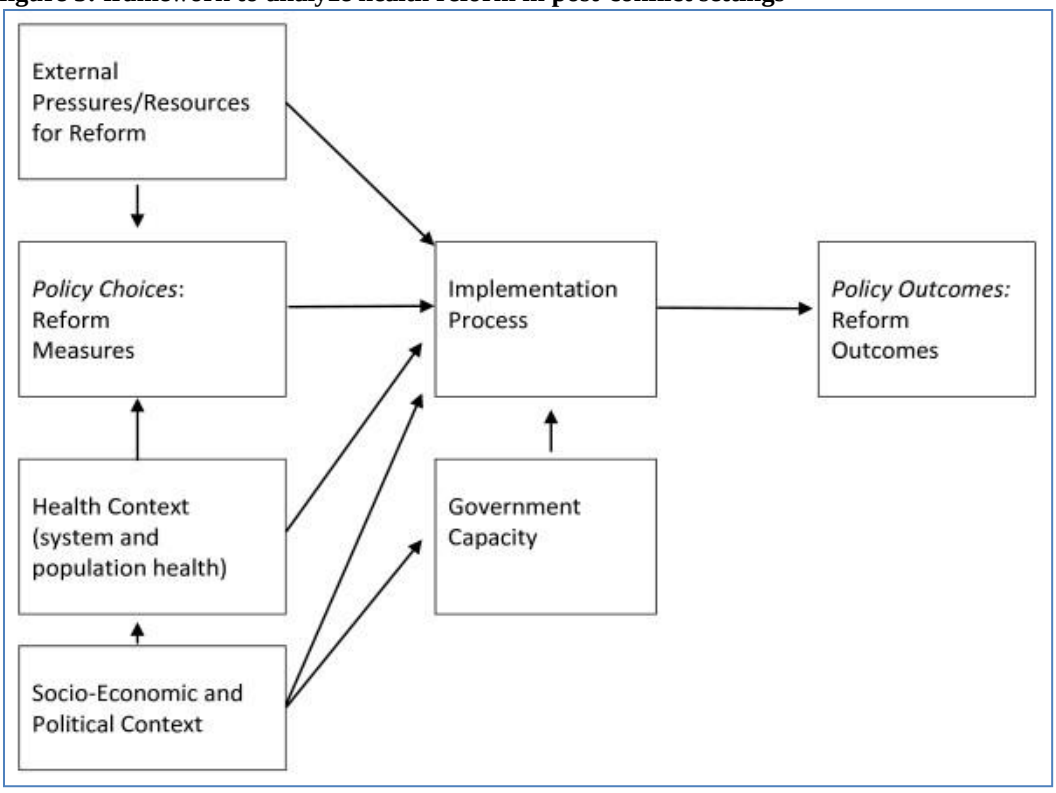
As described in section 1.3, the political situation in Ukraine has been very unstable, unpredictable and non-continuous since its independency in 1991, with multiple changes of government and frequent conflicts within governments, which has significantly compromised effective health care reform (Lekhan, Rudiy and Richardson, 2010). As Roberts et al. acknowledge themselves: 'the control knobs do not explain everything'; it is important to look at a nations cultural, political and structural aspects as well. Therefore I have sought for another framework, which

enables to 'zoom out', so that we are not only looking at the health sector and its reform, but also overseeing the political, social and economic environment influencing this reform.

The conceptual framework to analyse health reform in post-conflict settings, as developed by Percival and Sondorp (2010) for the analysis of the health reform in Kosovo, seems to meet this requirements, although it was originally developed for post conflict settings instead of for a 'chronically politically instable' country such as Ukraine.

The framework, as shown in figure 5, indicates that reform programs are often externally (donor) driven to solve the problems of the low health status of the population and to restore/renew a damaged health system. The socio-economic and political context of the country majorly affects the ability of the country to implement the reform. And external pressure (donors) can lead to 'over-rushed' implementation of the reform measures. All of these factors will affect the final outcomes of the health reform. Finally, the framework indicates it can be difficult to effectively evaluate these outcomes, partly due to lack of information systems and partly due to the time lag between reform measures and eventually improved health outcomes (Percival and Sondorp, 2010).

figure 5: framework to analyze health reform in post-conflict settings



Source: (Percival and Sondorp, 2010)

4. The two frameworks above were used to analyse Ukraine's PHC reform, the different phases of the process and the political, economic and environmental factors influencing it.

3 Results

3.1 The current state of Primary Health Care in Ukraine

As stated in the methods section, the framework of Kringos et al.. (2008) was used to categorise the currently available information on the present state of primary health care in Ukraine. As explained in the methods section as well, the present state is defined as the episode from 2007 – 2012. Episode 1992-2006 will be used to describe the evolution of PHC in Ukraine until now and the episode before 1991 will be used to describe PHC during the Soviet episode.

3.1.1 Stewardship: Policy vision, legislation and regulation

Reform of PHC and the introduction of GPs was described as a national policy goal for the first time in 1992 (Boerma and Kringos, 2010) and in 1997 the president officially declared there would be an operational GP system in 2000 (Gibbs et al.., 1999).
The constitution however, as approved by the parliament in 1996, which states that health care should be free of charge, determines as well that 'the existing network of health care facilities may not be reduced,' thus limiting the possibilities to reduce secondary care in favour of primary care (Boerma and Kringos, 2010).
In 2000 two significant documents were issued, incorporating family medicine as an important area of reform and providing the regulatory basis for the development of general practice, which started to develop from then on (Lekhan, Rudiy and Nolte, 2004). In 2002 a comprehensive reform plan, called 'Health of the Nation' was issued, based on the WHO recommendations for strengthening of PHC. Consequently all governmental reform plans, issued since then, are based on or similar to this plan.
An important milestone was the creation of a special 'primary health care' department at the Ministry of Health in 2007 (Boerma and Kringos, 2010).
In 2008 the cabinet of Ministers issued a program, called "The Ukrainian Breakthrough", aiming to develop the legislative basis for the implementation of general practice and aiming to provide every Ukrainian Family with a GP in 2013 (Gibbs, Khimion and Lysenko, 2008; Boerma and Kringos, 2010).

Until now the guiding document in (primary) health care has been the 'National Plan of the Health Care System Development 2007 – 2010', which included the following goals, concerning PHC (Boerma and Kringos, 2010):

- Intensification of PHC reorganisation according to the principles of general practice
- An increase in the training capacity of GPs
- Introduction of financial and other incentives for primary care workers
- Development and implementation of medical guidelines in primary care
- Recognition of the GP as a coordinator of care (including setting up a gatekeeping system)

Furthermore, a more recent reform plan has been issued by the Ukrainian Ministry of Health (MOH) in September 2011, aiming to be carried out from 2012-2014. The goals of this plan, regarding PHC, are:

- To divide health care in different levels of care: primary, secondary, tertiary
- Strengthen PHC and further develop the institute of Family Physicians
- Provide education on a healthy lifestyle and incentives for healthier living (MOH Ukraine, 2011)

3.1.2 Human resources, practice conditions and professional development

Human resources

In a fellowship with the UK Royal College of General Practitioners (1993-1997) Ukraine started training GPs in order to set up a family medicine based primary care (Gibbs, Mulka and Zaremba, 1998). At present there are 15 medical universities offering the 2-year postgraduate GP training (including 12 months in primary care) as well as the 6 months GP re-training course (without practical training in primary care) for physicians from other specialties. There are three medical academies offering only the 6 month retraining course. No professors in General Practice exist, as General Practice has not been recognized as a scientific specialty (Boerma and Kringos, 2010).

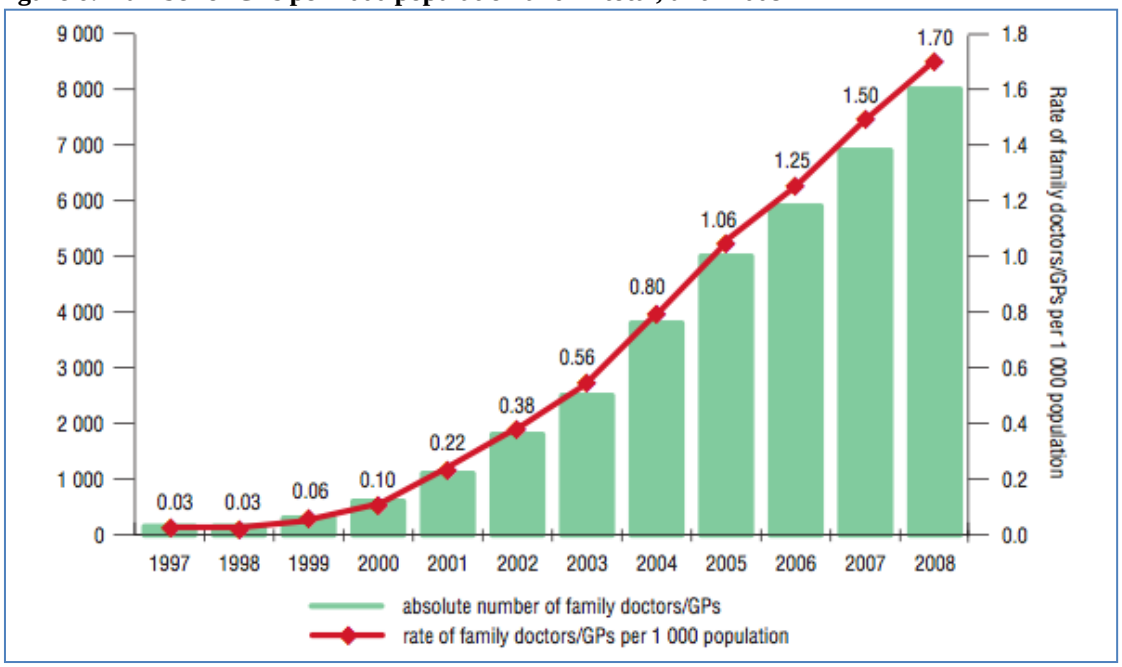
Numbers of GPs increased steadily between 1997 and 2008 (see figure 6; Lekhan, Rudiy and Richardson, 2010; Gibbs, Khimion and Lysenko, 2008). However, since 2008 the total number has stayed around 8000, and they make up 1/3rd of all primary care physicians (Boerma and Kringos, 2010; Parusinsky, 2011). Based on the governmentally specified workload of 1500 patients per GP, 33.000 GPs are needed nationwide (World Bank, 2007), which means at present less than 25% of the need is met.
According to USAID 626 GPs finished their training in 2010, while the same amount left their posts that year (Tarantino et al., 2011).

The two main reasons for this stabilization of GP numbers are:

1. 50% of these GPs leave their jobs yearly for other jobs, or to move abroad, due to the low salary and low status (Gibbs, Khimion and Lysenko, 2008), and (rurally) poor infrastructure and social conditions (Lekhan, Rudiy and Richardson, 2010).
2. Almost half of them are nearing the retirement age (Lekhan, Rudiy and Richardson, 2010).

The shortages are also reflected in the results of the PCET (Boerma and Kringos, 2010). The authors performed an evaluation of the current state of primary health care, based on questionnaires of GPs and patients in two different regions, subdivided in rural and urban areas, as well as on the reports of several relevant governmental and nongovernmental stakeholders. Their results indicate that 57% of the questioned primary care physicians reported a staff shortage, and that their workload lies around 50% above national norms (Boerma and Kringos, 2010; Lekhan, Rudiy and Richardson, 2010).

figure 6: Number of GPs per 1000 population and in total, until 2008



(Source Lekhan, Rudiy and Richardson, 2010)

Practice conditions and professional development

With respect to practice conditions, more than two thirds of patients and physicians, who were questioned in the PCET, indicated a severe shortage of medical equipment (Boerma and Kringos, 2010), which is an obstacle for the provision of medical-technical procedures and professional development.

As described above, a 24-month vocational training scheme in general practice exists, and a 6-month retraining course, provided in 18 medical departments (Boerma and Kringos, 2010; Gibbs, Khimion and Lysenko, 2008).

However, severe hindering factors for the professional development of family medicine are: the lack of financial resources for training, the absence of practical clinical guidelines (Boerma and Kringos, 2010), the fact that some parts of general practice cannot be trained due to 'protectionisme' of specialist groups, the absence of professors in Family Medicine and the fact that family medicine has not been recognised as a scientific specialty in Ukraine (Gibbs, Khimion and Lysenko, 2008). Finally, although a Family Medicine association exists and is involved in the development of clinical guidelines and professional development, only 150 GPs (2% of all GPs) are members (Boerma and Kringos, 2010).

3.1.3 Financing

Funding and health care expenditure:

Although the National plan of 2007 aimed to introduce a social health insurance, at present health care revenues are still raised through general taxation. Health care expenditure is 7,7% of GDP (World Bank, 2009). Most of this money (87%) is spent on inpatient care; an inheritance of the Soviet health system, which focused on hospital care. Public health and preventative services receive only 3.5-4% of health expenditure (Lekhan, Rudiy and Richardson, 2010).

Provider payment and financial incentives

The provider payment system in Ukraine has two important characteristics:

1. It is related to territory, which leads to inequality between rich and poor regions
2. It is an inflexible line-item budget system, based on capacity (number of visits or number of beds) and staffing levels, instead of linking it to the (quality and quantity of the) service provided. This system provides perverse incentives to maintain excess capacity, discourages to improve productivity and inhibits efficiency (Lekhan, Rudiy and Richardson, 2010; Pilyavski et al.., 2006).

Local initiatives have led to small experiments of global budgeting and per capita payments, which proved to increase accessibility and quality of care and to be more efficient. However, in the end these experiments were counteracted by local authorities and the Ministry of Finance, partly influenced by protests of specialists and hospitals, fearing to lose funding (Lekhan Rudiy and Richardson, 2010).

In an effort to increase the efficiency of the health care system, in 1997 a 1/3rd reduction in the number of hospital beds was achieved, but as the structure of facilities stayed the same, there was no efficiency gain (Lekhan, Rudiy and Richardson, 2010).

The problem of low salaries of GPs and the absence of any financial incentives for performance was raised by several authors (Boerma and Kringos, 2010; Gibbs, Khimion and Lysenko, 2008; Lekhan, Rudiy and Richardson, 2010; Parusinsky, 2011).

OOP payments

The Ukrainian constitution (1996) states there should be 'free health care for all'. Based on this there was a guaranteed free package of health care, paid for by the government. But due to lack of funding, over the past ten years it has been left to facilities to decide which services are covered, which has led to an increase in out of pocket (OOP) payments (Lekhan, Rudiy and Richardson, 2010), as will be described below.

3.1.4 Service Provision:

Access to primary care

OOP payments in Ukraine are estimated to be 40.7% of total health expenditure (WHO HFA DB, 2008) and are believed to be the biggest barrier to the accessibility of (primary) health care. As the state only covers 0,5-1% of the total cost of pharmaceutical and medical supplies, OOP costs for drugs make up a big proportion of this amount (Lekhan, Rudiy and Richardson, 2010).

In a study of Balabanova et al.. (2012), comparing accessibility of health care in 8 ex soviet countries, less than half of questioned people in Ukraine reported they would search health care if they had a health problem (versus 60% in neighbouring Belarus). When asked for the reasons for not consulting a doctor, 21% mentioned that they could not afford it. This rate was significantly higher than in Belarus (2,9%) or Russia (4,6%).

Most worrying is that when the authors performed the same study in 2004, the situation of Ukraine was close to Russia and Belarus (Balabanova et al., 2004), while in 2012 Ukraine was lagging far behind these countries (Balabanova et al.. 2012). According to the authors, the main reasons for increasing unaffordability of health care are the modernisation of health care, with market influences increasing the costs of pharmaceuticals, without effective systems to raise revenue, and thus decreasing government funding. Compared to Ukraine, Russia and Belarus are prioritizing PHC, conclude the authors, which decreases OOP costs and inequity (Balabanova et al., 2012).

Similarly, the PCET showed private payments as the biggest barrier (mentioned by almost one fifth of patients) to consult a primary care physician, followed by limited access during out of office hours (Boerma and Kringos, 2010).
Accessibility is also severely impaired by the low population density and the staff shortage: a growing number of rural communities are lacking medical facilities and/or medical staff (Lekhan, Rudiy and Richardson, 2010).

Coordination and continuity of care
Lekhan, Rudiy and Richardson (2010) state there is no distinction between primary and secondary care, and thus no gatekeeper's role for GPs in Ukraine. Boerma and Kringos (2010) reported slightly more positive results: of the interviewed patients more than three quarters indicated they would visit their GP or DT first with a new health problem.
Although almost none of the facilities had computerized information systems, most physicians indicated they kept medical records and wrote referral letters. However, patients were generally negative about the exchange of information between their own and other physicians. In all aspects, no significant differences between GPs and DTs were found (Boerma and Kringos, 2010).

Finally, at present vertical programs (prevention, screening and treatment of TB, HIV) are mainly carried out by hospitals in a fragmented way (Atun and Olynik, 2008). Given the rising rates of these diseases, an urgent need for more intersectoral collaboration and integration of these programs within PHC was mentioned by several authors (Maier et al., 2011; Atun and Olynik, 2008; Vasall et al., 2009).

Comprehensiveness of care:
Historically DTs were responsible for preventative checkups, immunisation and health education. This made up 50% of their work. They treated only 50% of their patients. The rest was referred or went directly to a specialist (Bradshaw, Ryan and Thomas, 1975).
Results of GP-pilot studies in the early nineties were very promising: the newly trained GPs tended to refer three times less than DTs, make more diagnoses (Shabarova, 2001) and have very satisfied patients (Gibbs, Mulka and Zaremba, 1998).
However, at the same time some concerns rose: there appeared to be no attention for determinants of health (smoking, obesity, sexual behaviour), no health education and no exploration of underlying psychological or social aspects by the newly trained GP's (Gibbs, 1999).
And the results of more recent studies on the differences between the 'traditional' DTs and newly trained GPs are mostly disappointing. Gibbs et al.. concluded in 2008 that little had changed over the past 10 years in the majority of practices, as patients still wished to be referred, due to lack of trust in GPs. Lekhan, Rudiy and Richardson (2010) described that GPs are indeed meant to have a broader task profile, including surgical treatments, monitoring of pregnant woman, and paediatric care. In practice however, they state that, due to a lack of experience in these fields, in reality the task profiles do not differ significantly. This coincides with the results of Boerma and Kringos (2010) who found negligible differences in the task profiles of GPs and DTs.
As described in the paragraph above involvement in TB screening and treatment is another 'missed opportunity' for PHC in Ukraine. Although primary care physicians should be the 'principal actors' in fighting this epidemic, their involvement is low, because TB services are not integrated in PHC. Moreover, there are perverse incentives for inefficient procedures and unnecessary hospital admissions (Atun and Olynik, 2008; Vasall et al., 2008; Maier et al., 2011).

In table 4 hereunder, the different aspects of the current state of PHC are summarised and compared with what is known on the state of PHC in Ukraine before its independency (1991).

Table 4: PHC in Soviet episode (before 1991) versus current state of PHC

	PHC before 1991:	**Current state of PHC (2007-2012):**
Stewardship		
- Policy vision - Regulations - Legislation	- No policy/plans on PHC - No difference between primary and secondary care[1] - Constitution: health care is free of charge and the existing network of health care facilities may not be reduced	- Plans aiming to strengthen PHC - No difference between primary and secondary care - Constitution: health care is free of charge and the existing network of health care facilities may not be reduced
Resource generation		
- Human resources	- No GP's	- 8000 GPs (1,7 GP/1000 pop.), less than 25% of the need is met.
- Practice conditions	- No figures on practice conditions	- 2/3rd of GPs and patients indicate a severe shortage of medical equipment
- Professional development	- No vocational scheme	- 24-month vocational scheme for newly graduated medical doctors or 6 months retraining course, with limited capacity and limited funding. Several aspects of FM are not included in the training
	- Family Medicine (FM) does not exist - No professors - No FM organisation	- FM exists, but is not a scientific specialty, - No professors, - FM association, but not influential
Financing		
- Funding	- General taxation (and less than 20% OOP costs)[2]	- General taxation (and more than 40% OOP costs)[3]
- Provider payment	- Fixed budget, based on capacity - 15% of total public health expenditure spent on outpatient care[2]	- Fixed budget, based on capacity - 13% of total public health expenditure spent on outpatient care[3]. - No financial incentives for performance
- Incentives	- No financial incentives for performance	
Service provision		
- Access	- No evidence on access found	- Access impeded by OOP costs and by shortage of physicians and facilities in rural areas
- Coordination and continuity of care	- 50% of patients choose to see a specialist directly	- 75% of interviewed patients (in a survey) said they would visit their GP/DT first[4] - Referral letters and medical records, but patients negative about the coordination
	- No gate keeping system	- No gate keeping system
- Comprehensive-ness of care	- Preventative check-ups make up 50% of DT work[1].	- No significant difference found between task profile of DT and the vocationally trained GPs[3,4]

1 [1] Bradshaw, Ryan and Thomas, 1975

2 [2] Lekhan, Rudiy and Nolte, 2004

3 [3] Lekhan, Rudiy and Richardson, 2010

4 [4] Boerma and Kringos, 2010

3.2 Differences between governmental plans and the present state of primary health care

In 2002 the first comprehensive health reform plan, 'Health of the Nation' was approved, developed according to the framework of WHO (Betliy, Kuziakiv and Onishchenko, 2007) and prioritising PHC. Since then, subsequent reform plans have been issued in 2007 and 2008 aiming to: increase the retraining capacity of GPs, lower the workload, strengthen professional development of family medicine, introduce financial incentives for primary care workers, introduce per capita funding and recognise the gate keeping role of GPs.
However, most of these aims were not very specific or measurable, and a clear policy on how to achieve these aims was not mentioned in the plans. In table 5 the governmental plans of 2007 and 2008 are compared with the current state of PHC. Hereunder the most important differences are summarised:

Financing:
There are no financial incentives for PHC staff and there is no per capita funding.

Generating Resources and professional development
There is a shortage of primary care physicians, leading to workloads above the norm, while the current retraining capacity of GPs is not sufficient to compensate for the high outflow (due to the low status and low salaries).
Furthermore, various restrictions exist for the professional development of Family Medicine: the lack of 'scientific backbone' of Family Medicine, a lack of practical clinical guidelines, the absence of an influential association of GPs, and protectionism of specialists restricting some areas in the vocational training

Accessibility of care
Accessibility is severely restricted by OOP and a shortage of primary care physicians and facilities, mainly in rural areas

Coordination of care
A gate keeping system is not in place and there is no distinction between primary and secondary care.

Comprehensiveness of care:
It is very doubtful if the existing Primary care facilities, based on the principles of Family Medicine, are truly different from the old polyclinics, and if the task profile of GPs is genuinely different from that of DTs. Compared to other CEE countries the task profile of GPs in Ukraine is fairly narrow (Boerma and Kringos, 2010) which could be explained by the lack of medical equipment, the short retraining course and the lack of follow up.

Table 5: differences between governmental plans and current state of PHC

National Plan of the health care system 2007-2010 [5],[6]	**Evidence of the current state of PHC**
1. Reorganizing PHC according to FM principles, with an accent on rural area's	• Weak, but existing Association of Family Medicine[6] • 19 Departments of General Practice, providing a 24 month vocational training[7]. • Family medicine present in undergraduate medical education[7] • 4228 primary care facilities, based on the principles of FM in 2009. However, often the transition was solely a change in name • Almost no difference in task profile of GPs, compared to DTs[5],[6] • Significant barriers to accessibility, due to OOPs and shortage of facilities and medical staff, mainly in rural area's [5],[6],[8] • Barriers to professional development of GPs, due to lack of funding for vocational training, protectionism of specialist to teach in certain area's [7]and shortage of equipment [6] • Patients still wishing referral to secondary care[7]. • Very little attention in PHC for determinants of health and health education[7],[9]
2. Recognition of GP as manager of patient care: gate keeping system	• No gate keeping system[6] • No distinction between primary and secondary care [5]
3. Introduction of per capita funding in PHC	• Inflexible line item funding of facilities, on basis of capacity[5] • Small experiments with global budgeting and payments per capita, counteracted by local authorities and Ministry of Finance[5]
4. Increasing the number of GPs	• Stabilization of number of GPs (8000) from 2008 – 2012 • 25% of the countries need of GPs is met[6],[5] • Present training capacity not enough to increase number of GPs, due to high number of GPs nearing retirement and high outflow to other jobs/abroad [75]
5. Introduction of (financial) incentives for PHC staff	• Almost no (financial) incentives for physicians • GPs salary 7% higher than DTs salary [6]
Program "Ukrainian breakthrough" 2008 [6],[7]	
1. Order on norms for workload of GPs: - 1200 patients in rural areas - 1600 patients in urban areas	• 21% of primary care physicians have more than 2500 assigned patients[5] • Average of 2106 patients per GP and 57% of primary care physicians reporting severe staff shortages[6]
2. Legislative basis for implementation of general practice: aims to provide every family with a GP in 2013	• Based on 1500 patients/GP, the actual 8000 GPs are less than one fourth of the 33000 GPs needed • Oley Musiy, president of the All-Ukrainian Medical association: "the present rate of training of general practitioners means the country's needs will be met in only 125 years." (Parusinsky, 2011).

For the latest policy plan of the Ukrainian Ministry of Health (MOH Ukraine, 2011), as summarised in table 6, with the full text available in the annex, the policies are planned to be implemented in 2013 and 2014. According to these plans the government is aiming to strengthen PHC, creating incentives for healthier living, changing the payment structures of health care providers to be based on performance, introduce contracting between government

5 [5] Lekhan, Rudiy and Richardson, 2010

6 [6] Boerma and Kringos, 2010

7 [7] Gibbs, Khimion and Lysenko, 2008

8 [8] Balabanova et al., 2012

9 [9] Maiet et al., 2010

and providers and between providers and patients. These policies aim amongst others to establish the preconditions for the introduction of a social health insurance after 2014 (MOH Ukraine, 2011).

Evidently it is too early now to measure if the latest governmental goals will indeed be reached. However, it does catch ones eye that the goals are again very vague and not measurable, and a specific policy on how to reach these goals is missing (Tarantino et al., 2011). Moreover, it appears that many of the goals that already have been stated from 2002 (Boerma and Kringos, 2010) seem to be repeated over and over in policy documents, merely changing the planned years of implementation.
However, at present, there are some pilot projects, being rolled out, which, if proven successful, will be expanded nationwide in 2013 and 2014. These pilot projects introduce the division of health care in primary, secondary and tertiary care with appurtenant local budgets, based on the needs of the population. Primary health services are provided by non-profit organisations and the quality of services will be evaluated using a set of quality indicators (MOH Ukraine, 2012).

Table 6: Summary of Ministry of Health policy plan on PHC 2012-2014

Summary of Ministry of Health policy plan on primary care 2012-2014[10]
• Structural, organizational and financial-economic division of levels of care
• Strengthening of PHC
• Improve the education of medical professionals
• Further development of the Institute of Family Physicians;
• Introduction of contractual relationship between government and providers (2013) and between patients and providers (2014). Financing will be based on quality and performance
• Introduction of medical standards (standardized clinical protocols) of care and indicators of the quality of health care in 2013
• Implement measures of medical and social prevention and education on a healthy lifestyle and incentives for healthier living
• Introduction of evaluation centers for quality of care in 2013
• Prepare the preconditions for introduction of social health insurance in 2013: providing financial stability of hospitals, increasing self management of facilities and promoting competition between providers

10 [10] Ministry of Health Ukraine, 2011

3.3 Applying the health reform policy cycle to the Ukrainian PHC reform

In order to be able to explain the differences between the current state of PHC in Ukraine and the governmental PHC reform plans, the health reform policy cycle of Roberts et al.. (2008), as is shown in figure 3, will be applied hereunder.

3.3.1 Problem definition

According to Roberts et al. (2008) the first step in implementing reform is to define what the actual problem is. They proposed to divide the problem into three aspects:

Health status of the population
Since the nineties, the low health status of the population in Ukraine, with a high avoidable mortality and morbidity, has been recognised, both nationally as internationally, to be a significant problem, needing to be addressed. (Lekhan, Rudiy and Richardson, 2004).
Similar to its previous health plans (2002, 2007 and 2008) the Ukrainian MOH describes the demographic crisis and the low life expectancy of its population as the main focus of its most recently approved plan (MOH Ukraine, 2011).

Satisfaction of citizens about health services
Access to health services has been severely hindered by a shortage of physicians (mainly rurally) and OOP costs for years (Balabanova 2004, Balabanova 2012; Lekhan, Rudiy and Nolte, 2004). Moreover, patients had little faith in their primary care physician, and saw PHC as 'forbidding them to see a specialist'(Gibbs 1997).

Financial risk protection
Due to OOP costs there is no capacity to protect individuals against the financial burden of health care. These OOP already existed before 1991, but have increased from 20% to more than 40% at present (WHO HFA DB, 2010). This leads to catastrophic health expenditures for one in five Ukrainians (World Bank, 2008).

3.3.2 Diagnosing the causes: exploring the 5 control knobs

Financing:
Financing is one of the 'control knobs' that could be amended in order to strengthen (access to) PHC. By setting up an efficient financing system, which allows physicians to be paid a normal wage, OOP costs might be reduced and thus accessibility of PHC increased.
Until now health care funding in Ukraine is done through general taxation. In the 2007 'National Health care plan of the Nation', the Ukrainian government planned to introduce social health insurance before 2010 (Lekhan, Rudiy and Richardson, 2010). However, this has not been accomplished yet.

Payment
Changing the way health care providers are paid, provides for another way of influencing the behaviour of health professionals and institutions.
Governmental payment of providers in Ukraine is done on the basis of capacity and historical needs, instead of health service needs (Tarantino et al.., 2011). This contributes to the maintaining of hospital overcapacity. Paralleling the decentralisation of financing streams from 2000, payment of providers has been decentralised as well, which has led to more

accountability of local authorities, but also to an increase in inequality between richer and poorer regions.
The 2007 governmental plan mentions introduction of contracting between purchasers and health service providers before 2010. However, this has not happened yet.

Organization
In order to institutionalise General Practice and gain the confidence of the population to use it, a number of changes can be made in the organisation of the health system. This would include amongst others: an acknowledged place of general practice within the health system, a valid training program, a gate keeping system and incentives to work in rural areas.
As described earlier in the background: the overall structure of the Ukrainian health care system has barely changed over the past 20 years and is still mainly reliant on secondary and inpatient care. Since 2003 there is a coordinative committee on the development of Family Medicine active within the Ministry of Health and since 2007 a department of PHC exists within the Ministry of Health (Boerma and Kringos, 2010). However, it is unclear how much power and influence this department has.
As shown in the overview of the health system (figure 1) due to financial decentralisation, regional medical facilities (including PHC facilities) are now governed by regional authorities. However, they still have to abide by the strict norms and standards of the MOH, which doesn't leave much room for new initiatives (Lekhan, Rudiy and Richardson, 2010).
Concerning the training of GPs, although there is a vocational training for GPs, the capacity of this program is too low to meet the needs, there is a lack of clinical standards of and funding for the program, it is not acknowledged as a scientific specialty and there are no professors in General Practice (Boerma and Kringos, 2010; Gibbs, Khimion and Lysenko, 2008). In spite of governmental plans, a gate keeping system has not been implemented yet. And although there are some financial incentives to work in rural areas, these are not enough to solve the shortage (Lekhan, Rudiy and Richardson, 2010).

Regulation
Apart from changing its organisational structure and incentives, the government can also use coercive power (legal rules) to institutionalise general practice. For example by giving general practice a legal basis and licensing system, or enforcing a gate keeping system by legislation. Unfortunately these changes in regulation have not been implemented (yet).
Furthermore, some of the reform plans are not compatible with the Constitution accepted in 1996, stating that medical care is free of charge and that the existing network of health care facilities should not be reduced. The latter seriously hampers the reallocation from secondary to primary care (Boerma and Kringos, 2010; Betliy, Kuziakiv and Onishchenko, 2007).

Behaviour
The last control knob, as mentioned by Roberts et al. (2008), is 'Behaviour': how can individual behaviour be changed in order to increase the use of primary health care?
At present there are no media campaigns explaining 'what a GP is and does' in order to encourage the population to be seen by a GP rather than a specialist. Nor do payment structures or guidelines exist, aiming to influence professional behaviour to be more client-orientated and more aimed towards preventative care.

3.3.3 Policy development

Summarising, to be able to institutionalise PHC preferably all five of the control knobs need to be amended. The past governmental plans (2002, 2007 and 2008) did indeed mention a lot of these aspects, but as described above, most of them have not been translated into effective

policy yet. This could be explained by the fact that most of the policy aims, as mentioned in the documents, were not very concrete and did not contain detailed policy plans, with corresponding specific and measurable outcomes, on how to achieve these goals (Lekhan, Rudiy and Richardson, 2010; Boerma and Kringos, 2010).

3.3.4 Policy implementation

As mentioned above, in spite of promising governmental plans, the actual implementation of plans in Ukraine has been the bottle neck until now.
At present small experimental programs, strengthening PHC and aiming to improve quality, access and healthy living are rolled out in Donetsk, Vinnytsia and Dnipropetrovsk oblasts as well as Ukraine's capital city Kyiv. The plan is to implement these nationwide after 2014 (MOH Ukraine, 2011). The future must reveal if these latest governmental plans will indeed be implemented in the coming years. The past has proved that medical professional and political resistance and difference in political majority between (western oriented) government and (Soviet oriented) parliament has hampered nationwide implementation of successful pilots (Lekhan, Rudiy and Richardson, 2010).

3.3.5 Evaluation

Although a culture of data collection and analysis exists and a health information system is in place in Ukraine, this is not always followed, due to a lack of training, equipment and skills. This has seriously impeded effective monitoring and evaluation on local as well as central level (Tarantino et al., 2011). Fortunately the most recent reform plans of the MOH of Ukraine (2011) include the introduction of quality indicators for the evaluation of health care, which will also be used to evaluate the current pilot projects.

Several NGO's have recently done evaluations of the Ukrainian health system. Hereunder the findings of the Economics Education Research Consortium (EERC), USAID and WHO will be summarized:

Betliy, Kuziakiv and Onishchenko (EERC) concluded in their evaluation of the Ukrainian health care reform in 2007 that the major restrictions for health reform are:

- The existence of equilibrium in the health care system, maintained by OOP payments and by leading stakeholders opposing reforms.

- The constitution declaring that health care should be free for all (which is not feasible) and that the existing network of facilities may not be reduced.

- Political parties only proposing reform plans aimed at changing finance structures, instead of the structural failures of the system.

- Absence of motivation of health care personnel and restriction of managerial autonomy and skills at the level of regional authorities/ health care facilities.

Therefore their recommendation is to correct the deficiencies of the present system by defining a more realistic state guaranteed health care package, introducing fee for service payment, improve performance by introducing quality control and reduce OOP payments. A second step would be to introduce compulsory health insurance (Betliy, Kuziakiv and Onishchenko, 2007).

Tarantino et al., in their evaluation for USAID in 2011, focused more on the present political and social situation of the country. Apart from mentioning the same legislative burden as Betliy, Kuziakiv and Onishchenko, they concluded that the Ukrainian health care reform is mainly undermined by:

- Fragmentation in health policy development and lack of continuity in health care administration, caused by frequent changes of government and political instability.

- The fact that local authorities, who are most active in the reform, are restricted by central planning and regulations.

- The high rate of corruption and decreasing GDP, which impedes introduction of market mechanisms.

They therefore recommend strengthening of leadership and governance, introduction of health financing and budgeting norms and improvement of the quality of care. Moreover, they state a reform of the structure of service delivery is needed to meet the health needs of the population. This means that PHC needs to be strengthened and HIV, TB and Family Planning services should be integrated in Primary Care.

The WHO 'Health Care Systems in Transitions'(HiT) profile of Ukraine concludes that the main difference in the Ukrainian health care system over the past 20 years is its transition from centralized to decentralised financing, while accountabilities stayed the same. Furthermore it mentions the same barriers for PHC reform as Betliy and Tarantino: political instability, constitutional barriers, stakeholders benefitting from the status quo and a lack of funding (Lekhan, Rudiy and Richardson, 2010).

As described in section 3.1, the results of Boerma and Kringos' primary care evaluation (PCET) for WHO in 2010 indicate a serious shortage of primary care physicians, an absence of incentives for professional development, a lack of training capacity of general practitioners and a lack of equipment. Moreover, the results show that the clinical task profile of primary care physicians is narrow. Between (re)trained GPs and DTs almost no difference in clinical task profile or performance was shown.
Similar to Lekhan et al., Tarantino et al. and Betliy et al., Boerma and Kringos mention legal restrictions, lengthy decision making and frequent changes of government as barriers for effective implementation of plans. Consequently, they recommend the involvement of local policymakers, primary care physicians as well as international stakeholders in the development of future reform plans, in order to strengthen the commitment of all these parties and contribute to the implementation of an evidence-based national policy plan (Boerma and Kringos, 2010).

Hopefully these evaluations will be taken into account by the Ukrainian government, when implementing their future plans.

3.4 Applying the 'conceptual framework for health reform in post-conflict settings' (Percival and Sondorp, 2010) to Ukraine

The reform framework of Hsiao and Roberts (2008) shows clearly the different 'knobs' that the government should have amended in order to effectively strengthen PHC and restructure the system.
However, while most of these control knobs were indeed described in the governmental plans, the stumbling block seemed to be the actual implementation of plans. As we know Ukraine has experienced political instability for years, with frequent changes of government and an increasing corruption (Kubicek, 2009), we might need a framework focussing more on the social, political and cultural environment of Ukraine, in order to explain its failure to implement its plans until now. Therefore hereunder Percival and Sondorps' 'conceptual framework for health reform in post-conflict settings' (see figure 4) will be applied to the Ukrainian situation.

3.4.1 Health context (system and population health)

The health status of the population in Ukraine has been worrying for years. Moreover, as described before, the Ukrainian health system, with an overcapacity of hospital beds and under capacity of primary care and preventative care, is unable to adequately respond to the health needs of its population.

3.4.2 Socio-economic and political context

Apart from the factors mentioned above, high poverty and low standards of living, an ageing population and low fertility rate (demographic crisis) are also playing a significant role in the low health status of the population in Ukraine.
Politically, the country has experienced very turbulent years as well. After 1994, the country suffered for a decade under the dictatorial and corrupt Kuchma regime. Therefore, when opposition leader Yukoschenko came to power after the orange revolution in 2004, this raised hopes that Ukraine would finally become a western- oriented and liberal democracy (Kubicek, 2008). And a United Nations Developmental Commission was installed to promote the implementation of economic reform plans (Sutela, 2012). However, continuous political disputes between president (government) and parliament (prime minister) and numerous changes of government prevented most of the new laws to be passed. Therefore Ukraine's laws and institutions did not change materially under the new regime (Kubicek, 2008). This eventually led Russia-oriented Yanukovich and his 'Party of the Regions' to win the most recent presidential (2010) and parliamentary (2006, 2007 and 2012) elections again. The new conformity between government and parliament might decrease internal political conflicts, but could at the same time lead to a switch to more conservative reform plans and therefore hamper PHC reform.

Summarizing the most important social-economic and political factors hindering the Ukrainian reform plans until now:

- The weak and corrupt Ukrainian government and the oligarch economic structure (Sutela, 2012)
- Old soviet power structure providing resistance to change (Tarantino et al., 2011; Kubicek, 2008)
- Constitution: free health care and no reduction of institutions (Betliy, Kuziakiv and Onishchenko, 2007; Boerma and Kringos 2010)
- Lack of funding (MOH Ukraine, 2011)

3.4.3 External pressures/resources for reform

According to Tarantino et al. (2011) the present health care reform plans are not only aimed to improve health outcomes, but are also a reaction to external pressure from amongst others International Monetary Fund (IMF). Currently the World Bank, the WHO and a number of other UN agencies provide technical advice and assistance to the Ukrainian Ministry of Health in order to favor effective implementation of health care reforms. Moreover, the World Bank considers a loan to support the reform plan and donors such as Global Fund, PEPFAR and the US/Ukraine partnership are supporting health system strengthening. On top of that, a long list of NGO's are providing medical developmental aid on more specific domains (HIV/AIDS, TB, maternity and child health etc.) which all need strong PHC to function effectively (Tarantino et al., 2011).

3.4.4 Policy choices: reform measures

Percival and Sondorp's framework (2010) indicates that the final policy choices for reform measures are a result of the three previously mentioned factors: the health context, the socio-economic and political context and the external pressures/resources for reform. The first Ukrainian health reform plan 'Health of the Nation' (2002) was developed according to the WHO policy guidelines (Betliy, Kuziakiv and Onishchenko, 2007). And all plans that were formulated since then have more or less maintained the same main features, as described in section 3.3. However, a concrete description of how these defined goals should be reached was never given, and most of the plans were never carried out.
This could support Betliy's questioning of the genuine motivation of the government's reform plans': are they not mainly developed in response to external pressure? (Betliy, Kuziakiv and Onishchenko, 2007) Another very common CEE motivation for reform is to move away from the Soviet system and be closer to the EU (Fuenzalida-Palma, 2002). If this would be (part of) the motivation behind the Ukrainian reform, rather than solely intending to make the system more effective, this could also easily explain the turmoil between the western oriented president and more Soviet oriented parliament in the past. The future needs to reveal what will happen now that since 2010 the majority in both government and parliament is in hands of the Soviet oriented 'Party of the Regions'

3.4.5 Government capacity

As mentioned in section 3.5.2 the Ukrainian government capacity is low and corruption is playing a major role (Sutela, 2012). Frequent changes of government and internal conflicts have been other hindering factors in the implementation of reforms (Boerma and Kringos, 2010; Lekhan, Rudiy and Richardson, 20100; Tarantino et al., 2011). Finally, due to many paralleling systems and decentralization of budgets, the actual power of the Ministry of Health to implement policy and change funding systems is limited (Lekhan et al., 2010).

3.4.6 Implementation process

As described in paragraph 3.4.4, this is the main bottle neck in the Ukrainian primary health care reform. Plans seem to be formulated over and over again, without ever being implemented.

3.4.7 Policy outcomes/ reform outcomes

The reform outcomes are described in section 3.2 (current state of PHC) and in the summarized health system evaluations in 3.4.5. These descriptions show that not much has changed in the health care system over the past twenty years and that the process of developing PHC is still in the beginning of its transition. However, lacking structures of monitoring and evaluation and the absence of quality indicators and medical standards hinder an effective and realistic evaluation of the present situation.

4 Discussion

The results show ambitious governmental plans, described since 2002. These plans aim to strengthen PHC, increase the training capacity of GPs in order to provide every Ukrainian with a GP in 2013, introduce financial incentives for primary care workers and recognize the gate keeping role of GPs. Moreover they aim to introduce media campaigns and implement preventative primary care programs, aimed at healthier living.
Unfortunately it appears that there is a significant difference between these plans and current practice: It is doubtful if the new primary care facilities are truly different from the old polyclinics, as the task profile of the new GPs seems to be almost similar to that of the old DTs. A gate-keeping system is not in place, there is no distinction between primary and secondary care, there is a severe shortage of GPs, while the current training capacity is insufficient to solve this. Moreover, there are serious restrictions for the professional development of Family Medicine: there are no professors, it is not recognized as a scientific specialty, there are no clinical guidelines and protectionism of specialists restricts some areas of the vocational training. Finally accessibility of (primary) health care is severely restricted by OOP payments.
Roberts et al.'s framework (2008) indicates we cannot see PHC reform separate from the functioning of the whole system. If we apply their framework to the Ukrainian PHC reform in order to explain the stagnation, we can see that most of the five 'control knobs' have not been changed:

1. The Ukrainian health care finance structure is based on general taxation. And this, being 7,7% of its GDP (WHO DB, 2009), does not provide enough funds to 'provide health care free of charge' (as prescribed by the constitution). The shortage of funds is compensated by OOPs, severely impeding accessibility of care for the most vulnerable groups.
2. The payment of providers in Ukraine is based on capacity, instead of services provided or quality of care, which maintains the overcapacity of secondary services and leads to under financing of PHC.
3. Similarly, the organization of health care is still more or less the same as twenty years ago. PHC has not been recognized as a scientific specialty, there is no valid vocational training with sufficient capacity, a division between primary, secondary and tertiary care has not been made and there is no gate keeping system.
4. Legislation is another control knob which has not been changed accordingly, as two constitutional laws are not compatible with the reform plans: the constitution dictates that the existing network of facilities may not be reduced, which seriously hampers the reallocation from secondary to primary care. Moreover it prescribes the economically infeasible rule, that health care should be free of charge.
5. Until now there have been no governmental campaigns promoting what a GP is and does, aiming to change the behavior of patients into seeing a GP instead of a specialist. And media campaigns targeting unhealthy behavior are very limited still. Moreover, there are no incentives for GPs to change their behavior to be more client-oriented and to improve the quality of care.

The latest (2011) governmental reform plans however, do intend to change most of these knobs. They aim to introduce social health insurance (2014) as a funding mechanism, change the payment structure of providers into a contractual relationship, partly based on quality and performance, change the organization of health care into primary, secondary and tertiary care, change the constitutional laws to be feasible with health care reform and start media campaigns intending to change people's behavior into healthier living. However, these are

still plans, and until now the Ukrainian bottle neck has been the implementation of plans.

In order to explain the struggles to implement the reform plans, the framework of Percival and Sondorp (2010) starts to focus on the driving forces behind the reform plans. The first driving force is the low health status of the population, needing a health system that is able to respond to their needs. Moreover the worrying high rate of poverty and low standards of living are asking for a reform of the system, in order to be more efficient and affordable. However, an even more important driving force for reform seems to be the external pressure of actors such as IMF, WB, WHO and numerous smaller NGO's who are active in the country. A motivation to move away from old Soviet structures and be closer to the EU might play a role as well for western oriented Ukrainian politicians.
Counteracting the driving forces, there are significant political and social-economic factors hampering reform in Ukraine: the weak and corrupt government, with frequent changes and internal conflicts, old soviet power structures, the oligarch economic structure and medical professionals strongly opposing any change, constitutional rules that are incompatible with reform and a lack of funding for reform plans. Due to corruption, internal conflicts and frequent changes in government, government capacity in Ukraine is low. Moreover, the power of the Ministry of Health is limited, due to many paralleling systems and decentralization of budgets.
The combination of all of these factors has lead to a list of reform plans being formulated over and over again since 2002. And although the plans are evidently based on the WHO-recommendations that PHC needs a team of skilled professionals, needs to involve ongoing relationships, needs to include health promotion and early detections (WHO, 2008), most of the plans do not have concrete descriptions of how to reach these goals. Moreover the required investment and resources (WHO, 2008) are lacking. And finally most of the plans were not approved by the parliament, due to differences in majority between government and parliament until 2010. Similarly the required changes in the constitution have never been passed.
Therefore, considering the definition of 'health sector reform', as mentioned in section 2.5: 'Sustained, purposeful and fundamental changes intended to improve the performance of the sector in terms of efficiency, equity and effectiveness' (Berman and Bossert, 2000), we can barely justify to call the strengthening of PHC in Ukraine until now 'a reform'.

Looking at analyses of health care reforms in other ex-Soviet countries, it is striking that most of them struggle or have struggled with the same issues. Mc Kee et al., in their literature review of central European (CEE) and former Soviet (CIS) countries, describe that most CEE countries have indeed implemented a PHC system, based on Family Medicine (Mc Kee et al., 2009). Latvia and Estonia are generally regarded as the most successful in their implementations (Tragakes et al., 2008; Lember, 2002).
Success factors in the Estonian reform seemed to be: the de-centralisation of management of health services on a local level, introduction of a gate-keeping system, the introduction of a health insurance system, fee for service financing of providers and the reduction of overcapacity of hospitals through increased autonomy of hospital management (Tragakes et al., 2008).
The paper 'learning from experience', based on the different health system reviews in CEE and CIS countries, mentions similar recommendations (Figueras et al., 2004): To implement effective health insurance schemes, create a more realistic benefits package, introduce performance related payment of providers, restructure health care into primary, secondary,

tertiary care with a gate-keeping system and most important: introduce a sustainable vocational training, continuous medical education and licensing for General Practitioners.

However, in contrast with the CEE countries, the CIS countries have much more difficulty implementing their intended reforms and in most of them the Soviet health system is still in place (Mc Kee et al., 2009). In order to explain the failures of the CIS reforms, Fuenzalida-Palma performed an extensive review in 2002 and concluded that:

1. In most countries the problem is a lack of attention for administrative, institutional and regulatory issues
2. Ministries of Health are often weak and influenced by hospital and specialist interests,
3. Differences in majorities in parliament and government are common, and therefore approved concept papers are mostly short-lived. Change can only be achieved if all political parties agree over the permanency of a plan and arrange for the required legislative changes and funding streams.
4. There is a general lack of a proper definition of PHC, licensing and legislation. Moreover, remuneration of GPs needs to make the job attractive.

These conclusions largely coincide with the outcomes of the analysis of the Ukrainian PHC reform in this study.
Similarly, Matthies et al. (2001) concluded, in their comparative study of healthy systems in amongst others Bulgaria, Czech Republic and Hungary, that effective implementation of reform needs to include a change in mentality of providers, patients as well as politicians. Evidently, in Ukraine this change has not yet happened.

Regarding the results of this study, the following limitations must be considered: In view of the scarce evidence available on PHC in Ukraine, the results are based on evidence from different years and partly based on grey literature. Furthermore, important information on PHC in Ukraine might have been missed, as the review was restricted to English literature.
Moreover, a considerable part of the results was predicated upon the results of the PCET. And although this evaluation was based on information from GPs, patients as well as political stakeholders and performed in two different regions, it does rely on self-reporting questionnaires and state-provided information, which could be biased by professional or health political desirability. Moreover, the results of the two regions might not be representative of the country as a whole.
Finally, although this study does include a translation of the most recent governmental health reform plan (MOH Ukraine, 2011), it would be even more informative to be able to have in depth interviews with Ukrainian policy makers at the MOH on the exact details of the most recent reform plans.

5 Conclusion and Recommendations

This study indicates that the process of developing a PHC system in Ukraine is still in the beginning of its transition. There are significant differences between governmental policy aims and current practice. Governmental plans seem to be formulated over and over again, without a description of concrete measures how to achieve their plans and with most plans never being approved by the parliament or implemented.
As described in the discussion sector the framework of Roberts et al. (2008) has provided an explanation for the differences in policy and practice by looking at the five 'control knobs', which the government needs to adapt in order to change the system. Percival and Sondorp's framework (2010) added to better understand the political, external and socio-economic factors that hampered effective reform in Ukraine.
Regarding the recommendations, stemming from studies in other CIS and CEE countries, it is striking that the latest governmental plans in Ukraine do contain most of these in their policy documents, while implementation until now has failed.

Therefore, combining the results of this study with the recommendations of most recent analyses of the Ukrainian health system (Betliy, Kuziakiv and Onishchenko, 2007; Boerma and Kringos, 2010; Lekhan, Rudiy and Richardson, 2010; Tarantino et al., 2011), the following recommendations for the implementation of an effective PHC reform in Ukraine can be made:

- Promote a discussion on PHC reform in which different political parties, external stakeholders (such as WHO and WB), regional and hospital authorities as well as GPs are involved, to identify barriers to approval and implementation of plans until now.

- Consequently develop a plan with a long term vision that is permanently agreed on by these different parties, in order to strengthen their long term commitment to this plan. As implementation of this plan will only work if it is indeed developed by a joint effort of these different stakeholders, instead of being developed by external actors, it is impossible to 'prescribe' the contents of this plan. However, it might include the following changes to the five 'control knobs' (Roberts et al., 2008):
    - A new funding system that provides sufficient funds to eradicate OOP payments by increasing salaries of medical staff to an acceptable level. This funding system could be based on a compulsory health insurance. Moreover the provision of sufficient long term funding to effectively implement the reform of PHC in Ukraine (for example by loans from the WB).
    - A provider payment system based on fee for services and the introduction of budgeting norms, aiming to reduce overcapacity of secondary services. Introduction of incentives for physicians to work in primary care and in rural areas.
    - Organisation of health care in primary, secondary and tertiary care with a gate-keeping system and a valid vocational training with sufficient capacity, a scientific basis of Family Medicine, clinical standards and protocols, quality control system and monitoring and evaluation system. This should lead to a stronger position of GPs, with a more comprehensive task profile, able to gain the confidence of the population. Vertical services (such as TB and HIV prevention and treatment) should be sufficiently integrated in the PHC system.
    - Change of the legislation (constitution) to allow for reduction of health services and a funding system able to avoid OOP payments

    - Media campaigns explaining what the role of a GP is and promoting healthier living.

- Start up a work group with enough leadership and management skills to translate the long term objectives into a comprehensive reform plan with specific and measurable goals and appurtenant action plans.

- Clearly identify the roles and responsibilities of different stakeholders (MOH, local authorities, hospital authorities, health care providers) in this comprehensive reform plan. Investigate if enough leadership skills exist on regional and hospital level for eventual decentralisation of responsibilities. If needed provide for up-skilling and training of management.

- Develop a monitoring and evaluation system, based on defined quality indicators, enabling to measure progress, control/reduce corruption and adjust the plans according to the feedback.

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Annex:

Indicative Plan of the Ukrainian Ministry of Health for 2012-2014

Source: Website Ministry of Health, Ukraine: http://moz.gov.ua/ua/portal/reform_program.html

Approved Minister of Health of Ukraine O. Anishchenko September 3, 2011

Section 1. The mission of the Ministry of Health of Ukraine

According to the approved plan, by the President of Ukraine № 467/2011 from 13.04.2011, the **Regulations of the Ministry of Health of Ukraine are as follows:**

1. Ministry of Health of Ukraine (MOH Ukraine) is the central body of executive power and is directed by the Cabinet of Ministers of Ukraine

Health of Ukraine is the main body in the system of central executive authorities in the formulation and implementation of national policy in the field of health policy-making in the areas of sanitary and epidemiological welfare, development, manufacturing, quality control and sale of drugs, medical pharmaceutical preparations and health care products, anti-AIDS and other socially dangerous diseases.

2. Ministry of Health of Ukraine in accordance with the Constitution and laws of Ukraine, acts of the President of Ukraine and the Cabinet of Ministers of Ukraine, other legislative acts of Ukraine, orders of the President of Ukraine.

3. The main tasks of the Ministry of Health of Ukraine:

- formulation and implementation of national policy on health care;
- public policy in the field of sanitary and epidemiological welfare, development, manufacturing, quality control and sale of drugs, pharmaceutical drugs and medical devices, combating AIDS and other socially dangerous diseases.

6. Health of Ukraine shall exercise its powers directly and through units on health of local state administrations.

7. Ministry of Health in the implementation of tasks assigned to it in due course interacts with other executive agencies, supporting agencies and services, formed by the President of Ukraine, as well as local authorities, relevant authorities of foreign states and international organizations, trade unions and employers' organizations, enterprises, institutions and organizations.

8. Ministry of Health of Ukraine provides, during the implementation of measures, to prevent corruption and monitor the implementation in the office of the Ministry, enterprises, institutions and organizations belonging to its jurisdiction.

9. Health of Ukraine within the powers on the basis and in pursuance of the Constitution and laws of Ukraine, acts and orders of the President of Ukraine, acts of the Cabinet of Ministers of Ukraine issued orders, organizes and supervises their implementation.

Legislation Ministry of Health of Ukraine are subject to state registration in accordance with legislation.

Decision Health of Ukraine adopted within its powers, binding central authorities and their regional bodies and local administrations, the authorities of the Autonomous Republic of Crimea, local authorities, enterprises, institutions and organizations of all forms of property and citizens.

14. Ministry of Health of Ukraine is a legal entity with its own balance sheet, accounts in the State Treasury of Ukraine, seal with the State Emblem of Ukraine and its name.

Section 2. Analysis of the current situation and impact assessment

2.1. General characteristics of the field

A medical and demographic situation has emerged in Ukraine over the last decade with evidence of poor health, resulting in lower fertility, high mortality, especially among men of working age, a negative natural population growth and a high prevalence of chronic noncommunicable diseases. They significantly affect life expectancy, disability and determine premature mortality. Life expectancy at birth in the European Region, according to WHO is more than 75 years, while in Ukraine only in 2010 it exceeded 70 years. The demographic crisis poses a

real threat of deep irreversible consequences to the socio-economic and spiritual development of the Ukrainian nation. One feature of the current demographic situation in Ukraine is relatively much higher than other developed countries: the level of premature mortality (according to WHO criteria considered premature death at the age of 65 years). The highest levels of premature mortality are observed amongst the pratseaktyvnoho population.

Among the external causes of death of young people suicides, murders and accidental alcohol poisoning account for a considerable part. Of particular concern is the current state of health and lifestyle of the most promising age groups of the population - children and youth. Today every sixth child is born with disabilities in health.

Leading role in the morbidity rates are played by chronic non-communicable diseases: diseases of the circulatory system (10.48%), endocrine system (9.11%), genitourinary (6.19%) digestive system(5.76%), neoplasms smoking, alcohol abuse, unhealthy diets and low physical activity. At the same time, according to research of the World Bank (2009) Ukraine could prevent 14% of deaths.

Experience in leading European countries indicates a decisive role of public health in addressing factors impact social determinants and reducing population needs medical care.

An important determinant of health is the capacity and rationality in the health care system, which requires significant restructuring.

2.2. The main problems of the health care system

The current health care system is not able to meet the needs of the population in providing high-quality and efficient health care, including the provision of costly medicines and technologies. The reforms that have been carried out in the health sector until now, were inconsistent, mostly fragmentary, and thus have further complicated the activities of our post-Soviet system in a market economy.

The low health status of the population, and the demographic situation are at least partly caused by the following problems:

- inadequate legal and regulatory framework;
- technological gap with the international medical standards and poor quality of health services;
- inadequate mechanisms for health financing and inefficient use of available resources. The current system of financing health care has meant that 90% of all funds are spent on salaries and utilities, and only 10% on medical care;
- ineffectiveness of organizational and functional structure of health care (lack of clear differentiation of health, excessive amount of hospital beds, over-specialization of medical facilities, inefficient use of available resources, etc.);
- poor material and technical conditions of medical institutions at various levels,
- Focus of the Ukrainian healthcare system on the incidence and sick person, instead of on disease prevention and on the healthy person. No system of public health - at the state and local levels, the community does not create conditions for healthy lifestyles among the general population.
- Besides medical reasons, there are other directions - social, economic, political, environmental, significantly affecting human health (unfavorable environmental situation, poor quality of drinking water and food, low incomes, lack of conditions for a healthy lifestyle, but ample accessibility of harmful products, such as tobacco, alcohol, etc.).
- Powerful uncontrolled influence of television, radio and other means of mass media is also a major factor, that adversely influences the physical and mental state of the population.

Section 3. Strategic goals, objectives and performance results of their performance

3.1. The strategy of the state policy in the field of health

Today, health care in the world is seen as a system of governmental, public, social, economic, scientific, cultural, educational, organizational, technical, sanitary and medical nature, aimed at maintaining and promoting health, extensions of the active life. The health of each person is an integral part of human well-being and the health of

the population as a whole is the key to successful development of society, economic growth, social security and political stability.

The state policy of Ukraine in the field of health care is aimed at the preservation and promotion of health, prevention and reduction of morbidity, disability and mortality, and to improve the quality, efficiency and equity of health care.

Future development of health is directed to the following areas:

- Improving health and reducing disability, overall mortality and mortality of the working age population by:
  - rational use of resources in the health care sector;
  - funding, based on the principle of solidarity;
  - improving the quality and efficiency of care.
- Reducing the need for medical care by:
  - prevention and early detection of diseases, monitoring the progress of diseases and preventing their adverse effects;
  - Strengthening of public health, involvement and motivation of the population to live a healthy lifestyle;
  - introduction of measures for rehabilitation
- Implementation of the reform of medical services under the program of economic reforms in 2010 - 2014 years, called: "Prosperous society, competitive economy, effective government."
- The main strategic objectives for health care for the years 2012-2014 are determined:

  Goal 1: Reforming the health care system.

  Goal 2: Improving the quality and accessibility of health care for children and mothers with the introduction of new technologies.

  Goal 3: Reduce morbidity and mortality due to all diseases, providing preventive health orientation and the promotion of healthy lifestyles.

  Goal 4: Creating a favorable regulatory environment for businesses and public health safety.

  Goal 5: Improve staff policies and innovative development of medical science.

To achieve the strategic goals, the following things are needed:

- Improvement of the legal framework for the recognition of health, as one of the key factors of national security, stability and welfare of society. The definition of health and life of citizens should be a priority at all levels of government;
- Improvement and optimization of health promoting measures throughout life;
- Development and implementation of new technologies to minimize disease risk factors and create a favorable environment for healthy living;
- Develop a strategy to stimulate the populations awareness that they are responsible for their own health and the health of their household members;
- Integration of existing and future target programs into a single national program for monitoring of diseases.
- Mechanisms for financing the system of care, which are focused on the scope and quality of care;
- Improved staffing and improved training for medical staff;
- Implementation and application of modern innovative scientific developments

, which requires the creation of an effective system of implementation in public health practice

- Research on the conservation and promotion of health through the formation of public health services, primary prevention programs and minimizing the negative impact of social determinants on health.
- pilot projects of the structural reorganization of health care, based on the needs of the population.

As a result, **by the end of 2013 we aim for a reduction in** :

- Overall infant mortality rate to 6.5 per 1,000 live births;
- The rate of maternal mortality by 13 women per 100 thousand live births;
- Premature mortality by 25 percent;
- Deaths from tuberculosis by 30 percent.

Risks that may affect our public policy:

- The global financial and economic crisis;
- Lack of budget for financing of the planned measures;
- Change in the course of public policy objectives and directions for the medical industry and so on.

State Policy Priorities for 2012

The main aim of the policy in the health sector - reform of the health care system is to improve the access to health services, the quality of health services and to improve the efficiency of existing health care resources in the prevention and early detection of diseases, especially in the rural population.
The health sector will address the following problems:

priority development of Primary Health Care through:

- Structural, organizational and financial-economic division of levels of care
- The creation of Primary Health Care,
- The introduction of medical standards (standardized clinical protocols) of care and indicators for the quality of health care;
- Development of the Institute of Family Physicians;
- Actively implement measures of medical and social prevention and educational prevention programs to increase the public awareness on the importance of living a healthy lifestyle;

improvement of emergency medical care by establishing a uniform system of emergency medical care and introduce regulation for its functioning, and by the introduction of standardized technologies for emergency medical care at various levels;

Implementation of health care reform in Vinnytsia, Dnipropetrovsk, Donetsk and Kyiv regions in order to develop new organizational, legal, financial and economic mechanisms to improve the efficiency and availability of medical services and the creation of economic incentives for health workers based on the volume and quality of work performed;

development of a system of care for children and mothers: This means the structural reorganization of obstetric and neonatal services and the development of perinatal care through a network of perinatal centers, provision of female infertility treatment methods of assisted reproductive technologies, improved spa software.

improve staff policy by improving training and retraining of health care workers and by introducing mechanisms to increase the wages of workers in this field, taking into account the unified tariff,

volume, quality, complexity, and effectiveness of health services and social protection;

Overall reduction in morbidity and mortality from all diseases, early detection of diseases, Especially socially significant : cardiovascular, cancer, tuberculosis, AIDS;

Quantitative and qualitative performance criteria policy

Implementation of tasks will allow: to increase the efficiency of health care, to form a system that provides affordable and high quality medical services at all levels of care.

MAIN AREAS OF DEVELOPMENT IN 2013 and 2014

In the years 2013-2014 the state policy in the health sector will focus on strengthening the prevention and early detection of disease, improve health care quality and the accessibility of health services, improve the effectiveness of public funding, create incentives for healthy living and healthy working conditions.

Further implementation of the pilot project on reforming the health care system in Vinnitsa, Dnepropetrovsk, Donetsk oblasts and Kyiv in 2013-2014 will lead to a new organizational model and of new legal, financial and economic mechanisms to improve the efficiency and availability of medical services. We will implement Health Care Reform in these regions and use a system of indicators to monitor progress. As part of the reform it is expected to introduce a contractual relationship between the customer and the provider of medical services, based on a uniform methodology to calculate the cost of medical services funded by the state. If the pilot project (improving quality of care and access to medical services in these regions) proves to be successful, the results will be extended to the whole country. During the implementation of the model of health reform at the national level the constitutional rights of citizens to healthcare will be preserved. It is expected that implementation of the planned measures will be the preparation for the introduction of mandatory social health insurance.

In addition, tasks and measures of public policy in the health sector in 2013-2014 will focus on:

- improving national measures for prevention, diagnosis and treatment of non-communicable diseases, through optimization of the programs in the health sector;
- increasing fertility rates and declining infant and maternal mortality, improving children's health;
- reducing the incidence of infectious diseases, which will be achieved by immunization, promoting immunology, genetic engineering and pharmaceutical developments;
- increase the efficiency of national measures to prevent malignancies, improving cancer prevention, improve access to care for cancer patients;
- ensure the implementation of preventive, curative and organizational measures and measures of care and support for HIV-infected and AIDS patients;
- further improvement of the treatment and prevention of tuberculosis to reduce morbidity and mortality from tuberculosis.

It is expected that the implementation of planned tasks and activities in the health sector in 2013-2014 will reduce the overall rate of infant mortality to 6,5 ‰, the maternal mortality rate to 13 ‰, premature mortality rate - 25%, mortality from malignant neoplasms - 3% mortality from tuberculosis - a 30% decrease, the number of deaths from AIDS to 8 persons per 100 thousand population.

Priority policies in the health sector in 2013-2014

In order to implement certain medium-term goals and ensure continuity of policy in accordance with state policy documents, including the State Economic and social development plan of Ukraine for 2012, the Cabinet of Ministers of Ukraine has identified that the main objectives of the health sector plans for 2013 – 2014 is to ensure the availability of quality health services, prevention and early detection of diseases. Reforming health care will be done by implementation of the new model produced in the pilot project in Vinnitsa, Dnepropetrovsk, Donetsk oblasts and Kyiv. Increased access to health services should be achieved through:

in 2013

- introducing a mechanism of governmental payment of services in health facilities on a contractual basis;
- introduction of clinical protocols;
- introduction of a system of indicators of quality of medical facilities,
- the establishment of independent centers for monitoring and evaluation of the quality of medical services;
- improving the system of remuneration of medical workers through the provision of two components: permanent (based on the unified tariff) and variable (depending on the amount and quality of medical care);
- create incentives for healthy living (introduction of programs that promote healthy lifestyles and healthy work environment programs);

in 2014:

- transfer all medical institutions to a system of contractual relationship between the customer and the provider of medical services;
- introduction of a uniform calculation methodology for the financing of medical services by the state;
- preparation of the pre-conditions for the transition to the model of social health insurance, through:
    - establishing financial stability of hospitals
    - optimizing the hospital network
    - increasing (financial) self management of medical institutions
    - increasing competition in the health care system.