Private provision of health services in Ukraine

Current challenges, future directions

Health policy paper series
Private provision of health services in Ukraine

Current challenges, future directions

Health policy paper series
Abstract

In most countries, health systems are mixed, with a range of public and private sector entities providing health-related goods and services. This report assesses the current policy framework regarding private health service providers (PHSPs) in Ukraine, focusing on regulations, contracting mechanisms, information and intelligence, and stakeholder engagement, in relation to UHC goals. It finds that the regulatory apparatus is comprehensive but enforcement is limited. PHSPs need to be held accountable for the safety, appropriateness and effectiveness of the care they provide. Except for primary health care, take-up of contracts with the National Health Service of Ukraine under the Programme of Medical Guarantees (PMG) has been limited by insufficient funding to cover PHSPs’ costs. New contractual modalities and adjusting payment structures may support the role of PHSPs in the health sector’s recovery and reconstruction efforts. Reforms should focus on integrating all PHSPs into national health information systems and establishing platforms for policy dialogue. Overall, with strong regulations and contracts, fully inclusive health information systems, and open, transparent, and purposeful dialogue, the PHSP sector can continue to grow without detriment to the Government’s key health policy goals.

Keywords

PRIVATE SECTOR, GOVERNMENT REGULATION, CONTRACTS, ECONOMIC COMPETITION, HEALTH INFORMATION SYSTEMS, STAKEHOLDER PARTICIPATION

Document number: WHO/EURO:2023-7625-47392-69619

© World Health Organization 2023

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

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: “This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition: Private provision of services in Ukraine: current challenges, future directions. Health policy papers series. Copenhagen: WHO Regional Office for Europe; 2023”.

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


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

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

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

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

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

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

Design by Djordje Dević

All photos: © WHO
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of illustrations</td>
<td>iv</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>v</td>
</tr>
<tr>
<td>Abbreviations</td>
<td>vi</td>
</tr>
<tr>
<td>Executive summary</td>
<td>viii</td>
</tr>
<tr>
<td>1. Introduction</td>
<td>1</td>
</tr>
<tr>
<td>2. Methodology</td>
<td>4</td>
</tr>
<tr>
<td>2.1 Data collection</td>
<td>4</td>
</tr>
<tr>
<td>2.2 Evaluation framework</td>
<td>4</td>
</tr>
<tr>
<td>2.3 Research questions</td>
<td>5</td>
</tr>
<tr>
<td>3. Structure of the PHSP sector in Ukraine</td>
<td>6</td>
</tr>
<tr>
<td>4. Evaluation results</td>
<td>10</td>
</tr>
<tr>
<td>4.1 Introduction</td>
<td>10</td>
</tr>
<tr>
<td>4.2 Evaluation questions</td>
<td>11</td>
</tr>
<tr>
<td>5. Areas for potential action</td>
<td>26</td>
</tr>
<tr>
<td>Action area 1: strengthen the regulatory framework</td>
<td>26</td>
</tr>
<tr>
<td>Action area 2: strengthen contracting arrangements</td>
<td>27</td>
</tr>
<tr>
<td>Action area 3: accelerate health information system integration</td>
<td>29</td>
</tr>
<tr>
<td>Action area 4: enable stakeholder participation in policy-making</td>
<td>30</td>
</tr>
<tr>
<td>6. References</td>
<td>32</td>
</tr>
</tbody>
</table>
LIST OF ILLUSTRATIONS

Table 1  Numbers and types of health service provider in Ukraine, 2020–2022
Table 2  Numbers of and aggregate payments to PHSPs contracted by the NHSU under the PMG, 2020–2022
ACKNOWLEDGEMENTS

The WHO Country Office in Ukraine would like to thank Mark Hellowell (WHO Country Office in Ukraine) for writing this document. Internal review was provided by Tomáš Roubal, Olga Demeshko, Kateryna Fishchuk and Loraine Hawkins (WHO Country Office in Ukraine), Triin Habicht (WHO Barcelona Office for Health Systems Financing), Tomas Zapata (Health Workforce and Service Delivery Unit, WHO Regional Office for Europe), and Joseph Kutzin (Health Systems Governance and Financing, WHO headquarters). Overall technical guidance of the report was provided by Jarno Habicht (WHO Country Office in Ukraine).

The Country Office would like to thank Toomas Palu and Olena Doroshenko (World Bank Group) for their technical contributions and review. WHO also expresses sincere gratitude to the Ministry of Health and the National Health Service of Ukraine for discussion and input provided during the report development process, as well as to all interviewees, for providing the information underpinning this analysis.

This publication forms part of a series of health policy work launched in 2020 to enhance the development of the health system in Ukraine, under the leadership of Jarno Habicht and Natasha Azzopardi-Muscat (WHO Regional Office for Europe). The policy brief was prepared in the context of the Biennial Collaborative Agreement between the Ministry of Health and the Regional Office.

The work was made possible with the financial support of the European Union, within the European Union and WHO initiative on health system development in Ukraine, and the Government of Switzerland (Swiss Agency for Development and Cooperation).
ABBREVIATIONS

COVID-19  coronavirus disease 2019
CPD     continuous professional development
EU      European Union
FOP     Fizychna Osoba-Pidpryemets (type of legal entity – individual entrepreneur or small or medium-sized enterprise)
NHSU    National Health Service of Ukraine
OOP     out-of-pocket
PHC     primary health care
PHSP    private health service provider
PMG     Programme of Medical Guarantees
SMEs    small and medium-sized enterprises
UHC     universal health coverage
VHI     voluntary health insurance
EXECUTIVE SUMMARY

In most countries, health systems are mixed, with a range of public and private sector entities providing health-related goods and services to the population. However, mixed health systems vary in the extent to which they promote universal health coverage (UHC). In mixed health systems that perform well in this regard, adequate public spending supports an accessible and universalist public sector, to which a well-regulated private sector plays a complementary role. It is a core task of governments to define this role and to create a policy framework through which this can be realized. To accelerate progress towards UHC, policy makers deploy a range of policy instruments to promote:

1. the safety, appropriateness, and quality of services across the health sector (public and private);
2. equity of access to care (such that only modest differences exist across socioeconomic strata or geographical locations, e.g. urban versus rural areas);
3. financial protection (such that low levels of out-of-pocket (OOP) payments minimize catastrophic and impoverishing health care-related expenses); and
4. attenuation of negative spillovers from the private to the public sector (such that the activities of private health service providers (PHSPs), and their funding arrangements, do not undermine the public sector's ability to mobilize the financial, human and technical resources needed to realize the right to health).

Drawing on this vision and set of objectives, this report provides an assessment of the Government of Ukraine's policy framework with regard to PHSPs. Its focus is on private health service providers in Ukraine, a growing number of which are active in service areas such as primary health care (PHC), inpatient and outpatient settings, and those providing diagnostic services. The report does not address policies relating to the pharmaceutical or medical devices industries or related distributors or retailers. The report first outlines the structure of the PHSP sector, and moves on to assess the nature and effectiveness of four key governmental functions with regard to the sector: legislation and regulation, contracting mechanisms, information and intelligence, and stakeholder engagement. This assessment is followed by a series of suggested areas for action in relation to each of the core functions.
Structure and financing of the PHSP industry

According to unpublished data compiled by the Ministry of Health, 19,726 licensed PHSPs existed in Ukraine in 2022 (compared with 23,441 licensed providers across all sectoral categories). This number represents an increase of 22% from 2021 and of 43% from 2020. However, these numbers overstate the true scale of the private sector’s contribution because the vast majority of PHSPs are Fizychna Osoba-Pidpryemets (FOPs), that is privately owned small and medium-sized enterprises (SMEs) operating as sole-practitioner or group-practitioner entities. In 2022 there were an estimated 15,777 of these entities in Ukraine, compared with an estimated 3,949 private entities with a different legal form (including a group of 21 large-scale investor-owned businesses, which hold a considerable proportion of the market share and, therefore, market power).
Although many PHSPs are contracted by the National Health Service of Ukraine (NHSU) under the Programme of Medical Guarantees (PMG), the monetary value of these contracts is relatively modest: at ₴3.2 billion (Ukrainian hryvnia): in 2022, it was equivalent to just 2.2% of the total value of all contracts issued by the NHSU in that year, and a small fraction of aggregate PHSP revenues (the vast majority of PHSPs – some 94.7% – do not have an NHSU contract). The voluntary (that is, private) health insurance (VHI) industry in Ukraine is also of negligible scale, generating premiums of just ₴1.1 billion in total (2020). As such, it is evident that the vast majority of PHSP revenues come from OOP payments – the most regressive form of health financing – although the total financial volume of the PHSPs is currently unknown.

The evaluation

Governments should take action to ensure (i) the safety, appropriateness and quality of services across the entirety of the health sector (public and private); (ii) equity of access to health services; (iii) financial protection; and (iv) the avoidance of negative spillovers from the private to the public sector, for example, by ensuring that the activities of PHSPs (and its funding sources) do not undermine the state/communal sector’s ability to mobilize sufficient financial, human and technical resources. As independent entities, PHSPs are not subject to direct control by the Government or other state or subnational authorities (in Ukraine, non-profit-making health care facilities owned by subnational governments are known as communal facilities). Instead, to promote the policy goals outlined in points i–iv (above), the Government has to deploy a range of policy instruments to influence the incentive and accountability environment in which PHSPs operate. As described in the previous section, the vast majority of PHSP activity occurs outside of NHSU contracting arrangements. Thus, the main levers of influence available to Government are regulatory – and these are used to promote the safety, appropriateness and effectiveness of PHSP-delivered care, alongside consumer protection. These instruments are examined in the first evaluation section. The regulations are not specific to PHSPs, but cover the entire health services sector in Ukraine. However, in the absence of other instruments (e.g. those relating to state ownership or contracts), they play an important role in influencing PHSP operations and performance.

For the minority of PHSP operations that occur inside NHSU contracting mechanisms, several additional levers of influence are available to state authorities, and additional policy objectives are present (examined in the second evaluation section). For example, as contracting rules require PHSPs to offer all services defined in the contracted care package free at the point of use and with no co-payments, equity of access and financial protection goals can be promoted. In addition, as PHSPs are encouraged to adjust their costs so that they are capable of
obtaining a surplus (or profit) from NHSU-defined payments, technical efficiency can be advanced. Furthermore, as “the money follows the patient”, providers (of all sectors) must attract and retain demand for their services – and as prices are fixed, they can do so only by responding to patient preferences. The resulting stimulus to patient choice and contestability may benefit patients, especially in service areas in which incumbent state/communal providers are unresponsive, non-transparent and revenue driven.

In addition, it is important that the Government of Ukraine has reliable and comprehensive information about the operations and performance of the private sector – both inside and outside the contracted network – and that the formulation of policies in relation to the private sector is open, transparent and inclusive of civil society organizations and of representatives of vulnerable and marginalized communities and the wider public.

The evaluation of the policy framework is presented in the following sections as responses to four key questions that are defined by the four core functions: legislation and regulation, contracting mechanisms, information and intelligence, and stakeholder engagement.

1. Legislative and regulatory apparatus: to what extent does this ensure that consumers are protected and services provided in the private sector are safe, appropriate and effective?

On paper, the legal and regulatory apparatus for PHSPs is comprehensive, incorporating a range of instruments and levers, including licensing and accreditation, professional regulation (attestation of medical workers’ qualifications), and clinical guidelines, standards and protocols. This combination can help to ensure that the health services provided by PHSPs are safe, appropriate and effective, and that consumer rights are protected. In practice, however, the apparatus has several gaps and limitations that should be addressed.

Some of the gaps are technical. For example, the licensing guidelines, while quite detailed, contain some outdated requirements, including equipment specifications that are inconsistent with modern clinical practice. These need to be updated. In most service domains in Ukraine, it is unclear how the accreditation process interfaces with NHSU contracting criteria, for example, the accreditation scores that a PHSP needs to achieve in order to become eligible for an NHSU contract. By signalling an intention to define this interface more clearly in the medium term, the Government can generate pressure on providers (public and private) to strengthen their ability to achieve defined standards. Other gaps are more complex. For example, the lack of ex ante enforcement of Ministry-defined clinical guidelines, medical standards and clinical protocols (such that any enforcement...
only takes place ex post, e.g. in the event of a patient complaint or lawsuit) indicates a deeper governance challenge of ensuring appropriate levels of accountability among PHSPs, for which merely technical solutions may be inadequate.

Individual licensing of professionals (doctors, nurses and other clinical professionals) has clear requirements for continuous professional development (CPD) and the development of new codes of ethical conduct and new systems for disciplinary liability in case of breaches. The emergence of new professional self-governance may play an important role in addressing such limitations, alongside developing national self-governance organizations. While the impacts of stronger accountability and governance arrangements have implications for the entire health sector, their impacts on PHSPs outside the public sector contracting network may be especially profound, given the absence of other forms of influence or leverage, such as those derived from state/communal ownership (e.g. by subnational governments) or contracting mechanisms.

2. Contracting mechanisms: to what extent do arrangements for NHSU contracting of PHSPs help to promote equity of access, adequacy of coverage and quality of care?

The NHSU was created in 2018 to manage the Government's health financing pool and to contract public and private providers nationwide to deliver services under the PMG. Recent years have seen growth in the number of PHSPs contracted by the NHSU, along with an increase in the aggregate value of payments made to PHSPs. For these entities, the pressures created by the regulatory apparatus are further increased by those generated by NHSU contractual conditions. For some packages, substantial engagement of the private sector has created a competitive fringe in related markets, thereby increasing patient choice and contestability among providers. For example, in PHC, approximately 10% of the total number of patient declarations were held by PHSPs in 2022.

However, for most packages outside PHC, the private sector take-up of NHSU contracts has been more limited. This lack of engagement is partly driven by the basis for determining NHSU payment rates for related services. The rates are set at a level sufficient to remunerate state/communal facilities for some of their total costs because some costs are covered by patient direct payments (e.g. inpatient medicines), whereas others (e.g. for capital, premises, utilities and

---

1 In Ukraine, the term package refers to a list of medical services and medicines necessary for the provision of services in a given service domain, which the NHSU pays for under the contract.

2 This fringe represents smaller companies that coexist with the larger companies that dominate market share.

3 Contestability is the extent to which a particular market is amenable to competition and open to new entry from competitors.

4 A patient declaration is a document that confirms a patient’s choice of primary care physician. This is provided in accordance with the procedure established in Ukrainian legislation (Order of the Ministry of Health No. 503 of 19 March 2018).
maintenance) are covered by the owners. If the Ministry of Health and NHSU wish to encourage greater entry of PHSPs across specialized care packages and other service domains, this uneven playing field may have to be tackled – for example, by shifting the cost of utilities from subnational government owners to NHSU tariffs and introducing a coefficient for premises costs, while acting to prevent duplicate payments to state/communal providers (which are provided with premises on a subsidized or free basis).

However, the case for encouraging further take-up of NHSU contracts with PHSPs is not straightforward. There are risks to ongoing reform agendas in service delivery (at PHC level) and network optimization (at the secondary and tertiary care levels).

In relation to service delivery, many NHSU contracts are held by small-scale FOPs, many of which are unable or unwilling to offer the comprehensive, multidisciplinary team-based care that has been called for in both national regulations and international normative guidance. Revisions to the current contractual conditions (e.g. enrichments to PHC packages) and higher minimum standards are needed in key areas (such as opening hours and after-hours coverage), alongside proper enforcement, to stimulate the organizational integration of providers.

In terms of network optimization, international experience suggests that non-selective contracting of PHSPs impedes strategic planning goals – especially where there are no adequate controls on volume (e.g. service delivery thresholds...
for care packages) and the risks of supplier-induced demand are significant (including for both NHSU-covered services and for self-referrals to services outside the contract, in which case OOP payments can be levied). If the Ministry of Health and NHSU wish to encourage PHSPs to enter into contracts for secondary and tertiary care packages, it will be important to ensure that related contracting mechanisms and payment methods are modified in order to control volumes, address fraud and inappropriate self-referrals, and encourage the realization of economies of scale. Otherwise, large-scale PHSP take-up of contracts may undermine financial sustainability across the rest of the PMG delivery network. The effective mitigation of such risks may not be possible unless the NHSU’s budget and staffing levels are increased and its monitoring and enforcement functions strengthened.

In addition, gaps in service provision have emerged as a result of the full-scale invasion of the country by the Russian Federation, particularly in localities where internally displaced populations have become concentrated or critical health facilities have been damaged or destroyed, or in territories reclaimed from occupation.

PHSPs have the potential to establish new capacity or scale up existing capacity, especially in service domains in which:

- major investments in specialized immovable assets are not required;
- PHSPs are able to realize economies of standardization, scale and focus; and
- there is already a high level of private sector engagement in NHSU contracting arrangements.

It follows that service domains in which PHSPs could play a useful role include PHC (including in mobile facilities), small-scale diagnostics and rehabilitation. However, PHSPs may be more risk-averse than state/communal providers in terms of willingness to incur the necessary investment costs. In addition, many PHSP representatives report that access to capital is a major constraint on their operations (citing high interest rates, unrealistic collateral requirements and short loan tenors). In this context, new contractual mechanisms and payment methods (e.g. service contracts in which funding is linked to the availability of services, rather than the volume of services delivered) may be required, alongside the provision of loans, risk capital and/or risk mitigation instruments by Government or external development partners. This suggests that further consultation with PHSPs alongside international development partners will be important, focusing on exploring whether and how NHSU contracts with PHSPs can or should be used to stimulate the role of PHSPs in ongoing recovery and reconstruction efforts.

---

5 Of course, such objectives are of paramount importance in terms of good contracting practice generally – and not only in relation to PHSPs.
3. Information and intelligence: to what extent are PHSPs integrated into the national health information system?

PHSPs are obliged to provide information to a range of authorities – including the state tax service, the state statistics service and the health departments of cities/regions (oblasts). However, the information is not provided in a way that can be readily disaggregated and this makes assessing and analysing the scale and revenues of the private sector difficult. The licensing process also generates information for the Ministry of Health on PHSP resources (e.g. facilities, equipment and staffing) and it is (outside of martial law conditions) mandatory to update the Ministry on any changes made to these resources over time. However, the level of compliance varies across providers. Integration with the health statistics and surveillance systems of the Public Health Centre of Ukraine is also a major challenge. Therefore, information on matters of core relevance to policy-makers – including what the private sector does, for whom, on what terms and at what level of quality – is unavailable to policy-makers in Ukraine.

There are signs that the Government of Ukraine has recognized this problem. As of 31 March 2023, all PHSPs, regardless of their NHSU contract status, are required to register in the e-health system and ensure the interoperability of their own medical information systems with this central health information system. However, actual registration is limited. As of April 2023, 6,867 PHSPs had registered in the e-health system, which represents only a small fraction of the total number. In addition, given the limitations of the e-health system (and a lack of incentives for private providers to submit information on the system after registering), it is unclear whether more comprehensive registration would address the current gaps in data coverage in key areas such as utilization and access, service coverage, service quality and outcomes, and the technical and human resources held by PHSPs.

In this context, it appears likely that policy-makers will continue to be unable to make evidence-based decisions or optimally allocate resources to PHSPs and that the wider public will not have access to information about the activities or performance of these important providers.

4. Stakeholder engagement: to what extent do open, inclusive and transparent structures for stakeholder participation exist for policy-making in relation to PHSPs?

The PHSP industry is becoming better organized. Policy dialogue is becoming more formalized, focused and purposeful. Government has access to a more defined list of interlocutors from whom it can obtain information, and with whom it can negotiate and deliberate – opening up opportunities to resolve policy challenges,
including those described in this analysis. However, the ongoing lack of open, inclusive and transparent structures for engagement of stakeholders – beyond those representing the interests of the industry’s most dominant companies – generates risks of bias, conflicts of interest, and corruption in decision-making, and impedes progress towards UHC objectives, such as equity of access and financial protection.

Parts of the PHSP market – in primary care, dental care, and diagnostic/laboratory services – are fragmented, involving many thousands of small-scale entities. However, in the secondary and tertiary care sectors, the market is heavily concentrated – enabling the accumulation of both market power and undue political influence for important companies.

It is therefore important that, as institutions for cross-sector engagement are strengthened, the Government engages a broad range of stakeholders – including civil society organizations, representatives of vulnerable and marginalized communities, and the wider public – in decision-making about PHSPs. This is important in the current situation, in which PHSP representatives are advocating for policy changes that reflect the interests of incumbent companies (e.g., to be able to charge co-payments to supplement NHSU payments, and for laws to be changed that would encourage the growth of VHI), but also have the potential to erode equity of access and financial protection. Such changes could thereby compromise the Ukrainian Government’s post-2018 health sector reform agenda.

**Proposed action areas**

The evaluation of the four core governmental functions (legislation and regulation, purchasing mechanisms, information and intelligence, and stakeholder engagement) have been used to propose action areas intended to support the Government in improving its activities, increasing its impact in relation to these four core functions and, thereby, its efforts to achieve UHC. Proposed action areas are to:

- strengthen regulation of PHSPs to promote the safety, appropriateness and effectiveness of care, along with consumer protection;
- strengthen arrangements for contracting PHSPs, focusing on promoting equity of access and financial protection in key service domains, but staying mindful of associated risks to government objectives for service delivery and network optimization;
- accelerate the process of integrating PHSPs into the national health information systems and strengthen enforcement; and
ensure that platforms for public–private dialogue are more open, inclusive and transparent to safeguard health sector objectives and the wider public interest.

**Action area 1: strengthen the regulatory framework**

Currently, a comprehensive range of regulatory instruments is in place, but enforcement is limited. For example, compliance with unified medical standards is variable across the sector. The Ministry of Health may consider strengthening enforcement mechanisms, including through transparent structures for monitoring and inspection. Given the lack of Ministry capacity in this area, the emerging structures for professional self-governance should be harnessed to strengthen the regulatory apparatus and its enforcement.

**Action area 2: strengthen contracting arrangements**

The extent of PHSP take-up of NHSU contracts differs across packages. To increase this, adjustments to payment rates (e.g. including utilities costs in NHSU payments) and enforcement of contracting conditions by NHSU with existing providers may be considered. However, the case for encouraging further PHSP entry varies by service domain – and should be carefully analysed for each domain, with risks identified and feasible plans for mitigating them defined. There are risks to service delivery (e.g. the risk that further PHSP entry will lead to fragmentation in PHC), to network optimization (e.g. the risk that further PHSP entry will erode strategic planning goals – especially as there are inadequate controls on volume such that the threat of supplier-induced demand is significant) and of financial protection (e.g. when PHSPs start charging patients on top of NHSU tariffs for services that are available for free in the public facilities). PHSPs can also play a valuable role in ongoing recovery and reconstruction efforts, alongside the public sector.6 PHSPs have the potential to establish new capacity or scale up existing capacity, especially in service domains in which:

- major investments in specialized immovable assets are not required;
- PHSPs are able to realize economies of standardization, scale and focus; and
- there is already a high level of private sector engagement in NHSU contracting arrangements.

In such domains, service contracts with PHSPs may be used to stimulate supply in specific services, such as PHC (including mobile facilities), small-scale diagnostics and rehabilitation.

---

6 It is important to acknowledge that, alongside military authorities, state/communal entities have demonstrated a high level of ability to respond rapidly and effectively to emerging unmet needs during the war.
**Action area 3: accelerate health information system integration**

The process of integrating PHSPs into national health information systems can be accelerated, enabling Ukraine to make further progress towards creating an integrated, unified national health system. This will benefit all providers and the PHSP sector should recognize and be responsive to this opportunity as part of the licensing and inspection system. Currently, however, only a small fraction of PHSPs is registered on the system. Moving forward, there needs to be a clear signal from Government and industry leaders that all PHSPs (regardless of NHSU contracting status) will be required to register on the e-health system and report against a defined set of indicators as a condition of their license. In the shorter term, the Ministry of Health may wish to ensure that the information PHSPs provide to a range of state authorities (e.g. state tax service, state statistics service, and oblast/city health departments) – often at great expense and inconvenience to themselves – is in a format that can be utilized for policy analysis and includes basic information on capacity (e.g. number of beds, employees, equipment) and activity (e.g. volume of services, patients treated or overall turnover).

**Action area 4: enable stakeholder participation in policy-making**

The PHSP sector is well organized as an industry, and its interactions with state authorities are becoming more frequent, focused and purposeful.

There is a powerful argument for ensuring that the Ministry of Health establishes platforms for the inclusion of diverse stakeholders – patient groups, representatives of vulnerable and marginalized communities and the wider population – in policy discussions related to PHSPs and their role in the wider health system. More generally, the Ministry of Health should clarify its unequivocal commitment to UHC as the driving force of its current reform programmes, and ensure that policy dialogue is focused on how best to achieve this. Platforms for public–private dialogue should be more open, inclusive and transparent to safeguard health sector objectives and the wider public interest.
1. INTRODUCTION

Recent years have seen a gradual increase in the scale of the private health services sector in Ukraine. This report presents an assessment of the Government of Ukraine’s policy framework for this growing industry as part of the health system reform initiated in 2018. Its focus is on PHSPs, including in PHC, inpatient and outpatient settings, and those providing diagnostic services. It does not address policies relating to the pharmaceutical or medical devices industries, or to related distributors or retailers. Growth in the scale of PHSP activity presents a number of opportunities – alongside some challenges – to health system policy-makers in Ukraine. In the former category, such growth is supportive of the Government’s goal to encourage greater competition and autonomy among health service providers, including those funded by the NHSU under the PMG. In the latter category, that is, the associated challenges, the profit-making orientation of PHSPs can create incentives which – if left unaddressed – may expose patients to unsafe, inappropriate or ineffective care, alongside financial exploitation.

Of course, such challenges are not restricted to PHSPs. For example, many state/communal providers are also strongly revenue driven – in terms of both formal and informal payments – and responsive to the financial incentives and regulatory environment. However, the policy instruments available to governments differ across the public–private divide. In the private sector, the instruments exist in the legal and regulatory apparatus and (where applicable) contracting mechanisms, as opposed to levers of state/communal ownership and control. In addition, to support decision-making, it is important that the Government has reliable and comprehensive information about the capacity and performance of the private sector (e.g. what is has, what it does, on what terms and with what outcomes for patients) and that policies are formulated in an open, transparent and inclusive way, with the effective engagement of multiple stakeholders without discrimination.

7 Nor does the assessment address the issue of public–private partnerships for health infrastructure and services (other than those established through the NHSU contracting framework). An assessment of, and guidance on, such transactions can be found in a 2022 WHO Regional Office for Europe publication entitled Public-private partnerships for health care infrastructure and services: considerations for policy makers in Ukraine (1).

8 Formally, many public health service providers have financial and operational autonomy from their state/subnational government “owners”. However, most receive various forms of subsidy from their owners – which in turn creates forms of leverage, incentive moderation and accountability, for which there is no equivalent among PHSPs.
To achieve its objectives, this report is shaped as follows. First, it presents an evaluation of the current policy framework in Ukraine as it relates to PHSPs, focusing on four core government functions defined by WHO (4):

1. legislation and regulation
2. contracting mechanisms
3. information and intelligence
4. stakeholder engagement.

Secondly, the report proposes a series of action areas for policy-makers in Ukraine to optimize state interventions across the four government functions and ensure progress towards core policy goals. In accordance with the principles of UHC, these goals include the safety, appropriateness and efficacy of health services; equity of access; and financial protection.9

---

9 These factors (which are technically subfunctions of two higher-level functions (governance and financing)) are key elements of system design that determine the ability of state authorities to exert influence on the incentive and accountability environment in which PHSPs operate. In turn, this environment determines the scale and scope of PHSP activity in the health sector and the levels of performance achieved.
2. METHODOLOGY

2.1 Data collection

The report is based on data and insights drawn from multiple sources:
- a literature review and document analysis;
- expert legal advice; and
- 42 key-informant interviews (conducted either in person at site visits or online), including individuals representing:
  - state authorities (at the central, regional and local levels);
  - private sector associations;
  - PHSPs of different legal forms (private entrepreneurs, limited liability companies and investor-owned corporations of other kinds) and service domains (PHC, diagnostics and laboratories, specialist outpatient care services, and multidisciplinary inpatient care);
  - patient associations; and
  - international organizations.

2.2 Evaluation framework

In most countries, health systems are mixed, with a range of public and private sector entities providing health-related goods and services to the population. However, mixed health systems vary in the extent to which they promote UHC – such that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. In mixed health systems that perform well in this regard, adequate public spending supports an accessible and universalist public sector, to which a well-regulated private sector plays a complementary role (5). It is a core task of governments to define this role and to create a policy framework through which this can be realized. To accelerate progress towards UHC, policy makers deploy a range of policy instruments to promote:
- the safety, appropriateness and quality of services across the health sector (public and private);
- equity of access to care (such that there are only modest differences across socioeconomic strata or geographical locations, e.g. urban versus rural areas);
• financial protection (such that low levels of OOP payments minimize catastrophic and impoverishing health care-related expenses); and
• attenuation of negative spillovers from the private to the public sector (such that the activities of PHSPs, and their funding arrangements, do not undermine the public sector’s ability to mobilise the financial, human and technical resources needed to realize the right to health).¹⁰

This report provides an assessment of the Government of Ukraine’s policy framework with regard to PHSPs, focusing on the operation of four core government functions: legislation and regulation, purchasing mechanisms, information and intelligence, and stakeholder engagement. Where these functions are present, and performing well, UHC is promoted. Conversely, if they are absent or inadequate, the commercial incentives of PHSPs may – in the context of information asymmetries between providers and patients – expose patients to unsafe, inappropriate or ineffective care, alongside financial exploitation, while the emergence of negative spillovers from the private to the public sector may create or reinforce inequities of access and coverage.¹¹

The report focuses on private health service providers in Ukraine, a growing number of which are active in service areas such as PHC, inpatient and outpatient settings, and those providing diagnostic services. The report does not address policies relating to the pharmaceutical or medical devices industries or to related distributors or retailers.

2.3 Research questions

Following a brief overview of the structure of the PHSP sector in Ukraine, the results are organized to address the following evaluation questions.

EQ1: to what extent do legislation and regulation ensure that the health services provided in the private sector are safe, appropriate and effective?

EQ2: to what extent do arrangements for purchasing from or contracting with PHSPs promote equity of access, adequacy of coverage and quality of care?

EQ3: to what extent are PHSPs integrated into the national health information system?

EQ4: to what extent are decisions about the policy framework open, inclusive and transparent?


¹¹ It should be noted that in Ukraine most providers of health services – in both the public/communal and private sectors – face commercial incentives of various kinds, owing to their (i) high level of financial and operational autonomy from state authorities (local, regional, national levels); (ii) ability to charge patients for services outside of those contracted by the NHSU under the PMG; and (iii) propensity to charge informal payments. Therefore, it is important to emphasize that the threats to patients’ interests generated by such incentives are sector wide and by no means exclusive to PHSPs.
3. STRUCTURE OF THE PHSP SECTOR IN UKRAINE

According to unpublished data compiled by the Ministry of Health and shared with the WHO Country Office in Ukraine, 19,726 licensed PHSPs existed in Ukraine in 2022 – an increase of 22% compared with 2021 and of 43% compared with 2020 (see Table 1). These numbers give the impression that the private sector occupies a dominant position in the health system (accounting for 84% of all licensed providers). However, this overstates the true picture of its scale and contribution as, in reality, PHSPs are on average much smaller than their state/communal counterparts. Constructing a more accurate indicator of PHSPs’ scale and contribution would require data on the service volumes and/or revenues of these entities; unfortunately, no reliable data on these variables exists.

The vast majority of PHSPs are FOPs, that is, privately owned SMEs that operate either as sole-practitioner or group-practitioner entities. In 2022 there were an estimated 15,777 of these entities in Ukraine, compared with an estimated 3,949 private entities with other legal forms. Most FOPs focus on a specific service area, such as PHC, dental care, diagnostic/laboratory services, dialysis, or obstetrics and gynaecology.

Table 1. Numbers and types of health service provider in Ukraine, 2020–2022

<table>
<thead>
<tr>
<th>Health service provider</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>Percentage increase (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2021 vs 2020</td>
</tr>
<tr>
<td>Total number of health service providers (state, communal, private)</td>
<td>16,550</td>
<td>19,602</td>
<td>23,441</td>
<td>18.44</td>
</tr>
<tr>
<td>Total number of PHSPs (both FOPs and all other private entities)</td>
<td>13,778</td>
<td>16,176</td>
<td>19,726</td>
<td>17.40</td>
</tr>
<tr>
<td>FOPs</td>
<td>10,806</td>
<td>12,831</td>
<td>15,777</td>
<td>18.74</td>
</tr>
<tr>
<td>All other private entities</td>
<td>2,972</td>
<td>3,345</td>
<td>3,949</td>
<td>12.55</td>
</tr>
<tr>
<td>Share of PHSPs (% of all providers)</td>
<td>83.25</td>
<td>82.52</td>
<td>84.15</td>
<td>-0.73pp</td>
</tr>
</tbody>
</table>

pp: percentage points.

Note: the types of health service provider are state owned, communal, privately owned SMEs (FOPs) and other private entities.

Source: unpublished data provided by the Ministry of Health of Ukraine.
FOPs have come to play a particularly important role in PHC, as capitation-based NHSU contracts have stimulated their entry into the market. In this area, FOPs tend to be established by experienced doctors (many of whom have worked in state/communal facilities) who are able to attract a sufficient level of patient declarations for such businesses to become and remain viable. Some owners of FOPs in the PHC sector operate as individual practitioners, while others employ additional doctors and nurses, thus effectively forming small group practices.

Conversely, most (non-FOP) private entities are financed by domestic investors, for whom PHSPs that focus on PHC, diagnostics and/or specialist outpatient care can offer a low-risk, medium-return investment with the potential for higher returns to be secured in the medium term (e.g. in the event of Ukraine’s accession to the European Union (EU)). In addition, analysis of commercial data (not in the public domain) by the International Finance Corporation identified a group of 21 large-scale investor-owned businesses – of which, they estimate, the top 10 account for 40% of the total revenue of the entire PHSP sector, thus affording them considerable market power (7). Most of these entities operate on a low-volume, high-margin business model, and focus on multidisciplinary inpatient and outpatient care services targeted towards the relatively high-income populations in Kyiv and other major cities. As discussed in more detail below, most of these businesses have not engaged in NHSU contracts under the PMG, but many play a prominent role in influencing policy-making processes with regard to the PHSP sector.
More generally, since 2020, the numbers of and aggregate payments to PHSPs contracted by the NHSU have increased under the PMG, thereby enabling more patients to obtain privately delivered PMG services free at the point of use (see Table 2).

Table 2. Numbers of and aggregate payments to PHSPs contracted by the NHSU under the PMG, 2020–2022

<table>
<thead>
<tr>
<th>Health service provider</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total for all contracted providers (state, communal and private)</td>
<td>3 884</td>
<td>3 495</td>
<td>3 499</td>
</tr>
<tr>
<td>Total for contracted PHSPs (FOPs and all other private entities)</td>
<td>902</td>
<td>933</td>
<td>1042</td>
</tr>
<tr>
<td>FOPs</td>
<td>664</td>
<td>603</td>
<td>688</td>
</tr>
<tr>
<td>All other private entities</td>
<td>238</td>
<td>330</td>
<td>354</td>
</tr>
<tr>
<td>Share of PHSPs (% of all providers)</td>
<td>23.22</td>
<td>26.70</td>
<td>29.78</td>
</tr>
</tbody>
</table>

*In Ukrainian hryvnia (billions).

Note: the types of health service provider are state owned, communal, privately owned SMEs (FOPs) and other private entities.

Source: datasets available on the Government of Ukraine’s Open Data web portal (8), as analysed by the WHO Country Office in Ukraine.

The NHSU was created in 2018 to manage the Government’s health financing pool and to contract with public and private providers nationwide to deliver services under the PMG. Although a large number of PHSPs have been contracted by the NHSU under the PMG (amounting to approximately one third of the total number of providers that were contracted in 2022), the vast majority of licensed PHSPs (94.7%) did not have an NHSU contract that year. In addition, the monetary value of contracts held by these PHSPs was modest: at ₴3.2 billion, it was equivalent to just 2.2% of the total value of all contracts issued by the NHSU. As a result of this (alongside the fact that VHI is negligible, generating premiums of just ₴1.1 billion in total in 2020), it is clear that the vast majority of PHSP revenue comes in the form of OOP payments.

In terms of their purely commercial activities – that is, those that are undertaken outside of NHSU contractual arrangements – PHSPs play a largely complementary role to the public sector. Their offer to patients focuses on amenity, pricing transparency and patient experience (e.g. better-appointed premises, superior equipment, more convenient appointment times, greater responsiveness and the absence of queues), rather than a greater range and/or quality of health services; indeed, most do not offer services beyond those available in the public sector.

---

12 Figures obtained from datasets available on the Government of Ukraine’s Open Data web portal (8), as compiled by the NHSU and the Ministry of Digital Transformation.
For health workers, mainly physicians, the growth of PHSPs creates new opportunities for full- or part-time employment outside the public sector and, thus, the chance to benefit from an alternative (or additional) source of income, alongside what is often perceived to be a less hierarchical, more flexible working environment than is commonly available in state/communal facilities. However, it is not always the case that salaries are higher in the private sector. For example, according to a recent costing study of PHC providers contracted by NHSU under the PMG, the average full-time salary for doctors in 2021 was around ₴22 000 per month in communal facilities and around ₴18 000 in FOPs. Similarly, the average full-time salary of nurses was slightly above ₴12 000 per month in communal facilities and around ₴9 500 per month in FOPs.

Although data to confirm this are unavailable, there is likely to be considerable variation in salaries across individual PHSPs and service domains. For example, clinicians may expect to receive a higher overall income in some public facilities (e.g. specialist inpatient care facilities) than would be available in many private facilities, due to the opportunities to collect informal payments in the former – these opportunities are more strictly curtailed in the latter. On the other hand, in interviews, representatives of some of the larger specialist outpatient and inpatient institutions (that are perceived as being high end) claimed to be able to offer the highest salaries across the health sector as a whole.

13 To be published in a forthcoming technical report by the WHO Regional Office for Europe on costing for provider payments in PHC in Ukraine.
4. RESULTS AND DISCUSSION

4.1 Introduction

As independent entities, PHSPs are not subject to direct control by the Government of Ukraine or other state/communal authorities (e.g. subnational governments). However, the incentive and accountability environment in which PHSPs operate is influenced by a range of policy instruments that are deployed to promote various policy objectives. As already described, the vast majority of PHSP activity occurs outside of NHSU contracting mechanisms. With this in mind, the main levers of influence available to government are regulatory; these are used to ensure that the services provided by the PHSPs are safe, appropriate and effective. In Ukraine, the instruments in place (albeit not always in use or properly enforced) include licensing of all PHSPs and accreditation for some; attestation of medical workers’ qualifications; and clinical guidelines, standards and protocols.

For the minority of PHSP operations that occur inside NHSU contracting mechanisms, state authorities have additional levers of influence – alongside additional policy objectives. These include:

- equity of access and financial protection (as contracted PHSPs must offer all services defined in the contracted package free at the point of use and with no co-payments);
- technical efficiency (as PHSPs are encouraged to adjust their costs so that they are capable of obtaining a surplus (or profit) from NHSU-defined payments); and
- enhanced intersectoral and intrasectoral competition (because “the money follows the patient”, providers of all sectors must attract and retain demand for their services and, because prices are fixed, they can do so only by responding to patient preferences).

In addition, it is important that the Government of Ukraine has reliable and comprehensive information about the operations and performance of the private sector – both inside and outside the contracted network – and that the formulation of policies in relation to the private sector is open, inclusive and transparent, and includes the effective engagement of multiple stakeholders. This section is structured to cover all relevant governmental functions in terms of the regulatory and contracting mechanisms that determine incentives and forms of accountability for PHSPs, and the information-generation and -sharing and stakeholder-engagement processes that shape the nature of policy-making in relation to them.
4.2 Evaluation questions

4.2.1 EQ1: to what extent do legislation and regulation ensure that the health services provided in the private sector are safe, appropriate and effective?\textsuperscript{14}

On paper, the legal and regulatory apparatus for PHSPs in Ukraine is comprehensive, incorporating a range of instruments and levers, including licensing and accreditation; professional regulation (attestation of medical workers’ qualifications); clinical guidelines, standards and protocols; and protection of consumer rights. In practice, however, the apparatus has several gaps and limitations that should be addressed.

4.2.1.1 Licensing

All health service providers in Ukraine – including all PHSPs – must be licensed.\textsuperscript{15} All premises, equipment and staffing must be in place \textbf{before} the licence is granted. This generates financial risk for the applicant, as decisions relating to licensing are subject to authorities’ discretion such that the process is vulnerable to forms of bias, conflicts of interest, and (potentially) corruption. The guidelines are detailed and comprehensive, but contain some outdated requirements, for example, equipment specifications that are misaligned with modern clinical practice, as defined in relevant national and/or international protocols. They also include some references to obsolete documents.

From the point of view of issuing licences, the licensee is obliged to inform the authorities of any changes in the premises, equipment or staffing as indicated in the original application.\textsuperscript{16} In principle, the information contained in these updates, alongside that contained in the original application, provides the Ministry of Health with data on the current resource base of providers, including PHSPs. This is potentially a useful tool for decision-making. However, the ability of the Ministry to use this information for analytical purposes is limited by:

- the absence of any standardized format for the submission of updates
- limited requirements for the specification of provider type or locality
- underprovision of such updates by PHSPs.

State authorities have powers to ensure compliance with the licensing conditions, for example in the event of a patient complaint, by conducting inspections of

\textsuperscript{14} Many of the regulatory procedures discussed in this section have been temporarily suspended or relaxed as part of the introduction of martial law.

\textsuperscript{15} The legal foundation for the licensing of medical practices is established by Law of Ukraine No. 23 of 2 March 2015 “on licensing of certain types of economic activities” (with amendments) (9) and Law No. 285 of 2 March 2016 on the approval of “licensing conditions for carrying out business activities in medical practice” (with amendments), as approved by Resolution of the Cabinet of Ministers of Ukraine (10).

\textsuperscript{16} This requirement has been relaxed during the martial law period.
facilities. If a failure to comply with the licensing conditions is discovered, this can result in suspension or revocation of the licence. As such, the licensing process is a useful consumer-protection tool, placing pressure on PHSPs (and other providers) to ensure minimum quality-control systems are in place for delivering safe, effective and appropriate care.

The value of licensing conditions as a consumer-protection tool could be further enhanced by:

- updating the guidelines to reflect (feasible) best clinical practice in national and international contexts;
- removing references to obsolete documents, which create confusion and may aggravate the potential for discretionary decision-making (in the context of bias, conflicts of interest and, potentially, corruption);
- standardizing forms for updating information about premises, equipment and staffing, thus giving the Ministry of Health access to current information on the resources held and deployed by the PHSP sector; and
- introduction of a two-tier inspection system, wherein patient complaints are first inspected by the oblast-level Department of Health and the Ministry of Health serves as a second-level check, e.g. to help resolve disputes, ensure due process and reduce corruption vulnerabilities.

4.2.1.2 Accreditation

For some types of PHSPs (that is, legal entities – not FOPs – active in the secondary or tertiary care domains), licensing is supplemented by accreditation. This was originally mandatory, but has been voluntary in recent years (pre-dating the introduction of martial law).\(^\text{17}\) Accreditation involves certification that a facility:

- has the resources required to provide high-quality services
- maintains established standards in the services delivered
- employs staff who are formally qualified for their positions.

The process, which covers some 25 service domains, is conducted by working groups of designated experts and coordinated by accreditation commissions under state authorities at the central and subnational levels. The outcome of the process is one of three accreditation categories awarded for each domain: second, first and highest.

While the licensing procedure helps to establish minimum standards for key inputs, the accreditation mechanism has the potential to generate pressure on PHSPs

\(^\text{17}\) Resolution of the Cabinet of Ministers of Ukraine No. 765 of 15 July 1997 (with amendments) (11). Since 2011, accreditation follows a set of new standards and criteria established by the Ministry of Health.
to ensure that systems are in place to guarantee high-quality services. As such, a move from (the current) voluntary to (the previous) mandatory application (at least across larger PHSPs) appears to be a sensible step. In addition, in many countries, there is a requirement that contractors must fulfil defined accreditation criteria in order to become (and to remain) eligible for a contract (12). Alongside other elements of the contractual arrangements, this can generate strong pressure on actual or prospective contractors to establish the quality systems and standards defined in the accreditation documents. In Ukraine in most service domains, it is unclear how the accreditation process interfaces with NHSU contracting criteria, for example, the accreditation scores that a PHSP needs to achieve in order to become eligible for an NHSU contract. These need to be more clearly defined. By signalling today an intention to define this interface more clearly in future (e.g. by introducing an explicit stipulation that only service providers, including PHSPs, with high accreditation scores will be eligible to receive NHSU contracts), the Government can generate pressure on all providers to invest in quality systems and standards.

4.2.1.3 Clinical guidelines, standards and protocols

In principle, all health service providers in Ukraine (regardless of sector) are required to observe Ministry-defined clinical guidelines, medical standards and clinical protocols as a condition of their license. This suite of regulations – if properly specified and enforced – represents a promising instrument for ensuring and promoting the safety, appropriateness and efficacy of the care provided by PHSPs.

However, in practice, there are several factors that undermine its impact. The Ministry of Health allows providers to use regulations from outside Ukraine as an alternative to the national guidelines. This was intended to:

- minimize opportunities for conflicts of interest (e.g. the inclusion of specific brand names in clinical protocols); and
- mitigate the risk that nationally defined regulations will contain gaps or fail to keep pace with international best practice.

However, it is important that protocols are selected that are applicable to the Ukrainian context, for example, that the equipment and medicines cited are those that are registered in the country and that the protocols are accurately translated into Ukrainian, which requires access to interpreters with the relevant clinical knowledge.

There is currently no routinized process of inspection or monitoring of performance (in the absence of a patient compliant or similar problem) in relation to this suite

---

18 Order No. 751 of the Ministry of Health of Ukraine “on the creation and implementation of medical and technological documents on the standardization of medical care in the system of the Ministry of Health of Ukraine” of 28 September 2012 (13).
of guidelines, standards and protocols. The incentive to comply with evidence-based guidelines of any kind, whether national or international, is limited and, indeed, the widespread perception in the health sector is that actual compliance is limited. Hence, in the absence of enforcement mechanisms, the guidelines do not exert adequate pressure on providers to achieve good clinical practice.\textsuperscript{19}

### 4.2.1.4 Professional (self-)regulation

In addition, key informants expressed concern about the lack of professional (individual) licensing in the Ukrainian health sector. Attestation of doctors’ qualifications is carried out once every 5 years and is mandatory, and doctors are required to engage in CPD and to collect at least 50 CPD points during a calendar year. However, for several years legislators have sought to expand the scope of regulations in this area, in the form of a law on the self-governance of medical professions, which would define, inter alia:

- conditions for entry into the profession;
- the creation of a register of doctors;
- the basis for individual licensing of professionals;
- the role of professionals in development of guidelines, standards and protocols;
- the role of professional associations in creating workforce policies
- the basis for CPD;
- codes of ethical conduct; and
- systems for disciplinary liability for breaches of ethical conduct codes.

The need for such structures is not restricted to doctors: it extends to other health care professions operating within PHSPs, including physiotherapists, occupational therapists, clinical psychologists and laboratory/radiology technicians. In the absence of enforced regulations, there is an incentive for PHSPs to employ undertrained and underqualified (but less expensive) people in these professional positions.\textsuperscript{20} Similarly, for nurses, the lack of advanced professional qualifications, limitations on scope of practice and the absence of CPD all limit the scope for task-shifting. Hence, nursing roles are extremely limited in Ukraine compared with standard EU practices.

In this context, the PHSP sector – like other parts of the health sector – is developing a more doctor-dominated service model, which is likely to hinder efficiency at the

\textsuperscript{19} Some performance pressure is created by the fact that when patient complaints arise, as administrative claims and/or lawsuits (e.g. claims for reimbursement of pecuniary or non-pecuniary damages), experts can be engaged that may compare the actions of, or failure to act by, service providers, with the course of actions/checklists prescribed under the guidelines, standards and protocols. The type of liability most relevant to PHSPs is civil liability for medical malpractice. The amount of compensation adjudicated by the courts may result in considerable sums to pay that may be material to the financial position or even solvency of PHSPs, especially in the absence of compulsory medical malpractice insurance in Ukraine.

\textsuperscript{20} Suggestions for new regulations in certain areas (focusing on fields relevant to war-related health needs, such as rehabilitation and mental health) were under discussion at the time of writing.
provider and sectoral levels, with potential spillover effects for the wider system (e.g. if this places additional pressure on the availability of highly qualified medical staff for state/communal facilities).

4.2.2 EQ2: to what extent do arrangements for purchasing from or contracting with PHSPs promote equity of access, adequacy of coverage and quality of care?

As shown in Table 2, recent years have seen major growth in the number of PHSPs contracted by the NHSU under the PMG, and the aggregate value of payments made to PHSPs has also increased. For these entities, the pressures created by the regulatory apparatus are further increased by those generated by NHSU contractual mechanisms. Such pressures include:

- the need for PHSPs to take action to attract and retain demand for their services, since payments under entry contracts are determined by patient choice; and
- the incentive for PHSPs to achieve technical efficiency – and/or (re-)define their business models – to ensure that they are able to obtain a profit, since prices are fixed.

Collectively, these policy instruments or levers generate additional pressure on PHSPs to enhance the quality of care, remain responsive to patient preferences, ensure technical efficiency and enable more patients in Ukraine to obtain privately delivered services free at the point of use.

Currently, the impact of these instruments on the industry at large is limited, since the vast majority of PHSPs (94.7%) did not have an NHSU contract in 2022 and total payments to them remain modest (₴3.2 billion in 2022; section 3). However, in certain service domains, such as PHC, the growth in contracted PHSPs has established a competitive fringe, which enhances the degree of patient choice and contestability among providers, at least in some geographical areas (i.e. larger urban centres). In 2022 approximately 10% of the total number of patient declarations were held by FOPs and other private entities. In addition, the private sector has gained market share in other service areas – including colonoscopy (10.2% of total market share), haemodialysis (15.6%), mammography (13%) and rehabilitation (10.8%) – indicating a developing competitive fringe in this market in Ukraine.

Including PHSPs in the PMG service delivery network generates a range of opportunities, and some challenges, for policy-makers.

21 The literature on industrial organization indicates that the market power of incumbent companies can be reduced by a competitive fringe of small companies. In the PHC market, in which prices are fixed, small companies increase the pressure on contracted providers to respond to patient preferences (and perhaps to increase quality of care, insofar as they believe this affects patient choice) and, thereby, attract and retain patient demand.

22 Based on analysis of NHSU analytical panel data (14) by the WHO Country Office in Ukraine.
4.2.2.1 Opportunities

4.2.2.1.1 Leveraging the benefits of choice and contestability

When money follows the patient, patients have choices – and providers must compete to attract customers in order to sustain their operations. Competition occurs on an intrasectoral (across providers within the same sector) or intersectoral basis (across providers in different sectors). In relation to intersectoral competition, a strong theme that became evident in interviews with managers of state/communal facilities was their intention to invest in higher-quality care to attract demand from PHSPs (in relation to both NHSU-financed services and those paid for by the patient through OOP payments or – rarely – a VHI mechanism).

However, what providers do in response to competition depends on a number of factors, including:

- market structure – that is, the extent of contestability across providers – which is likely to be very limited in some geographical contexts; and
- the extent to which patients can select providers on an informed basis – in the Ukrainian health sector, patients cannot readily assess the quality of care offered by different providers.

In Ukraine (as in many other countries), it is common for patients to seek information about health service providers from peers, friends and relatives – which, in the context of highly differentiated health needs and services, does not constitute informed choice. If patients make choices without good information about clinical quality, there is no reason to expect that competition will improve this specific
area of performance; that said, the tendency is likely to be to enhance the degree to which providers try to respond to patient preferences more generally (15).²³

It is notable, however, that patients groups communicated strong support for the inclusion of PHSPs in the service delivery network for PMG services. Such groups perceive that the services provided by PHSPs are of higher quality than those available in the public sector – and feel that these services should be available for free to the patients they represent. Some PHSPs said that they face strong pressure from patients to enter into NHSU contracts so that previously paid-for services can be made available free at the point of use.

4.2.2.1.2 Leveraging private sector capacity to address unmet needs

Gaps in service provision may emerge as a result of wartime conditions, for example in localities where internally displaced populations are concentrated or territories recently reclaimed from Russian occupation. These gaps may result in unmet needs. PHSPs have the potential to establish new services or scale up existing ones, alongside public sector services; however, they are unlikely to realize this potential in the absence of a clear and predictable revenue stream (that is, an NHSU contract). Establishing private service provision in this way may be most efficient for service domains in which:

- major investments in specialized immovable assets (e.g. hospitals) are not required;
- PHSPs are able (and perhaps more able than in the public sector) to realize economies of standardization, scale and focus (16); and
- there is already a high level of private sector engagement in NHSU contracting arrangements.

The implication of this is that service domains such as PHC, smaller-scale diagnostics and rehabilitation could provide the focus for such efforts. The private sector could also potentially be contracted to provide mobile services, home-based services and nursing care – which have proved to be an important source of care in many locations reclaimed from Russian occupation.

However, PHSPs may have reasons for being more risk-averse than the public sector about incurring the necessary investment costs, given (i) the ongoing risk of renewed conflict and (ii) the lack of access to capital, public sector and humanitarian supplies, and concessional donor/philanthropic funds. In this context, it is likely that new contractual arrangements and payment methods

²³ For example, at primary care level, unless patients have access to reliable information on the performance of different providers (in terms of service coverage and quality of care) and are, therefore, able to make informed decisions about which health care provider to choose, there may be limited pressure on providers to perform effectively in these specific areas (i.e. incentive to ensure they have the competencies to provide the full range of services included in the care package and at consistently high quality).
will be required, including the use of availability-based rather than volume-based payment methods. When payments to providers are availability based (e.g. structured as prospective/retrospective global budgets), payment amounts are determined according to the extent that contractually defined services are/ have been made available to users. In contrast, when payments are volume based, payment amounts are determined according to the level of demand for the services. In war-damaged and depopulated areas of the country, PHSPs may be unable or unwilling to bear the demand-related risks associated with volume-based payment. In the availability-based model, demand risks are retained by the state, while providers’ risks relate to their ability to establish, equip and staff the new facilities, and to sustain these over the contractual period. Some PHSPs may be willing and able to bear such risks; however, access to loans, risk capital and/or credit enhancement is likely to play an important role in stimulating the needed investments.

4.2.2.2 Challenges

Despite the potential opportunities created, including PHSPs in NHSU contracting arrangements has also given rise to a number of implementation challenges.

4.2.2.2.1 Service delivery

At PHC level, many NHSU contracts are held by small-scale PHSPs, some of which are unable to offer the full range of services included in legislation\(^{24}\) or to hire adequate nursing staff, provide home visits or provide childhood/coronavirus disease 2019 (COVID-19) vaccinations. In the absence of NHSU enforcement, such decisions are made at the discretion of individual providers; it should also be recognized that, at individual facility level, many state/communal facilities (e.g. in smaller, more rural branches) may also face similar constraints. The experiences of several EU countries suggest that there are technical mechanisms for addressing this problem. For example, in Croatia, modification of contractual arrangements (enrichments to the PHC package, alongside higher minimum standards, for, for example, opening hours – with proper enforcement)\(^{(18)}\) were used to encourage consolidation, thus enabling a more comprehensive, integrated, multidisciplinary team-based model of care to emerge, consistent with both international normative guidance\(^{(19)}\) and recent Government of Ukraine regulations\(^{(17,20)}\).

4.2.2.2.2 Network optimization

In specialist outpatient, pre-hospital emergency and hospital care, inclusion of PHSPs into the market may conflict with – or at least complicate – the critical

---

\(^{24}\) Order of the Ministry of Health No. 504 of 19 March 2018 “On approval of the procedure for the provision of primary health care”\(^{(17)}\).
Ministry of Health objective of reducing excess capacity. Experience in other European countries suggests that (i) non-selective purchasing strategies (such as those employed in Ukraine) can impede planning goals, especially if there are no adequate controls on volume (e.g. service delivery thresholds for care packages), and (ii) the risk of supplier-induced demand are significant (including for both NHSU-covered services and for self-referrals to services outside the contract, in which case OOP payments can be levied). For example, in Bulgaria, where the National Health Insurance Fund was required to contract with all hospitals that met formal requirements, major cuts to the number of acute-care hospital beds in the public sector between 2006 and 2011 were offset by increases in the number of beds in the private sector – such that the overall number of beds actually increased over this period (21).

The capitation rate set by the NHSU for the PHC package is regarded by PHSPs to be adequate – that is, it is set at a rate that is sufficient to remunerate efficient FOPs and private entities for their costs (including salaries, utilities, maintenance, equipment, expendables), while providing an acceptable profit margin.25 This is despite the fact that FOPs and other private entities do not have access to the subsidies for, for example, premises and utilities costs, which are available to state/communal facilities. It is clear that PHSP take-up of contracts has been limited to date. Yet there has been a consistent increase in the numbers and revenues of PHSPs over time and this trend is likely to continue, given the low barriers to entry combined with the financial and non-financial advantages of business ownership and employment outside the state/communal health sector.

Outside PHC, take-up of NHSU contracts by PHSPs has been limited. The principal reason is that for most PMG packages in secondary and tertiary care, NHSU payments/tariffs are too low to cover the costs of PHSP delivery – even for the most efficient PHSPs. This is because payment rates for PMG packages are based on the available budget to fund the PMG rather than the real costs of service delivery. In the public sector, many providers are able to sustain their operations because:

- some costs (e.g. of medicines and salaries) are partly covered by informal payments; and
- other costs (e.g. of investing in, purchasing or renting premises, utilities, and maintenance) are covered by subnational government owners.

However, in the private sector, providers do not generally have access to these alternative sources of income.

25 For some multiprofile limited liability companies, contracts may offer advantages outside the capitation rate. For some providers, a PHC contract may be loss-making in its own terms; however, such losses can be offset by offering supplementary services to patients, or by (self-)referring patients to secondary care services, for which the company does not have a contract. In such cases, patients must pay OOP (in which case, the provider is not bound by the rates set by NHSU).
Thus, questions arise as to whether the government should seek to expand PHSP entry into the PMG service delivery network and, if so, how (and into which service areas). Regarding the first question, some service domains may be dominated by inefficient, non-transparent and revenue-driven state/communal providers. In such cases, further entry into NHSU contractual networks may be justified on grounds of access and the resulting stimulus to patient choice and contestability. However, even in such cases, it will be important to ensure that contracting modalities are reformed to more effectively control volumes, address risks of fraud and inappropriate self-referrals, and ensure economies of scale than has been achieved to date.

For example, without selective, needs-based contracting with specified volumes of care, higher take-up of contracts by PHSPs may result in higher volumes – and, if the budget envelope does not increase sufficiently, the NHSU will have to reduce tariffs, thereby exacerbating existing pressures to reduce quality of care, and/or leverage informal payments for balance billing. It is likely to take time for the related challenges to be addressed, for example, by increasing the NHSU budget and staffing levels and strengthening its monitoring and enforcement functions.

On the second question, expansion of take-up by PHSPs will require reforms to payment structures that address the current unevenness of the competitive playing field. Options for this include:

- setting tariffs according to the full economic costs of service delivery (including those related to capital, maintenance and operations, including utilities);
- introducing a coefficient for premises costs, while acting to prevent duplicate payments to state/communal providers (which are provided with premises on a subsidized or free basis) (22); and
- allowing PHSPs to apply to receive subsidized inputs (e.g. centrally procured vaccines and other public health goods) on an equitable basis.

4.2.3 EQ3: to what extent are PHSPs integrated into the national health information system?

PHSPs are obliged to provide information to a range of state authorities – the state tax service, state statistics service and health departments of cities/oblasts. However, the level of compliance varies across providers. Integration with the health statistics and surveillance systems of the Ministry of Health’s Public Health Centre is also a major challenge. Private sector informants complain that the statistical reporting process is manual and needs to be integrated with their medical
information system to improve completeness and accuracy of data provided and reduce compliance costs. In addition, datasets cannot be disaggregated in a way that would allow for analysis of what the private sector does, for whom, on what terms or at what level of quality. Although there is a national register of all licensed health care institutions and their branches (including PHSPs), the information is of variable quality and there are significant gaps in terms of the scope of activities and revenues – this basic information is needed to inform decision-making.

Recently, there have been differences in the scope of information provided by PHSPs, both with and without an NHSU contract. Those with an NHSU contract must be registered on the NHSU e-health system. However, the e-health system focuses on the NHSU and mostly serves the purchasing functions of the system, that is, to calculate the appropriate payment rates and amounts. Although providers have strong incentives to record in the e-health system the information required to ensure that they are paid in full, other aspects of information – such as utilization and access, service coverage, service quality and outcomes, and health service resources (facilities, health workers, equipment) – are not routinely provided.

As of March 2023, all PHSPs (regardless of their contractual status with the NHSU) are, in principle, required to register on the e-health system and ensure the interoperability of their own medical information systems. This new framework constitutes an important step towards the Government of Ukraine's goal of creating a single unified space for public health service providers and PHSPs. However, as of April 2023, only 6,867 PHSPs had registered on the e-health system – a small fraction of the total number – suggesting a need for further enforcement action (i.e. by making registration on the e-health system a condition for licensing and a precondition for new / renewed NHSU contracts), alongside actions to ensure that information systems for licensing and e-health are interoperable. In addition, in the short–medium term, given the limitations of the e-health system – alongside the lack of incentives for private providers to submit information in the system once registered – it is unclear whether the e-health system will address the current systemic challenges and, thereby, enable policy-makers to identify problems and needs, make evidence-based decisions on health policy, or allocate resources optimally, in alignment with WHO guidance.

4.2.4 EQ4: to what extent are decisions about the policy framework open, inclusive and transparent?

Formalized processes for multistakeholder dialogue are emerging in Ukraine. The evidence suggests that the PHSP sector is already more organized as an

---

26 As yet unpublished information from a health information system assessment carried out by WHO in Ukraine in 2022.
industry and is becoming more involved in key policy discussions related to both NHSU contracting arrangements and the future direction of the industry more generally. Ongoing deliberations concerning the Government of Ukraine’s Health Strategy 2030 provide an important focus for such interactions. However, there are risks that the Health Strategy 2030, and the policy agenda in general, is being influenced by the narrow interests of large, established PHSPs, most of which have historically had low-volume, high-margin business models targeting demand among higher-income groups. Policy dialogue does not currently involve open, transparent, inclusive consultation with a wider set of PHSPs nor with other policy actors.

A lack of formalized processes for wider stakeholder engagement – encompassing the routine inclusion of feedback from the population (in particular, patients) to inform deliberations and the involvement of civil society organizations and representatives of vulnerable and marginalized communities – deprives policymakers of information and perspectives that could be critical for designing effective policies with regard to PHSPs. Dialogue that takes place in the absence of these voices may encourage decision-making behind closed doors, thereby aggravating risks to Government policy goals and the wider public interest.

Recent conferences and symposia have brought together Ministry of Health, NHSU and PHSP stakeholders and representative groups; this appears to have motivated the latter to adopt well-defined policy positions and to advocate for these.

Two policy issues appear to be prominent, according to our key informants. First, the desire among PHSPs to charge co-payments on top of NHSU payments to address gaps between the NHSU payment rates and underlying economic costs of PHSPs; and secondly, the request to change the law to encourage – and incentivize – further development of the VHI industry.

4.2.4.1 Introducing the right for PHSPs to charge co-payments for services covered by the NHSU

As described in section 4.2.2.2, many PHSP managers see current NHSU purchasing approaches as exclusionary, claiming that they unfairly favour public facilities, in which salaries are supplemented by informal payments and which are subsidized for a range of costs (including premises, utilities and maintenance). As a result, PHSP representatives are advocating for the right to charge co-payments for NHSU-covered services. The NHSU is aware that this could play a role in encouraging PHSPs to provide PMG services, but has so far resisted the idea.

27 To go before the Cabinet of Ministers for approval in June 2023.
The evidence shows that such payments are likely to increase the risk of supplier-induced demand, aggravate inequities of access and expose patients to financial exploitation (23). It is certainly true that to mitigate the potential impacts of co-payments on inequities of access (e.g. those resulting from discrimination against people who are exempt from co-payments), assiduous regulation and monitoring by the NHSU would be required, and it is doubtful that the NHSU currently has the monitoring capacity to perform this function effectively.

As discussed in section 5, a more logical option would be for the NHSU to (i) pay a rate for all providers (including PHSPs) that includes all capital, maintenance and operating costs (such as utilities), ensuring that such payments are not duplicated across different levels of Government (national and subnational); and (ii) diagnose the causes of informal payments in the public sector and take enforcement action to eliminate these over time.

4.2.4.2 Changing the law to grow the market for VHI

As noted in section 3, the vast majority of PHSP revenues are in the form of OOP payments. However, a small VHI industry also exists in Ukraine. This industry experienced organic growth prior to 2022 but has seen a fall in income from premiums of around one third since the Russian invasion.

The current attempt by the Government of Ukraine to more explicitly define the services included under the PMG (what the state will and will not pay for) creates scope for further development and growth of the VHI industry to provide additional coverage (for services that are not included in the PMG, or providers that are not contracted) (24). The danger is that this will set in chain a dynamic of effectively decreasing the depth of coverage provided under the PMG and enabling the growth of a VHI market that protects only high-income groups, leading to further impoverishment and/or foregone care in the rest of the population, including low-income and more vulnerable groups.

In general terms, the industry is advocating for changes to the tax code, which would lower the burden for employers that provide VHI for their employees. The League of Insurance Organizations of Ukraine is currently in discussion with the Committee on Health Care and Committee on Budget of the Parliament of Ukraine (Verkhovna Rada) on this issue (although the current official position is that now is not the time for a major reform of private health insurance policies in the country). More specifically, the industry is engaging in discussions around financing reform, including in relation to the specification of the PMG (to create opportunities for supplementary insurance) and, as noted in section 4.2.4.1, the issue of formal co-payments, the implementation of which would create opportunities for complementary insurance.
The League is advocating for adoption by the Verkhovna Rada of laws on health care system financing and on medical insurance that would cover these and other related issues.

In principle, VHI may expand protection to some extent against the financial risks of ill health for those with VHI coverage, if it leads to a net decrease in OOP expenditure; however, evidence for this is weak (in most countries with VHI, this has not been the outcome). The evidence shows that a large VHI sector leads to a two-tier, socially stratified system in which people with VHI coverage have enhanced access to broader benefits, including privately delivered health services, as is the case in South Africa. Moreover, as VHI expenditure largely occurs in the private sector, it contributes to higher income opportunities for health workers (doctors in particular) in that sector and, as such, motivates health workers to shift to providing private sector services. This could lead to shortages of skilled health workers in state/communal facilities, thus further reinforcing inequities in access to essential health services. In this context, it is evident that changes to the tax code to lower the burden for employers that provide VHI for their employees would be inconsistent with UHC goals by reducing the public money available to fund PMGs on behalf of the general population and instead enabling those with higher incomes and their employers to purchase extra coverage for health services outside the PMGs.

Overall, it is apparent that the introduction of co-payments and the strategic role of VHI in the wider health system are matters of central importance to the future development of the health system in Ukraine. Therefore, it is important that policy dialogue concerning such matters is not restricted to larger PHSPs, or indeed to any special interest group, and that the Government engages a broad range of stakeholders – including civil society organizations, vulnerable and marginalized communities, and the wider public – in related decision-making.

28 See, for example, the analysis by Sagan and Thomson on VHI in Europe (20).
This section draws on the evaluation of the four core governmental functions (legislation and regulation, purchasing mechanisms, information and intelligence, and stakeholder engagement) to propose action areas for the Government of Ukraine to improve its activity and impact in relation to these core functions and, thereby, also support its efforts to achieve UHC. Proposed action areas are to:

1. strengthen regulation of PHSPs to promote the safety, appropriateness and effectiveness of care, along with consumer protection;
2. strengthen arrangements for contracting PHSPs, focusing on promoting equity of access and financial protection in key service domains, but staying mindful of associated risks to Government objectives for service delivery and network optimization;
3. accelerate the process of integrating PHSPs into the national health information systems and strengthen enforcement; and
4. ensure that platforms for public-private dialogue are more open, inclusive and transparent to safeguard health sector objectives and the wider public interest.

**Action area 1: strengthen the regulatory framework**

By definition, all PHSPs are autonomous of state ownership and bureaucratic control. In addition, the majority of their operations occur outside of NHSU contracting mechanisms and the levers of influence that such mechanisms afford. As such, the regulatory framework constitutes the main lever of Government influence over PHSP’ activities therefore, ensuring that this framework is well specified and comprehensively enforced is critical to the promotion of safe, appropriate and effective care, alongside consumer protection. In Ukraine, a comprehensive range of regulatory instruments is in place, but enforcement is limited, especially in the absence of patient complaints. For example, compliance
with unified medical standards is variable across the sector. The Ministry of Health may wish to consider strengthening the mechanisms for enforcement across all provider types (public and private), including through a two-level inspection system with oblast departments of health at the first level and the national Ministry of Health at the second in order to prevent bias/corruption. Given the lack of oblast/Ministry of Health capacities in this area, the emerging structures for professional self-governance should be harnessed to strengthen the regulatory apparatus – and its enforcement.

**Action area 2: strengthen contracting arrangements**

The degree of PHSP involvement in NHSU contracts differs across packages. For most packages, private sector take-up of NHSU contracts has been limited. This lack of engagement is partly driven by the basis on which NHSU payment rates for related services have been determined. They are set at a sufficient level to remunerate state/communal facilities for some of their total costs, as many costs are covered by informal payments, while others (e.g. for premises, utilities and maintenance) are covered by the owners. If the Ministry of Health and NHSU wish
to encourage more PHSP take-up of contracts across a wider range of packages, this “uneven playing field” has to be tackled, for example, by:

- setting tariffs according to the full economic costs of service delivery (including coefficients for costs relating to capital, maintenance and operations, including utilities), and
- introducing a coefficient for premises costs; while acting to prevent duplicate payments to state/communal providers (which are provided with premises on a subsidized or free basis) (22).

However, the case for encouraging further PHSP entry varies by service domain – and should be carefully analysed for each domain, with the risks identified and plans for mitigating them defined. Risks may emerge in relation to service delivery (i.e. of fragmentation), in which case revisions to the current contractual conditions (e.g. enrichments to PHC packages and higher minimum standards in key areas such as opening hours and after-hours coverage, alongside proper enforcement), may be required to stimulate the horizontal integration of providers. In addition, risks may emerge in relation to network optimization, in which case contracting mechanisms and payment methods may need to be modified in order to control volumes, address fraud and ensure economies of scale to ensure that further entry by PHSPs into the PMG service delivery network does not erode the capacity of, or quality of care offered within, the wider network. The effective mitigation of such risks may not be possible unless the NHSU budget and staffing are increased, and its monitoring and enforcement functions strengthened.

A model of inclusive contracting that protects the financial sustainability of the wider PMG service delivery network while also promoting fair choice and competition may incorporate the following features:

- needs-based selective contracting by the NHSU for a specified volume of services;
- longer-term contracts with strict enforcement of specifications, including the prevention of informal payments via administrative and legal enforcement; and
- inclusion of the costs of maintenance, depreciation and utilities in NHSU tariffs, while avoiding duplication of payment to providers in receipt of related subsidies.

PHSPs can also play a valuable role in ongoing recovery and reconstruction efforts, alongside and in support of the military authorities and wider public sector. PHSPs have the potential to establish new capacity or scale up existing capacity, especially in service domains in which:
major investments in specialized immovable assets are not required;
- PHSPs are able to realize economies of standardization, scale and focus; and
- there is already a high level of private sector engagement in NHSU contracting arrangements.

In such domains, contracts with PHSPs may be used to stimulate supply in specific services, such as PHC (including in mobile facilities), small-scale diagnostics and rehabilitation.

**Action area 3: accelerate health information system integration**

There is a legal requirement for all PHSPs to be registered in the e-health system. This constitutes an important step towards an integrated, unified health system in Ukraine, to the benefit of all providers and which the PHSP sector as a whole should recognize and be responsive to. Currently, however, only a small fraction of PHSPs is registered on the system; even among PHSPs with an NHSU contract, engagement is variable.

Unless the degree of engagement improves, it is unclear whether the e-health system will provide adequate information for policy-makers to be able to make fully informed decisions, for example, on utilization and access, service coverage, service quality and outcomes, and the health service resources that are held and deployed. There needs to be a clear signal from Government and industry leaders
that, moving forward, all PHSPs (regardless of their contracting status) will be required to register on the e-health system and report against a defined set of indicators as a condition of their licence – with automatic inspection of compliance of reporting within the interoperable e-health and licensing information systems.

In the shorter term, the Ministry of Health may wish to ensure that the information that PHSPs provide to state authorities (e.g. state tax service, state statistics service and oblasti/city health departments) – often incurring high administration costs in doing so – is in a format that can actually be utilized for policy analysis. This is likely to require both enrichment and standardization of formats for the submission of information, for example, the inclusion of variables that allow information to be disaggregated across private versus state and communal entities, and across provider categories and service areas (e.g. PHC, specialized care, laboratories).

**Action area 4: enable stakeholder participation in policy-making**

The PHSP sector is well organized as an industry, and its interactions with state authorities are becoming more frequent, more focused and more purposeful. Currently, industry leaders are advocating for reforms that would (i) allow NHSU-contracted PHSPs to charge co-payments on top of NHSU tariffs; and (ii) stimulate the growth of VHI. Both reforms, if implemented, would impede and perhaps reverse the progress that Ukraine has made towards UHC. Given the critical nature of policy issues related to the operation and financing of PHSPs, in particular the apparent mismatch between corporate interests and UHC goals, the Ministry of Health should establish platforms that include diverse stakeholders in related deliberations. These platforms may enable the routinized engagement of patient groups, representatives of vulnerable and marginalized communities, and the wider population of Ukraine, thus ensuring that their perspectives are heard in deliberations about the policy framework for PHSPs. More generally, the Ministry of Health should clarify its unequivocal commitment to UHC as the driving force of its current reform programmes, and ensure that policy dialogue focuses on how best to achieve this.29

29 The forthcoming Health Strategy 2030 will provide an opportunity to give focus and purpose to such a dialogue.
6. REFERENCES


All references were accessed 30 May 2023.


The WHO Regional Office for Europe

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

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

WHO/EURO: 2023-7625-47392-69619

World Health Organization
Country Office in Ukraine
58, Yaroslavska str., Block B
Kyiv 04071, Ukraine
Tel: +380 44 428 5555
Email: eurowhoukr@who.int
Website: www.who.int/ukraine