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## Attitudes towards patient payments in Ukraine: is there a place for official patient charges?

**Key words:** official patient payments, Ukrainian health care system, unofficial patient payments

### ■ Introduction

Official patient payments in health care were introduced quite actively in different countries of Eastern Europe during the last decades. “Willingness to pay” was one of the principles in the development of the official patient payment policy [1] although willingness-to-pay was rarely measured for the purpose of designing official patient payment mechanisms. In Ukraine, where the constitution proclaims free of charge medical care within the public sector, there is a very limited list of public health care services for which charges can be levied. Nevertheless, the idea to introduce a wider list of officially paid public health care services appeared several times in policy discussions at the State and city Kyiv levels. Payments for services in the public health care sector are also done by means of charities. In practice, this mechanism of payment is almost universal and compulsory. Such payments are actually a type of quasi-official payments for health care.

As a result, according to the National Health Accounts, in 2007 in Ukraine, the total expenditure on the health care sector was 48 640 millions UAH (9632 millions US dollars), which is 6.8% of GDP. However, only 55.7% of this expenditure are from public sources. In 2008 and 2009, public expenditure was 56.1% and 54.4% of total health expenditure respectively, which is more or less the same as previous years [2, 3]. Thus, the share of private expenditure constituted around 43.9–45.6% of the total expenditure. Almost all of this money is spent by households on pharmaceuticals but it looks like these numbers include also the charity contributions. It is obvious, that the Ukrainian health care system, namely the provision of health care services, suffers from underfunding from the government and that this deficit is partly made up by unofficial payments by patients.

The insufficient funding of the public health care sector results in informal patient payments for services [4].

While there are no reliable data about the scale of informal patient payments, experts suggest that these payments are widespread. The situation with informal patient payments in the health care sector in Ukraine is dramatic and constitutes an impediment to equity and access to medical services in general. Unofficial patient payments create a barrier to generate funds for development of the health care system. A well-established system of unofficial payments does not enable patients to plan their expenditures, protect their rights in case of not getting care in time or when getting low quality care. These payments limit access to health care [4, 5]. The introduction of official patient payments – i.e. a system with transparency about what patients need to pay and for which services and what they may expect in return for these payments – seems a rational solution as people pay for services anyway.

Despite that, the attitude of stakeholders toward official patient payments has never been a subject of empirical research in Ukraine. In this study, we attempt to study these attitudes and based on this, to answer the question about the role and objectives of patient charges for health care services in Ukraine. Thus, this study can help to evaluate the perspectives of an introduction of official patient payments in Ukraine in the public health sector. For this purpose, we use results from focus group discussions with health care consumers and providers, and in-depth interviews with policy-experts in Ukraine. The data were collected in May–June 2009. Before outlining the results and discussing the findings, the paper first presents a description of the Ukrainian health care context.

### ■ Features of the Ukrainian health care system

The Ukrainian health care system emerged when the country obtained independence in 1991, after the collapse of the Soviet Union. It fully inherited the infrastructure, system of financing and organization from the Soviet

times. However, unlike other domains of the domestic economy, the health care system has remained practically unchanged preserving all the old principles of functioning, e.g. centralized planning and control, and officially free-of-charge service provision. Nevertheless, the system is characterized by unsustainable underfunding [1, 2], the existence of informal patient payments [4–9], an oversupply of narrowly specialized medical staff, and a shortage of nursing personnel and general specialists (general practitioners, family doctors) [11]. There is also a concern about heavy oversupply of hospital beds, which is mostly caused by input-based funding and, the financial incentives for hospital management to maintain the beds. Primary care and some special types of care, e.g. emergency, social, and maternity care, are rather unevenly distributed across territories and do not meet care needs on average [13].

The capstone of the health care system in Ukraine is the clause 49 of the Constitution of Ukraine, which postulates some of its main principles: (1) health care is provided through public financing, which assures efficient and accessible medical aid for all citizens, (2) in State-owned and communal health care facilities, medical aid is provided free-of-charge, and (3) the existing network [auth.: for 1996] of health care facilities cannot be reduced [8, 14]. This limitation postulated by the Constitutions is the main pretext for the failure of many of the reforms attempts – such as the failure hitherto to introduce social health insurance or formal patient charges.

### *Organization of health care provision*

Most of the medical and health care facilities in Ukraine remain publicly owned. They belong either to the national (State owned) or local authorities (communal owned regional, district, city institutions), or to the rural communities. At the same time, the private sector is still relatively small covering less than 2% of the population [13]. The network of public facilities is rather extended and it is related to the administrative-territorial division of Ukraine. There are basically three levels of subordination: national, regional, district and community. At national level, facilities are subordinate to the Ministry of Health of Ukraine. At this level, there are also so-called ministerial and departmental facilities that are subordinated and financed by certain ministries (The Ministry of Defence, the Ministry of Internal Affairs, the Security Service of Ukraine, the Ministry of Transport), or departments and administrations. They provide parallel services to their own employees and their families. Regional level facilities are subordinated to and financed by the regional and municipal administrations, though regional and municipal councils take part in budget allocation decisions. Finally, district public health care facilities are subordinated to and financed by district, municipal, and even regional administrations, while communal facilities administratively belong to community councils, though some financing and regulation may be done by regional administrations. The State Department for the Penitentiary System is responsible for organizing and providing health and preventive services within the penal system.

Such fragmented and to a certain extent, ambiguous hierarchy leads to regional, territorial and institutional inequalities in the location and state of the facilities. The ministerial and departmental facilities are usually better maintained and supplied than the rest. Access to these hospitals for “external” patients is hard but possible through informal payments. Rural areas mostly suffer from a shortage of facilities, supplies and specialists, and the state of these facilities in some regions is critically bad. There is a collision of responsibility when the health care posts in villages are financed by local councils, while they are subordinated to the central district hospitals which, in their turn, are responsible for the population health status on the territory.

The distinction of health care provision into primary secondary and tertiary levels in Ukraine is rather vague. There is no legislative definition of these levels of care. Some facilities and even specialists provide care at two or three of these levels at once. All medical staff in public facilities consists of public servants receiving fixed salaries. This means a lack of formal incentives to improve efficiency and quality of health care provided.

One of the most pressing problems at present is the underdeveloped primary health care and the concentration of physicians at the secondary and tertiary levels of care. The primary health care system is represented by the district physicians in polyclinics, work related clinics, women’s consultation clinics, rural “family” ambulatories, outpatient departments in rural hospitals, and feldsher-obstetrician centers. The specialists from the central regional hospitals control their colleagues at the district levels. District physicians, namely district pediatricians, district internists or family doctors, are Ukrainian analogues of general practitioners in their catchment areas – districts. A rural physician’s catchment area contains on average four to five feldsher-obstetrician posts or “family” ambulatories that provide simple curative services, first aid, prescription of drugs, antenatal and postnatal care as well as basic preventive activities such as immunization. Some primary facilities or even feldsher-obstetrician posts may have inpatient beds. The gate-keeping role of the primary care system is often neglected as there is the possibility for patients, though informal, to have direct access to a medical specialist and bypassing the primary contact with a district physician. Secondary and sometimes tertiary care is provided at polyclinics, outpatient departments of hospitals, and dispensaries. In rural areas, secondary care is usually concentrated at a district level. Tertiary care is provided mainly in district hospitals and dispensaries.

The wide network of primary health care facilities in the cities contrasts with problems of access in the villages resulting from the inefficient location of facilities in rural areas and the absence of own transport or working capital in the rural medical facilities. The funding of rural facilities and practices is done on an input basis from the budget of the respective level. The poor state of rural facilities is mostly explained by the small budgets of villages and towns.

### **Health care system funding**

The Ukrainian public health care sector is officially financed by public funds through the general taxation system. A very small part of the government expenditure on health (around 0.8%) is administered through social insurance funds (SFI) (e.g. SFI against Temporal Disability and Costs Caused by Births and Funerals, SFI against Occupational Accidents and Occupational Diseases, and Fund for Social Protection of the Disabled), which cover special cases of occupational trauma or disorder, reimburse sick or maternity leaves, and cover treatment in health resorts for insured [13]. Insurance premiums to these funds are salary based and distributed between employers and employees. Despite declared public financing, private expenditures make up a substantial part of total health expenditure in Ukraine. As was mentioned before, by the methodology of WHO National Health Accounts, 43.9% of total health expenditures were private in 2008, with most of this (92.6%) being out-of-pocket [2]. Similar statistics can be seen in OECD Health Data [3].

Medical facilities and executors of national and local health care programs receive funding from the State and local budgets on an input basis (hospital beds, specialists, laboratories, departments etc.). This is done by means of a strict line-item budget approved by local and national administrations or councils depending on the facility belonging. Medical facilities have little autonomy in funds distribution and each deviation from the budget can be passed only through decision of the respective administration or council.

Although the Constitution prohibits the existence of the official patient payments, the legislative field related to the existence of such payments is controversial. "The legal basis of health care" from 1992 [15] followed by the decree of the Cabinet of Ministers from 1996 [16] (the decree is still in force) allow State-owned and communal facilities to charge fees for medical services. The Constitutional Court limited this permission to charge fees (given by the abovementioned legislation) to some specific services (e.g. medical examinations for driver's license, weapon carrying permission, permission for trips abroad) and also allowed charging fees for so-called "paramedical services", although no list of such services exists. From the Soviet times, it is still possible to receive paid anonymous treatment for addictions and to receive paid dental services [17, 18]. Foreign citizens are also officially charged for the health care services they receive in Ukraine [19, 20].

Thus, in a very limited number of cases official patient charges do exist. They are even the main source of income of "self-financing" public facilities such as dental clinics. Furthermore, some facilities establish their own "official" price-lists which are sometimes supported by decrees of local administrations. However, this latter case is broadly discussed and seen as violating the Constitution.

As was mentioned before, the legal sources of additional income for the public facilities are charitable contributions and donations to the health care facilities. They are regulated by the process of giving and receiving

charitable (voluntary) contributions and donations from persons and legal entities to public institutions as defined by the Decree of the Cabinet of Ministers and The Law of Ukraine "On Charity and Charitable Activities" [21, 22]. However, "charitable contributions" at some period of time became obligatory or at least common (i.e. semi-legal/quasi-official) and a way of gathering patient payments from the Ukrainian population.

Despite the constitutional guarantee, there is much non-academic evidence about informal patient payments. The academic literature does not offer reliable data on the volume of the informal sector in Ukrainian health care. However, some studies provide evidence of their existence [4–9]. Preliminary studies have shown that patients have to purchase practically all pharmaceuticals themselves in the market or from the physicians. The practice of "thanking" doctors with money, or sometimes in kind, is very common. The same is true for the health services.

For example, empirical evidence indicates that the Odessa population spent out-of-pocket 20 million US dollars on out-patient and in-patient treatment during a period of 12 months in 1999–2000. This amount was twice higher than the total city budget for health care during that period. A study conducted in Lviv in 1995 among private and public doctors (N = 325) regarding their honoraria, shows that private spending for medical care was around 2.5 million US dollars. As much as 90% of this amount was paid informally to physicians in the public sector [6, 7].

The results of a study conducted in 2001 in 8 former-USSR countries demonstrate that around 30% of respondents in Ukraine pay informally at the medical settings [8]. Qualitative research conducted at Kyiv maternity houses shows that up to 90–95% of income of obstetricians – gynecologists in 2008 consisted of informal patient payments for deliveries of babies. Usually, income of physicians was not less than 20 000 UAH per month while the official salary is not higher than 1500 UAH per month [9]. The data of a household survey conducted in October 2009 in Ukraine show that almost 84% of households reported that a member of their household could not see a physician, and more than 98% could not get medical procedures or treatment at the in-patient clinics because of high costs of care [5].

### **The future of the reform process**

Ukraine has experienced many attempts to reform its health care system. Each new Minister of Health has tried to reform the Ukrainian health care system. Since 1991 (during the 19 years after Ukraine have obtained its independence), there were 14 Ministers of Health. This means that each minister stayed on their post for about 1 year. This did not ensure a consistent and continuous development of the sector. The latest attempt to reform the Ukrainian health care system is the Regulation of the Cabinet of Ministries of Ukraine from February 17 2010 # 208. According to the "Regulation" there is a plan to split primary and secondary health care. It is proposed to

create Centers of Primary Health, General Hospitals with urgent care, rehabilitation, palliative care, social care, and diagnostics. It is also planned to reorganize emergency/acute care, and to create University Clinics. Centers of Primary Health should be based on the health needs of the population. Vinnytskiy and Dnipropetrovskiy regions are two pilot regions; the pilot will start on January, 1, 2011 [23].

The current president of Ukraine has stated that the reforms in the public health care sector should be central although each previous president has stated the same. The current president promised that a new regulatory base will be presented to the Parliament soon. He also stressed the necessity to solve the problem of roads in Ukraine in order to provide adequate care in case of emergency. The new idea for structural reforms is to create so-called "hospital areas". This idea is derived from the understanding that at the same street of the regional city, two hospitals with the same departments can exist: of regional and city subordination. Previously the idea to eliminate this inefficiency was called "creation of unified medical environment". The president has also promised to raise the salaries of the medical professionals and control the situation in maternal and child care [24].

## Methods

Focus group discussions and in-depth interviews were carried out in Ukraine in May–June 2009. Their objective was to study the opinion and attitudes towards patient payments and to identify criteria important for the assessment of patient payment policies. On the whole, four target groups were considered: health care consumers (including working individuals, families with children, pensioners, students, disabled and chronically sick individuals and individuals living in rural areas); health care providers (including primary care providers, outpatient specialists, physicians and nurses in city hospitals, primary care providers practicing in rural areas and physicians in district hospitals), health insurance experts (including experts from government and independent organisations), and health policy makers (including health policy-makers at national and regional level, and financial policy-makers at national level).

Data among health care consumers and providers were collected via focus group discussions. Since these target groups are rather large and diverse, focus groups discussions allowed the inclusion of more individuals. Nevertheless, the objective was to assure a certain level of homogeneity of each focus group in order to reach a consensus during the discussion. In total, 10 focus group discussions were carried out: 6 focus groups with consumers and 4 focus groups with health care providers. On average, each focus group included 8 participants. It was not possible to organize focus group discussions with primary care providers practicing in rural areas and with physicians in district hospitals, because of distances and busy time-schedules of these health care providers. Therefore, these focus group discussions were replaced with in-depth interviews with 6 respondents.

Data among policy-makers and health insurance experts were collected via face-to-face semi-structured in-depth interviews. This choice of data-collection method was based on the fact that these target groups are relatively small and moreover, they might feel more comfortable to express their opinion if contacted individually. In total, 5 in-depth interviews were carried out with policy-makers and 5 in-depth interviews with health insurance experts.

For the purpose of the focus group discussions and in-depth interviews, a list with key questions was developed based on a preliminary literature review. The same key questions were used for all target groups with slight modifications to reflect the specificity of a given target group. The key questions were used to develop guides for focus group discussions and in-depth interviews, as well as a standardised questionnaire to collect additional quantitative data on the topic. The following issues were discussed: (1) opinions about the objectives and design of patient payments, (2) criteria for the assessment of patient payment policies, (3) the relation between formal and informal patient payments. Additionally, we asked all respondents to fill in self-administrated questionnaires at the end of individual or focus-group discussions.

We observed that only 2–3 persons participated actively during focus-group discussions, thus, their opinions prevail in case of group discussion. It was a good solution to apply self-administrated questionnaires at the end of the discussions as we could thereby register the opinion of all participants without group pressure. The results of focus groups discussions and of self-administrated questionnaires were different: the opinions of the respondents were more radical when expressed in self-administrated questionnaire anonymously.

## Results

Official patient payment is an absolutely new topic for discussion with the Ukrainian population. As it is observed in the study, attitudes towards informal payments and the introduction of health insurance are already formed in contrast to attitudes towards official patient payments and their characteristics.

### *Formal and informal patient payments*

We ask the opinion of respondents whether the introduction of official payments can replace informal payments. All groups of respondents believe that official patient payments have to replace informal patient payments. However, opinions of respondents are at variance. Although some respondents believe that the introduction of official patient payments would reduce the portion of unofficial payments, most representatives of the four groups believe that two types of payments would co-exist at first. Some of the interviewed indicate that it is impossible to eliminate completely the unofficial payments by introducing the official ones. The positive effects of introducing the official payments are diminished when informal payments exist.

The consumers of health care services (more intensively than other groups) argue that the introduction of official patient payments would impose an additional burden on patients since they would have to pay twice. In case of the introduction of such payments without other actions (e.g. increasing salaries of health care staff, improving quality of services) the reasons for the under-the-table payments will remain: to motivate the staff and to obtain essential medical treatment. Some of the consumers also expressed their idea that it is more convenient for them to pay into the pocket of their physicians, even if there is a possibility to pay at the cash-desk officially. One respondent observes: in that way the physician gets a higher income and the patient pays less.

Further, the attitude towards informal payments depends on the type of payment whether it is “a bribe” or “gratitude”. Most of interviewees understand “gratuity” to mean a voluntary payment to the physicians after the treatment, while “a bribe” is a payment which a physician requests before the treatment. Thus, some of the health care consumers believe that “gratitude” payment should be able to exist. Patients explain that the physician and the patient establish relationships that go beyond the official ones, which in turn provide the patient with an opportunity to get a consultation with a private call, and receive a service or a consultation after the physician’s official working hours. Nevertheless, some patients and medical staff do not feel comfortable when cash or presents are given unofficially.

Some interesting ideas were expressed by the representatives of policy-makers such as that the State is unable to offer higher official salaries for physicians. Thus, informal payments contribute to an adequate income for medical staff. Besides, by informal payments patients can receive higher quality services, which are not provided by the State.

While discussing informal payments with groups of health care providers, the topic of investments in health care facilities appeared. Representatives of medical staff argue that polyclinics and hospitals do not have proper funding, which results in out-of-order equipment, absence of consumables, and lamentable state of buildings. Despite the fact that physicians buy some consumables using the money they earn, informally, they cannot afford renovation of equipment or rooms. Also, it is known from experience that at the peripheral level of health care, the staff sometimes spend their earnings for renovation and equipment and even renovate their wards themselves. Thus, if official patient payments increase the health care budget, polyclinics and hospitals would have consumables and equipment.

### ***Role and objectives of patient charges in Ukraine***

Most respondents are positive about the introduction of official payments, arguing that (1) anyway health care services are *de facto* paid, (2) they would avoid overspending since they can estimate their capabilities according to a price-list, (3) official payments would make physician-client relations legitimate, thus, patients

would be able to claim their rights and physicians would be more responsible. However, a few respondents especially from rural areas are extremely negative about the possibility of introducing official payments. Besides, all groups are quite pessimistic regarding the possibility of introducing such payments due to the lack of a legislative base for this type of reform.

With regard to the lack of funds in health care, we expect to hear from all groups of respondents that “generating additional resources” for the health care system of Ukraine has to be one of the main goals of official payments. Thus, consumers and service providers note the importance of giving health care facilities the right to generate additional resources. Insurance experts and consumers as well emphasise “the control on the health expenses” role. All policy-makers-respondents, almost all the insurance-experts-respondents, nearly half of the service providers as well as consumers claim that the payments should go to the health care facilities which provided the service.

Policy-makers in our study also point out that the goal should be to reduce unnecessary consumption of the health care services, complaining that there is an excess demand for health care services especially by senior people, retired people, and young mothers. However, one of the respondents expressed the opposite idea that “unnecessary use of health care services” is not relevant to Ukraine since people even avoid visiting physicians because of high price of the services. Apparently, this representative of the authorities was referring to the unofficial patient payments.

It is certainly clear that the service providers stress the need to increase the income of separate service providers. Nevertheless, the issue of providers’ income does not seem very relevant to patients. Thus, health care consumers-respondents stress the need to handle the unofficial payments as one of the important goals of the official patient payments. They also underline the need to improve the quality of services and to improve the motivation of the health care workers.

### ***Scope of level patient charges***

All groups of respondents express the common idea that a certain part of the basic services should be provided by the State free-of-charge. Emergency care, primary care, and the minimal level of medical assistance at the in-patient facilities should be included in the list of free services.

All interviewed argue that “minimal scope of health care services” for in-patient should be provided free-of-charge by the State. In addition, most of the respondents note that examinations, dental care, and “hotel services” (additional comfort) should be charged for. Moreover, during the focus-group discussions respondents state that emergency care, even dental nature, have to be free-of-charge. Taking into account opinions expressed in the self-administrated questionnaires all four groups of respondents indicate that dental, out-patient, and in-patient services can be charged for. All respondents, except the

policy-makers and half of the providers, believe that first aid should stay free-of-charge.

When we ask respondents about the types of patient payments that should be introduced, none of the respondents have a specific and well-defined opinion. This is mainly because the existing approaches are not clear to them or are difficult for them to understand. Still, policy-makers and insurance-interviewee appeal to co-payments and co-insurance more often. The same situation is observed with regards to limits on official payments. Although we described the possibilities of limits, it seems that respondents are faced with such concepts for the first time. With regard to the possibilities of misunderstanding, consumers prefer to limit payments on the basis of the number of visits. Policy-makers suggest using the amounts of payments as limits, while every visit has to be paid for, otherwise, the high demand for the health care services would take place.

We asked the respondents to indicate the specific amounts that patients have to pay for health care services. Despite the fact that most of the respondents think it is problematic to state the price for different services, some of the interviewees appeal to prices in private facilities when referring to the prices for public ones: "...less than in the private clinics but higher than the current ones in the public clinics". Policy-makers mention that the prices for the health care services have to be formed with regard to an average salary of people in Ukraine.

For those providers who indicate exact prices, 20–140 UAH sounds reasonable to charge for the visit to the primary level physician, 100 UAH for one day of in-patient care. The opinions of the consumers varied more than that. The pensioners and the urban residents suppose that the price for a visit (or examination) of a primary level physician should range from 50 to 500 UAH, families with children mention amounts like 50–100 UAH, students and unemployed citizens indicate 10–15 UAH and 6–20 UAH respectively. Additionally, the consumers mention that the out-patient services can cost from 5 to 100 UAH, complicated cases 250 UAH. The cost of treatment in an in-patient facility is estimated to range from 20 to 200 UAH. Only the pensioners say about 500–1000, supposedly based on their own experience. Almost all respondents believe that emergency first aid should be free-of-charge.

All respondents support the idea that more expensive services or services of higher quality have to be more expensive for consumers. The representatives of authorities stress the need to introduce a certain methodology of setting up payments for services and providing the differences in different health care establishments:

### ***Concerns about equity***

Health care consumers in our study believe that all representatives of vulnerable population groups should be exempted from official patient payments. However, respondents are concerned about the proportion of such population group in the society, because (1) it could appear that 80 % of population are exempted; and (2) peo-

ple should be interested in financial independence from the State, and thus, not to be included in the low-income group.

Similarly, the representatives of policy-makers are cautious in their attitudes to such a group in the population as "people with low income". However, they recommend paying attention to patients' expenses since official income may form only a small part of the individual's income. Policy-makers-respondents are more reserved on the issue of exempting chronically ill people from paying for services since there are a lot of different types of chronic diseases. According to their opinion, there should be a list of chronic diseases that would provide a person with an exemption of payment for the health care services. Moreover, it was a common believe for the policy-makers interviewed that representatives of vulnerable groups have different levels of income. Therefore, it is not necessary to have all of them exempted from official payments. Additionally, on the one hand, taking into account the demographic situation in Ukraine, pregnant women and children should be protected by the State. On the other hand, such population groups have also different levels of income. Thus, according to policy-makers, it would not be right to exempt these groups completely from the payment for services.

Some health care providers whom we interviewed argue that pensioners, children under 14 years, disabled people, and people suffering from chronic diseases should pay at least some part of the service costs.

Some other population groups that could be exempted from paying are added: (1) women, who are on maternity leave, (2) the members of families with many children, (3) people, who were injured when performing their professional duties at work, including the workers of the nuclear power plants. There are also ideas that the services related to the diagnostics and treatment of the socially dangerous diseases, for example, tuberculosis, AIDS, prevention of HIV infection and other sexually transmitted diseases should be free-of-charge.

Overall, almost all respondents believe that disabled people must belong to the group of people exempted or partly exempted from paying for service. All respondents, except health insurance experts, note that pregnant women should also belong to the exempted group. All respondents, except consumers, believe that this group should include children. All respondents, except policy-makers, would restrict the payment for health care services for the people with low income. Health care consumers and some of the providers, policy-makers and insurance experts would include chronically ill people into the exempted group. Providers and insurance experts also named senior people. Policy-makers do not believe that there should be restrictions for people with low income and elderly people.

### **Discussion and conclusions**

This article addresses the perspectives on the introduction of official patient payments in Ukraine. As the Ukrainian public health care system is in general under-

funded, *de facto*, people pay informally for public health services. The scale of informal and quasi-official charges is significant, and private expenditures make up nearly half of the total expenditure on health care, although household spending on health care is mostly on medicines. Public expenditures cover expenses for salaries of medical personnel and utilities at the health institutions. It is worth mentioning that quasi-official payments done by people as charitable (voluntary) contributions cannot be used for the remuneration of medical staff, e.g. spent on salaries.

Thus, it is not surprising that almost all respondents expressed the opinion that official payments in Ukraine are necessary as a method of financing the health care. As all respondents believe, this would enable attracting additional resources for the health care sector. However, as is known from the literature, when official payments are introduced they frequently do not generate more than 15% of total resources [25–27]. The reasons for that are the administrative expenses, low cost of the services, free of charge services for the vulnerable groups of people, and the unwillingness of patients to pay. The amount of money received by the health care system depends on the: (1) mechanisms of payments; (2) willingness to pay; (3) the market of the private services; (4) possibilities to receive additional insurance [26–28].

Some critical remarks and negative attitudes to the introduction of official patient payments expressed by respondents, could be explained by the fact that there have been no real health care reforms in Ukraine either in the organization or in the financing of health care since the Soviet times. In our study, respondents note that besides the introduction of official patient payments, it would be essential to have significant additional public funding of health care. A lot of respondents consider the introduction of social health insurance necessary. It will also be important to determine the list of free services together with the introduction of official payments. A similar system exists in Kyrgyzstan [29].

The expectations of policy-makers regarding the reduction of overuse of services by introducing official payments is justified, since empirical findings demonstrate that the consumption of the health care services reduces after official payments are introduced [e.g. 30–40]. However, this raises the issue of access to health care and equity since official patient payments could be an additional burden for households. This kind of burden on households was observed in Kyrgyzstan and Tajikistan and resulted in the non-use of medical services because of the inability to pay [29, 31]. In our study, respondents from rural areas were especially concerned about the possibility to get medical assistance once official charges are introduced.

A study on the behavior of health care consumers and how out-of-pocket payments influence this behavior, took place in 2000 in Georgia [32]. As a result, it was found that patient payments create financial barriers to health care services. Additionally, poorer households seem to seek health care less frequently than households with higher income. Consequently, recommendations to

the government were composed including as a key message: funding of services for the poor is the priority for the government; introduce pre-paid out-of-pocket payments on the basis of communities in order to reduce risk and financial pressures on households.

If the goal of the official patient payment policy is to provide physicians with the right to attract additional resources, then the establishment that provides the services should be the recipient of official payments. This opinion was expressed by Ukrainian stakeholders in our study. This is supported by the literature as well. The income from official payments to separate institutions of health care in the countries where the health care systems are disorganized, provides encouraging results since health care services could be renewed [30–41]. The patients are more willing to pay some, although not large, amounts for services with better quality [42–44].

An important policy goal of official patient payments is to phase out the unofficial patient payments. This is particularly stressed by the health care consumers in our study. Nevertheless, the opinions of the respondents were ambivalent or even paradoxical at times. For example, the representatives of the authorities believed that it would be impossible to provide the physicians with a decent income when the informal payments are phased out. They supported the unofficial payments as a means to provide for the quality of services, and some patients mentioned the advantages of unofficial payments in motivating the doctors. A situation like this is evidence of the collapse of the health care system, caused by the absence of the transformation process, and the need of creating an opposition towards informal patient payments among policy-makers as well, in addition to an overall social opposition.

Maryna Bazylevych [45] states that “the officials who have found a lucrative niche” are resistant to reforms as well as medical doctors who “established their clientele and receive regular informal income at cost of the State, which provides free room and board for patients, free utilities, and labor of the supporting staff”. Experts say that for the last two decades, the processes of self-organization and quasi-privatization are dominant in the health care system in Ukraine [46, 47]. Anyway, in our study, even officials told us stories how they or their relatives, colleagues who occupied high positions in Ukrainian health care system suffer when they become clients of the Ukrainian health system. Most of them believe that official payments for services are a good approach and could help to establish a kind of order in the deteriorated system of public health. It is worthy to mention that if doctors could be well-paid most of them would not take money from their clients [46].

The regulatory basis in Ukraine is not supportive for introducing official patient payments. As was mentioned above, several attempts to implement a wider list of paid services (either on the State or on city Kyiv level) failed although this study shows quite strong support for patient payments among different population groups including policy-makers. The difficulties in changing the legal frame could also be explained by the need of politicians to get “political dividends”: to show their “love and care”

for people. In their eyes, the introduction of patient payments seems to be an unpopular approach.

Should official patient payments be introduced, exemption for “people with low income”, “chronically ill”, “seniors” should be well defined to meet criteria for reduced fees or no fees at all in order to prevent considerable equity deterioration. It could be especially problematic if policy-makers do not consider low-income groups as a group that needs to be exempted (as indicated by our results). It is also an issue for Ukraine to define the groups that are considered to be those who suffered from the Chernobyl disaster. Overall, the designs of payments for services are based upon some values or are “clinically sensitive”: a certain list of services and restrictions are usually introduced. According to the Bulgarian experience, chronically ill people, miners, unemployed, conscripts, war veterans, disabled, persons under arrest or imprisoned, and persons with zero and low income are exempted [48]; in Kyrgyz Republic unemployed, children under 16 and pensioners were exempted [29]. Moreover, patients demonstrate high support of broader exemption system in Bulgaria [48].

All respondents in our study, except the policy-makers, believed that the primary health care should be free of charge, but not all of them think that emergency services should be free of charge. Positions like that are dangerous with regards to their consequences for the health of the population. Taking into account the international experience, typical services that are free of charge include maternity care, prevention activities, emergency, in-patient care in case of life-threatening diseases. There was also some advocacy for abolishing the payments for the services of the primary medical-sanitary care [49]. For instance, in Kyrgyzstan primary health care patients’ spending was not covered by the State initially. However, in a few years the State has assumed such obligation. Nevertheless, informal patient payments increased [29].

At the same time, it is interesting that before the introduction of official patient payments in Bulgaria in 2000, results from studies suggested that patients accepted payments for primary and dentist care in contrast to hospital care. Respondents were willing to pay for health services in public facilities if these services are provided with appropriate quality and fast access [44]. It appears from our study that Ukrainians might also be willing to pay for the services of higher quality and for fast access to care. Our respondents especially stressed the issue of quality of health care and the role of professional associations in establishing them. Nevertheless, higher charges for better quality can be only acceptable if the quality refers to luxury aspects of care. Life-saving and essential health care services should be provided with an adequate quality to all users.

Thus, when talking about the perspectives, the need for legalising patient payments, as well as a need for changes in financing the health care system and paying for the labour of those involved in it – it is all perceived and realised as something urgent. On the other hand, all these processes are not seen to take place in the nearest future. The priority goals of introduction of the official

patient payments in Ukraine are: attracting additional resources to the health care sector, especially to some particular institutions, increase in salaries of the service providers in a legal way for the patients, but with time these payments can eliminate the unofficial ones and “revitalise” the health care system. The policy and the design of the official patients’ payments have to take into account the equality/fairness, social acceptability and the system of financing the health care sector in general. The reduction in unofficial patient payments and unreasonable consumption of services, attraction of additional resources, health indicators can be seen as the criteria for evaluating the system of official patient payments.

The principles of patient payments policy in Ukraine should be determined by the list of paid or free of charge services, the level/ amounts of payments for different services, exempted groups. The patient payments policy should be based, first of all on the level of income, and mechanisms of payments. Local peculiarities should be taken into account. Thus, many regulative and organizational changes should be done followed by deep analytical work.

#### Acknowledgement:

The study is financed by the European Commission under the 7<sup>th</sup> Framework Programme, Theme 8 Socio-economic Sciences and Humanities, Project ASSPRO CEE 2007 (Grant Agreement no. 217431). The views expressed in this publication are the sole responsibility of the authors and do not necessarily reflect the views of the European Commission or its services.

#### Abstract:

The attitudes of health care system stakeholders towards official patient charges have not been studied in Ukraine although both the central and local governments have several times considered to introduce such charges. Instead, informal patient payments are widespread and well-established. Ukrainian patients pay either unofficially or quasi-officially (i.e. charitable contributions) to health care institutions. The reasonable solution for dealing with these types of payments would be the introduction of official patient charges. However, the legal base for such reform in Ukraine is ambiguous. The Constitution declares that health care provision is free-of-charge. Nevertheless, in our study, representatives of stakeholders groups appear keen not only on discussing official charges but are also favor their introduction. The expectations regarding the possible objectives of these charges expressed by different stakeholders are the focus of this paper.

#### Streszczenie:

*Stosunek do dopłat pacjentów na Ukrainie: czy jest miejsce na oficjalne opłaty pacjentów?*

**Słowa kluczowe:** oficjalne dopłaty pacjentów, ukraiński system opieki zdrowotnej, nieoficjalne opłaty pacjentów

Stosunek uczestników systemu opieki zdrowotnej do oficjalnych opłat pacjentów na Ukrainie nie był do tej przedmiotem badań, chociaż rząd i samorządy lokalne wiele razy rozważały wprowadzenie takich opłat. Zamiast tego nieformalne opłaty pacjentów są powszechne i ogólnie przyjęte. Pacjenci na Ukrainie płacą nieoficjalnie albo quasi-oficjalnie (dobroczynne datki) placówkom opieki zdrowotnej. Rozsądnym rozwiązaniem w celu uporania się z tego typu opłatami mogłoby być wprowadzenie oficjalnych dopłat pacjentów. Jednakże brakuje jasnej podstawy

prawnej do wprowadzenia takiej reformy. Zapisy konstytucji stanowią bowiem, że korzystanie z usług zdrowotnych na Ukrainie jest nieodpłatne. Niemniej jednak uczestniczący w badaniu przedstawiciele różnych grup uczestników systemu opieki zdrowotnej byli chętni nie tylko do dyskusji na temat oficjalnych opłat, ale także byli zwolennikami ich wprowadzenia. Oczekiwania względem prawdopodobnych celów takich dopłat wyrażane przez poszczególne grupy udziałowców są tematem niniejszego artykułu.

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