How is it working?
A new approach to measure governance in the health system in Ukraine

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Acronyms and Abbreviations

ACU	Accounting Chamber of Ukraine
ARC	Autonomous Republic of Crimea
BEEP	Business Environment and Enterprise Performance Survey
CD	Chief Doctor
CIS	Commonwealth of Independent States
CMS	Center for Medical Statistics
CPIA	Country Policy and Institutional Assessment
CSOs	Civil Society Organizations
CVDs	Cardio-vascular Diseases
CoM	Council of Ministers
ECA	Europe and Central Asia
EU	European Union
FM	Financial Management
FSE	Former Soviet Union Economies
GDP	Gross Domestic Product
GNI	Gross National Income
HD	Human development
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR	Human resources
HRM	Human resources management
IT	Information technology
M&E	Monitoring and Evaluation
MIS	Management information system
MoF	Ministry of Finance
MoH	Ministry of Health
NCDs	Non-communicable Diseases
OECD	Organization for Economic Cooperation and Development
OOP	Out-of-Pocket Payments
PB	Planning and Budgeting
PBB	Program-based Budgeting
PEFA	Public Expenditure and Financial Accountability
PFM	Public Financial Management
PISA	Program for International Student Assessment
PPP	Public Private Partnership
SABER	SYSTEMS APPROACH FOR BETTER EDUCATION RESULTS
SFI	State Financial Inspection
TB	Tuberculosis
TSA	Treasury Single Account
UAH	Ukrainian hryvnia
UCLL	Ukraine Code of Labor Laws
WHO	World Health Organization

Chapter 1: Overview

Introduction

The advent of the "actionable governance indicators"[1] phenomenon has taken hold within the World Bank Group, other development partners, civil society organizations (CSOs), and governments. It has successfully put the issue of using evidence-based policymaking to improve governance on the map. But much of the initial success has been focused on measuring "classic" functions of the public sector that governance and anti-corruption practitioners are familiar with. These include budgetary processes, public financial management, and oversight mechanisms such as ombudsmen, audit institutions, and procurement.

Fewer resources have been invested to date in developing actionable governance indicators around functions, such as Human Resources (HR) and Information Management in specific sectors, including health. These functions are critical in determining service delivery results in human development (HD) sectors (see below). In the health sector, some aspects of governance have been successfully assessed in fieldwork, including pharmaceuticals procurement, prevalence of "ghost" employees and doctors' absenteeism (see for example, Chaudhury, N., and J. Hammer, 2004[2]). **However, in general the sector-specific research agenda to date has not yet developed specific standard tools to study "upstream" public sector management functions**. In Ukraine, while there is recognition that better governance is critical for better service delivery and results, there has never been a systematic attempt at measuring governance in the social sectors.

This study develops a new, original methodology, taking on board some of the key features of the Public Expenditure and Financial Accountability (PEFA) Framework (Box 1), previous work in Brazil and India to measure governance indicators by La Forgia *et al.* (2007[3]), and other key public sector management diagnostic instruments developed by the World Bank Poverty Reduction and Economic Management and Human Development Networks (such as SABER[4] in education). It also draws on the experience of the World Bank and other institutions (OECD) of fiduciary-system diagnostics.

This methodology includes both a desk review of existing laws and regulations, as well as face-to-face in-depth interviews. It allows specific, quantifiable measurement of key governance functions, and precise policy recommendations on which sub-functions require greater attention. As the following chapters will show, by applying this innovative methodology to investigate issues of governance in the health sector, the study sheds new light on the strengths and weaknesses in the current organization of the health care system in Ukraine, and provides a strong basis for developing a specific, evidence-based dialogue with government and other stake-holders on necessary and priority reforms[5].

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[1] Actionable governance indicators (AGIs) provide evidence on the characteristics and functioning of particular elements and sub-elements of the various dimensions of governance. See:
http://intranet.worldbank.org/WBSITE/INTRANET/SECTORS/PUBLICSECTORANDGOVERNANCE/0,,contentMDK:21637392~menuPK:285748~pagePK:210082~piPK:210098~theSitePK:285742,00.html

[2] Chaudhury, N., J. Hammer, 2004, Ghost Doctors:Absenteeism in Rural Bangladeshi Health Facilities, World Bank Econ. Review

[3] La Forgia, Gerard, Couttolenc B., and Y. Matsuda, 2007, Governance in Brazil's Unified Health System (SUS): Raising the Quality of Public Spending and Resource Management, The World Bank.

[4] http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTEDUCATION/0,,contentMDK:23389788~pagePK:148956~piPK:216618~theSitePK:282386,00.html. For HR management, see: "Teacher Policies around the World: Objectives, Rationale, Methodological Approach, and Products", July 27, 2010.

[5] In future the same methodology could be applied to other public service delivery sectors and other countries, with some modifications.

Chapter Outline

To put the study in context, this Chapter briefly reviews the evidence on governance performance and specifically health sector performance in Ukraine. In addition, to justify the core analysis and results, the Chapter discusses: i) what is meant by governance; ii) why governance matters for health service provision and outcomes; iii) the perspective and methodology used.

Evidence on governance performance in Ukraine

Over the last decade several studies have looked into governance performance and corruption in Ukraine, without a specific sector focus. The most problematic areas these studies have identified have been the following: i) lack of control of corruption, ii) limited enforcement of the rule of law; and iii) guaranteeing stability/strengthening of institutions.

Main findings: In 2007 a detailed comparison of Ukraine with other countries was conducted using World Bank Governance indicators, Country Policy and Institutional Assessment (CPIA) ratings, Freedom House Nations in Transition Corruption Perception Index, Transparency International Corruption Barometer Survey (2005), and Business Environment and Enterprise Performance Surveys (BEEPs, 2002 and 2005). All indicators showed that control of corruption is a key challenge in Ukraine.

According to the same studies, Ukraine scored just below average among CIS countries on Government Effectiveness, and better than its neighbors and other middle-income nations on the Voice and Accountability, and Quality of Regulation dimensions. Over recent years, the indicator of Government Effectiveness has continued to worsen, as Figure 1: 1 shows:

Figure 1: Government Effectiveness Index, 2003-2011 (higher is better)
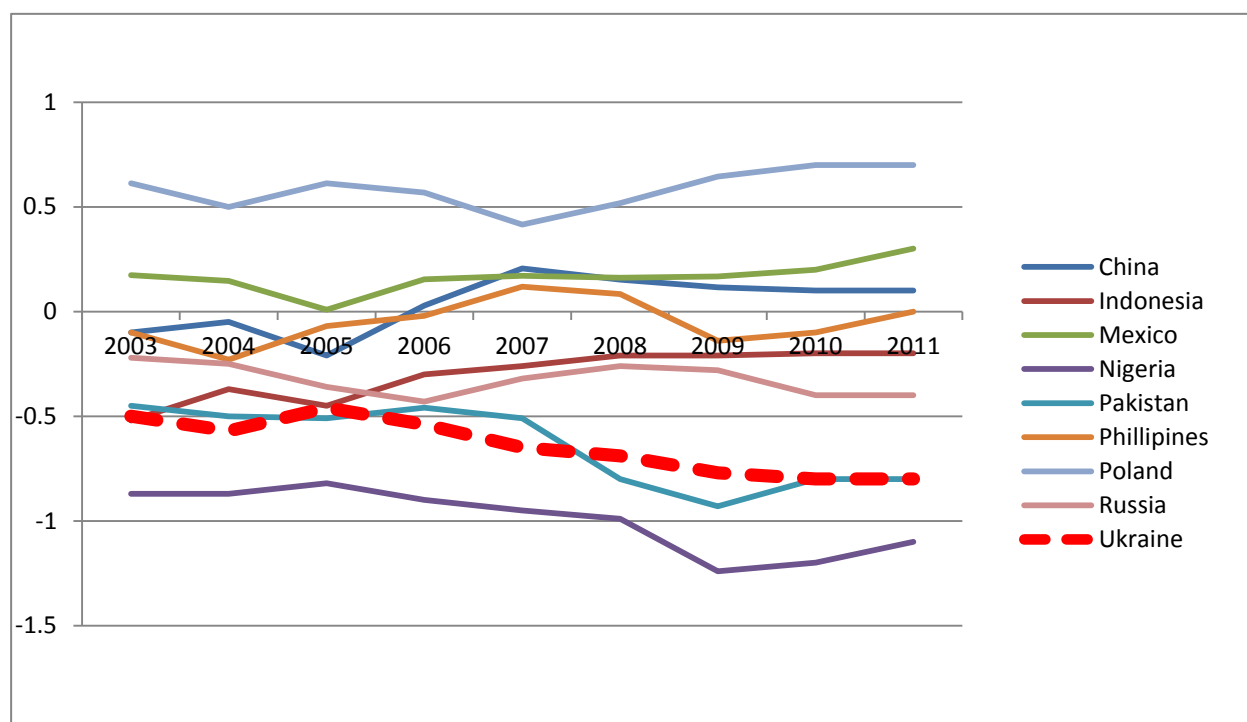
Source: World Governance Indicators, World Bank

According to the Corruption Barometer Survey the health and the education sectors are respectively number four and number six as the most corrupt public sectors in people's perception.   In the BEEPs, more than 40 percent of firms interviewed identified corruption as a problem, with some significant improvement between 2002 and 2005. Other surveys carried out in 2007 - 2009[6] also showed that corruption in Ukraine is extremely widespread and often accepted by the population as a customary means of getting things done. In 2009, 62.5% of respondents indicated that they were involved in corrupt transactions with government officials over the past 12 months. According to the anti-corruption watchdog Transparency International, Ukraine ranked 144 out of 180 countries in 2012 in the Corruption Perception Index[7].

The 2006 Ukraine Governance Assessment (Sigma 2006) identified institutional weakness as a key governance challenge, and civil service reform as a priority area. According to this report, in Ukraine there is no divide between political and administrative functions, civil servants are politicized, and do not function as a strong, independent professional corps committed to the rule of law and with defined rights, obligations, accountability, and constraints; procedures are poorly defined, and the principle of legality is not enforced by the courts.

The main tool used by the Bank to assess governance issues in Ukraine to date has been under the Expenditure and Financial Accountability (PEFA) program[8]. Specifically, under PEFA, the Public Financial Management Performance Measurement Framework (or PEFA Framework) was developed to assess whether a country has the tools to deliver three main budgetary outcomes: (1) aggregate fiscal discipline, (2) strategic resource allocation, and (3) efficient use of resources for service delivery. The results of the PEFA assessment for Ukraine are described in Box 1 . The assessment was undertaken in 2006, and then repeated in 2011.

Box 1: **Main findings of the Ukraine PEFA assessment**

The recent 2011 PEFA Assessment in Ukraine provided an update from the baseline PEFA undertaken in 2006. The 2011 PEFA had shown that improvements to the PFM systems in Ukraine, introduced over the last decade, have contributed to improved fiscal management at an aggregate level and helped Ukraine to maintain budget discipline during a period of serious economic and political disturbance in 2008-9. A well established and transparent budget process, a strong centralized Treasury system and improved tax collection provided the foundations for this relatively good performance.

Budget transparency kept the high scores of the previous assessment. All budget execution reports and budget documents are published and include comprehensive information regarding all major elements of the budget including expenditures, revenues, financing figures.

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[6] Comparative Analysis of National Surveys: 2007-2009, MSI/KIIS, 2009; Neutze, Jan & Adrian Karatnycky (2007) Corruption, Democracy, and Investment in Ukraine, Washington, The Atlantic Council.

[7] The Doing Business Report, which looks at *de jure* attributes relevant for ease of doing business, ranked Ukraine 137nd

[8] The PEFA Program was founded in October 2001 as a multi-donor partnership between seven donor agencies and "international financial institutions" to assess the condition of country public expenditure, procurement and financial accountability systems and develop a practical sequence for reform and capacity-building actions. The PEFA Framework was created as a high level analytical instrument which consists of a set of 31 indicators and a supporting Public Financial Management Performance Report, providing an overview of the performance of a country's PFM system. It draws on established international standards and codes, and other commonly recognized good practices in PFM. This approach seeks to mainstream the PFM best practices that are already being applied in some countries.

Policy-based budgeting remains weak. While medium term budgeting elements are present and evolving, the link between policy and budget continues to be missing. The budgeting process continues to be input rather than result driven.

As for predictability and control in budget execution Ukraine scores well. The Ukrainian PFM system is highly centralized with a focus on input controls. The automated treasury system is applied across all units of government at all levels and it does a satisfactory job in controlling expenditures and commitments. The high degree of control is evidenced by good scores on most PEFA indicators related to Treasury control as well as internal audit sub-dimensions. The public procurement framework has improved markedly since the previous assessment and is now largely compliant with international good practice.

The accounting and reporting practices have also improved. The Treasury Single Account (TSA), which was established under the first phase of PFM reforms, underpins the strong financial reporting and cash management practices in government. Coverage of the TSA is comprehensive, and combined with the improved budget classification system, enables the treasury to produce good quality, timely in-year reports on budget execution and cash flows. Treasury practices have further improved since the 2006 assessment with the incorporation of commitment control and monitoring. In addition, Treasury has been able to reduce the production time for in-year budget reports whilst simultaneously, through the improvements in budget classification, generating reports with considerably more detail than before – reports are generated for 3 different classification structures (administrative, economic and functional) and for the different tiers of government (central government, local government).

External scrutiny and audit remains an issue. The limited role of Supreme Audit Institution also prevents the external audit function from being efficient. The former can only audit state budget expenditures as well as undertaking only a limited degree of follow up.

The main PFM weaknesses that negatively affect spending efficiency and overall governance perceptions in Ukraine are as follows:

a) weak links between policy objectives and budget allocations and poor capital budgeting practices that mean resources are used sub-optimally;

b) a target driven approach to revenue collection, which ensures high collection ratios but at significant cost to business and contributing to negative external perceptions of Ukraine as a place to do business;

c) lack of focused oversight of state owned enterprises, which represent a large part of the economy and have, from time to time, imposed heavy burdens on the budget in the form of tax write offs and recapitalizations;

d) the narrow focus of scrutiny by the State Financial Inspection on transaction processing and compliance and the absence of a modern internal audit function that would focus on improving systems; and

e) limitations on the scope of work of the Accounting Chamber of Ukraine (ACU) and the lack of a dedicated audit committee in the legislature, which limit accountability for how public funds are used and reduce the incentives for ministers and officials to pay attention to performance and efficiency.

The important message on the reform process going forward is that changes should improve the systems in order to improve service delivery to Ukrainian citizens. The PFM system needs reorientation to improve the management of public funds and the quality of services. This requires a shift from input-driven traditional mode to result-oriented system, greater involvement of civil society and better evaluation and feedback mechanisms, in the form of modern internal and external audit and accountability for results At the same time this will improve perceptions of governance.

During the last decade, several sector-specific reviews of Ukraine's Healthcare System tangentially discussed selected Governance aspects of service provision. All of these studies, as discussed below, raise a list of similar concerns about how Ukraine's healthcare is managed. The key concerns include: lack of financial autonomy and competition across service providers; input-based rather than results-based financing; inadequate remuneration systems for medical professionals which impede their motivation. In a way, this generally shared broad diagnosis of the Governance problems in Ukraine's healthcare is the first step in fully unpacking the disease and finding concrete and practical recommendations for change. In what concerns Governance and resource management, most of these studies formulate conclusions which still require much additional exploration in order to understand the exact mechanics of the wrong incentives and processes, institutional barriers to reforms, and ways to measure these "softer" aspects of service provision to track progress over time.

- Back in 2002, the EU Tacis Bistro project "Introducing European Experience in Financing Health Care Services" described fundamental weaknesses in how Ukraine manages the resources it spends on health care. The study showed how most of the distorted incentives and outcomes in the sector can be attributed to input-based financing: *"Budget-dependent health facilities have an 'inborn' right to be funded from the budget; the grounds for financing these facilities is the fact of their existence rather than their success in maintaining and improving public health".* Unless this budgeting approach is changed, the sector would continue to suffer from unnecessary hospitalizations, dubious statistical base, and lack of motivation for change among facility managers. The study also flagged the problem of lacking legislative clarity about what services should be provided by the hospitals free of charge, which makes it difficult to clearly divide responsibilities in service provision and promotes unfunded mandates on service providers. The study referred to interviews with medical professionals, but it was rather exploratory rather than based on structured and systemic tools.

- Later in 2004, another EU project which tried to design measures for re-employment of healthcare staff after potential reductions, showed how the prospects for reforms in medical staffing were hampered by Ukraine's rigid healthcare norms. Staff reductions at needed levels, as recommended by the report, were not seen as feasible within the current legislation. The only way to implement needed change was to first achieve reduction in hospital beds, opening some leeway to streamline respective network of providers. In other words, human resource management in the sector was shown to be limited by exogenous governance factors which made it difficult to change approaches even where stakeholders agreed it was necessary.

- During 2006-2008, the World Bank conducted a Public Expenditure Review for Ukraine, focusing in particular on Improving intergovernmental fiscal relations and expenditure policy in Healthcare and Education. The study revealed a critical barrier in the sector funding which still remains unaddressed: the fundamental mismatch between the input-based central norms imposed on healthcare facilities, on the one hand, and the allocation of funding within intergovernmental equalization scheme which became largely per capita after the 2001 budget reforms. The 2008 PER demonstrated how these outdated input-based norms are incompatible with Ukraine's fiscal decentralization agenda. It also showed how quality of services is a hostage of these inefficient arrangements, rather than low levels of funding as such.

- The *2010 Health System Review by the European Observatory on Health Systems and Policies* palpated a range of problems in the sector's funding, regulation, planning and administration. For example, this review described low motivation of facility managers for structural reforms, service quality control or reducing provision costs, attributing it to weak

financial autonomy of tax-funded providers and lack of competition between them. However, these causal links still lack measurable evidence and therefore remain hypothetical.

▪ Limited managerial autonomy of the facilities was also described as a major Governance barrier by the *2011 Health System Assessment* by the USAID Health Systems 20/20 Project. Similarly to the European Observatory, USAID also pointed at the input-based and historical budgeting, disconnected from the service needs. Both studies also expressed concerns over remuneration systems for medical professionals. In addition, the USAID Assessment pointed at considerable fragmentation of roles and relationships in the decision-making process and overall lack of leadership. Again, while these major barriers featured strongly in the report, it was more challenging to identify tangible evidence and systemic approach to explore them in more detail and to produce actionable recommendations for change.

▪ Much of the existing specific evidence on problems in resource management in Ukraine's health sector could be found in a series of reports produced on the subject by the National Institute of Strategic Studies (NISS) during 2012. One of the core premises of these studies seems to be expressed by the following thought: *"(Growing costs of modern healthcare, on the one hand, and limited resources, on the other hand) create a catch-22, the only way out of this trap is not to increase spending, but to find better ways to use available resources"[9].* The NISS identified a large range of particular barriers to efficient resource utilization, including: line-item and highly rigid budgeting requirements, absence of links between facility funding and their performance, as well as between remuneration and performance of the staff. The studies emphasized institutional barriers to service quality assurance such as lack of credible performance audit and clinical audit structures, poor usage of patient feedback, weak systems of evidence-based medical standards and clinical protocols. A separate set of analysis by NISS looked into human resource management issues in the sector. It described extreme distortions in the current usage of medical expertise, including decreasing quality of medical education and continuous education for professionals (resulting, in turn, from inefficient policies for student selection, poor personnel accounting systems, lack of public and professional oversight over accreditation and licensing process) and inadequate systems of financial stimulation for medical staff (low levels of compensation, leading to corruption and prompting shadow service market funded out-of-pocket). NISS supplied all of these findings and recommendations with ample statistics and legislative analysis.

As the above brief summary shows, governance issues have been extensively studied in Ukraine. However, we still lack systematic evidence on the severity and variability of the identified governance constraints in specific sectors, and across different governance functions. Some of the governance constraints in Ukraine's healthcare do feature in the sector-level reviews with growing frequency. However, the existing empirical evidence is often anecdotal. Even where statistical data and legislative analysis is applied to illustrate identified barriers, it requires further investigation to understand and address individual institutional mechanisms and incentives. Moreover, none of these studies have yet focused specifically and systemically on the governance dimension of service delivery, covering the entire spectrum of the resource management and using a standardized approach which would help to identify weakest links and priorities for reform.

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[9] Reforming Ukraine's Healthcare: Organisational, Legal, Financial and Economic Issues (NISS Analytical Report); Page 30.

Before delving into the analysis of governance issues specific to the health sector, this introductory chapter provides a brief overview of some of the main performance issues in the sector. In other words, before discussing the causes of her illness and what can be done to make her feel better, we briefly need to explain that the patient is indeed ill.

Health sector performance in Ukraine

Health outcomes

The health outcomes of Ukrainians are poor by international standards.[10] Overall, life expectancy is 71 years (which is approximately the same as it was in 1970 at 70.6 years, and 11 years shorter than current EU life expectancy).[11] **Error! Reference source not found.** illustrates Ukraine's international ranking for major health outcomes, as well as GNI per capita.

Table 1. Selected Health Outcome Indicators, Ukraine in regional comparison

	Maternal Mortality Rate, 2009	Under 5 Mortality Rate, 2010	Life Expectancy at birth, 2009		Adult Mortality, 2009*		Age standardized adult mortality rate, CVDs and diabetes per 100,000 pop.**	TB Incidence, 2010 per 100,000 pop.	HIV Prevalence, 2009 per 100,000 pop.	GNI per Capita, PPP current US$
			Male	Female	Male	Female				
Kazakhstan	51	33	59	70	432	185	650	151	250	11,310
Ukraine	32	13	62	74	395	148	500	101	786	7,080
Russian Federation	34	12	62	74	391	144	517	106	696	19,940
Moldova	41	19	65	73	309	134	401	182	338	3,670
Belarus	4	6	64	76	324	117	446	70	172	14,560

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[10] For a more detailed analysis of the health and demographic situation in Ukraine, see Report: An Avoidable Tragedy: Combating Ukraine's Health Crisis, World Bank 2009.

[11] The poor results in health outcomes contribute to Ukraine's overall problematic human development outcomes (Ukraine is ranked 78/182 by the latest Human Development Index). These problematic human development outcomes are also the result of a complex nexus of causes, including low income (at approximately USD 3,200 per capita in 2012), poverty (7.5 percent of population lived with less than 5 dollars per day in 2010), and recurrent and deep socio-economic shocks (in the 1990s, and more recently in 2008-09).

Armenia	30	20	66	74	246	103	378	73	62	6,140
Georgia	67	22	67	75	235	97	450	107	81	5,390
Latvia	34	10	67	77	284	105	359	39	43	17,820
Lithuania	8	7	68	79	274	95	312	69	37	19,690
Turkey	20	13	72	77	134	73	268	28	6.1	17,340
Estonia	2	5	70	80	234	77	269	25	736	20,830
Poland	5	6	72	80	197	76	219	23	70	20,480
Czech Republic	5	4	74	80	138	63	164	6.8	19	24,280
Sweden	4	3	79	83	74	47	79	6.8	88	42,200

Source: WHO, World Health Statistics.

Note: Countries are ranked according to average life expectancy.

* Probability of dying between 15 and 60 years of age per 1,000 population

** Age standardized adult mortality rate, cardiovascular diseases and diabetes, ages 30-70 per 100,000 population

Trends have not been positive, with the exception of maternal and child health, where Ukraine has been able to improve significantly over the last decade, and it is now performing at par with other East European Countries, as Table 1 above indicates**.**

The more troubling results are concerning adult mortality. For example, between 1970 and 2010 Ukraine lost 92 positions in adult male mortality and 97 in female adult mortality[12], and now ranks as almost the worst of all nations in the probability of death between age 15 and 60 (15q45). In 2009, according to WHO 15q45 was 395 per 1,000 for males, and 148 per 1,000 for females, more than twice the EU average[13].

Non Communicable Diseases (NCDs) account for the majority of Ukraine excess mortality. Similarly to other former Soviet Union Economies (FSE), the Ukrainian mortality gap vis-a-vis other European Nations is largely explained by NCDs (first in order of importance is cardiovascular disease) which, in Ukraine, are responsible for approximately 79 percent of the total number of deaths across all age groups, followed by injuries and poisoning (14 percent), and communicable diseases (7

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[12] Between 1970 and 2010 Ukraine moved from number 73 to 165 in the International ranking for adult male mortality, and from number 25 to 122 for adult female mortality, becoming one of the worst performers in the world.

[13] See World Health Statistics 2011, p. 53 at: http://www.who.int/whosis/whostat/EN_WHS2011_Full.pdf.

percent). The mortality gap vis-a-vis other European Nations is highest among young and middle-aged men, and most of these deaths would be either preventable or treatable; preventable through targeting risk factors and healthier life-styles, and treatable through early detection and appropriate, timely treatment.

In addition to exceptionally high levels of NCDs, over the last 20 years Ukraine has seen an emerging HIV/AIDS epidemic, and worsening TB incidence and prevalence. Since 1999, the reported cases of HIV have quadrupled, TB cases have seen a steady increase, and TB mortality rates have stagnated at around 20/100,000, also because of the continuous growth of TB/HIV mortality.

These problematic health outcomes are the result of a combination of causes, including entrenched life-style factors, such as smoking, drinking, poor diet and sedentary life. However, they also reflect a situation where the almost exclusively government-run health system has failed to respond to the emerging Non Communicable Diseases "epidemic" that has emerged during the transition years. The system has also failed to transform additional funds and expanded inputs into effective programs and improved outputs and outcomes, and to adjust to the changing circumstances.[14] This is partly because of severe governance weaknesses.

Financial protection

The share of out-of-pocket payments (OOP) over total health expenditure is high – 40.8% of total health expenditure in 2010, according to the State Statistics Service of Ukraine. This is equivalent to approximately 3 percent of GDP[15]. The high level of OOP creates severe financial barriers for the poor, and potentially catastrophic OOP expenses for those who seek care, and/or need to purchase medicines for chronic diseases. According to the Household Budget Survey data 2010, 33 percent of the households interviewed had spent more than 10 percent of their total monthly expenditure on health services; 9.7% percent had spent more than 25 percent of the total on health services. The vast majority of those who did not access health services or medicines when needed did so because of the high costs at the point of service (see Table 2 below). The question asked: "Household member did not access care when needed, last year?" 14.5 percent of the sample interviewed answered "yes").

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[14] See World Bank (2007); "Improving Intergovernmental Fiscal Relations and Public Health and Education Expenditure Policy - Selected Issues", Report No.42450-UA, Poverty Reduction and Economic Management Unit, Europe and Central Asia Region chapter 4, pp.79-104. This report clearly showed the government's highly inefficient spending in the social sectors, with the lion's share of government expenditure going to maintain an inefficient network of hospitals and schools, and the rigid, input-based norms which drive budgeting and allocation of resources at the local level.

[15] At the same time, the government has been spending approximately 3.5 percent of GDP on health, which is low but still significant by international standards.

Table 2 shows the main reasons for not accessing different types of health care services when needed: clearly financial barriers are the main reason for failing to access or complete health care services when needed.

Table 2. Reason for not accessing health services when needed

Why did you fail to buy drugs when needed?	%	Why did you fail to have medical examination when needed?	%
Extremely high price	96.8	Long queue	1.9
Couldn't find	3.1	Doc of needed profile absent	2.8
Other	0	Extremely high cost	95.3
Total	100	Total	100

Why did you fail to get curative procedures needed?	%	Why did you fail to visit a doctor when needed?	%
Long queue	0.6	Long queue	9
Doc of needed profile absent	2.1	Doc of needed profile absent	8.8
Extremely high cost	97.3	Extremely high cost	82.2
Total	100	Total	100

Why did you fail to undergo treatment in a hospital when needed?	%
No place	0.8
Needed unit missing	2.1
Extremely high cost	97
Total	100

Source: Household Budget Survey, 2006

Satisfaction with services

According to many surveys, Ukrainians rank at the bottom of all countries in terms of satisfaction with their health services, and they want their government to do more for health. For example, the Gallup World Poll shown below asked Ukrainians to answer the following question: "In this country, do you have confidence in each of the following, or not? How about healthcare or medical systems?" As the figure below indicates, only few Sub-Saharan counties fared worse than Ukraine.

At the same time, health was identified as the top priority sector for additional government financing, showing that there is an acute perception amongst the public of the financial barrier to accessing health services, and of the catastrophic OOP payments those who seek care need to make. When asked: "In your opinion, which of these fields should be the first and second priorities for extra government spending?" in two separate rounds of the Life in Transition survey (2006 and 2010), a majority of respondents in Ukraine put health first.

Figure 2. Confidence in healthcare systems around the world

"Answer to question: In this country, do you have confidence in each of the following, or not? How about healthcare or medical systems?"
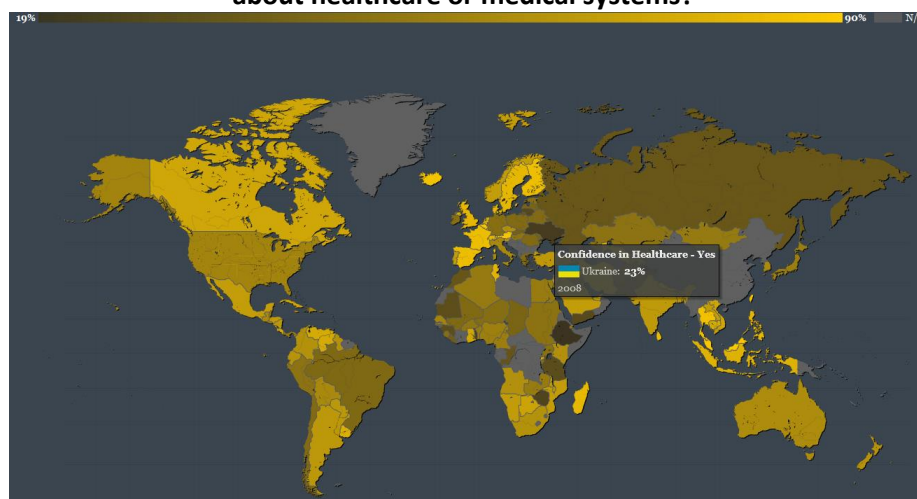
Source: Gallup World Poll, 2008, dark green means 30 percent or below; light yellow is between 80 and 90 percent. All intermediate colors reflect continuum of percentage from 30 to 80 percent

In looking at intermediate outcomes, the same problematic picture emerges: overall, the health sector in Ukraine has struggled to deliver results:

– For example, the number of hospital beds per capita and length of stay have remained very high at respectively, 8.7 per 1,000 population, the fourth largest in the world, and at 12.7 the highest in the region after the Russian Federation. These outcomes are falling in other countries. Now that input mixes have changed (with increased technology and more qualified human resources) and their prices have substantially increased, Ukraine's considerable overcapacity in a hyper-fragmented hospital sector means a heavy-burden of allocative inefficiency in spending. Overall, opportunities to take advantage of less invasive technologies, new standards of care and more dynamic service modalities are lost, results stagnate and cost increases do not yield commensurate benefits, thus closing a vicious circle, as in other ECA countries (see World Bank, 2013).[16]

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[16] World Bank, 2013, Getting Better: Improving Health System Results in Eastern Europe and Central Asia.

- Authority between the different vertical programs responsible for infectious diseases' control is extremely fragmented, with overlapping responsibilities for different functions. In addition, the different agencies lack ability to coordinate. A specific instance of governance and health system failure is Multidrug Resistant Tuberculosis (MDR-TB), which has spread as a result of insufficient and outdated prevention and detection practices, lack of coordination between TB system, the general health system and the prison system, and excessive use of inpatient care for treatment of TB patients.

What is Governance?

In the title, and the above brief introduction to the study, we have used several terms, such as "governance", "corruption", "public sector management", "outcomes", "performance". What do these terms mean? How are they related? Why is it important to study them? These and other questions are addressed in the following paragraphs.

Governance: In the literature there are several definitions of governance.[17] The etymology of the word is from ancient Greek, where κυβερνήτης means *captain.* "Κυβερνώ λέμβο" means "to steer a boat". One of the clearest definition in recent literature sees governance as: *"the set of political, social, economic and institutional factors which define the lines of authority, the flow of information, and the individual incentives within any organization, and therefore determine the way it functions"* (Savedoff, 2009, p. 7)[18].

The key elements that define governance. From the above definition and in keeping with the ancient Greek etymology, we can take away two main points. The **first** is that, in discussing governance, one always has to refer to the specific "boat" (it can be an individual organization, public or private, or a specific sector such as health, or the overall functioning of a country's government) whose governance is being addressed, since the most relevant factors which determine the way distinct "boats" are piloted are different. For example, in the case of private corporations, the main relationship which defines governance is that between shareholders and managers, while

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[17] One of the first definitions was that by Kaufmann, Kraay and Zoido-Lobaton (1999) who define governance as: *"the traditions and institutions by which authority in a country is exercised. This includes the process by which governments are selected, monitored and replaced; the capacity of the government to effectively formulate and implement sound policies; and the respect of citizens and the state for the institutions that govern economic and social interactions among them".* The definition commonly accepted within the Bank (including its GAC Strategy 2006) is the following: *"The way in which the state exercises its authority over public resources to provide public goods and services."* This definition underscores the direct relation between state power, institutions (=i.e., the way in which this power is exercised) and service provision. There are also governance definitions from the New Public Management theory, emphasizing the difference between *steering* rather than 'rowing' (Osborne D and Gaebler T, 1992, *Reinventing Government*, Reading, Mass: Addison Wesley). There is also the pioneering work of both Pfeffer J (1981, *Power in organizations.* Marshfield, MA: Pitman) and Mintzberg H (1983, *Power in and around organizations*, Englewood Cliffs, NJ: Prentice Hill) comparing Governance and Management. Finally, there are the definitions from the policy theory authors, mainly Rhodes, RAW (1997, Understanding Governance: Policy Networks, Governance, Reflexivity and Accountability, Buckingham: Open University Press; 2003, 'What is New About Governance and Why Does it Matter?' in Hayward J and Menon A (eds.) Governing Europe, Oxford: Oxford University Press); or Pierre J and Peters BG (2000), Governance, Politics and the State, Basingstoke, MacMillan Press; Richards D and Smith MJ (2002), Governance and Public Policy in the UK, Oxford: Oxford University Press; and Salamon L M (ed.) (2002), *The Tools of Government: A Guide to the New Governance*, New York: Oxford University Press. An application to the medical sphere of these definitions is in Burau V and Vrangbæk K (2008), Institutions and non-linear change in governance: Reforming the governance of medical performance in Europe, *Journal of Health Organization and Management* 22(4): 350-367) and the use for *inter-country comparison* in Kuhlmann E, Allsop J and Saks M, 2009, Professional Governance and Public Control: A Comparison of Healthcare in United Kingdom and Germany, *Current Sociology* 57:511-528.

[18] Savedoff, W., 2009, "Governance in the Health Sector: A Strategy for Measuring Determinants and Performance".

in the case of public sector organizations, three different actors are relevant: citizens/clients, policy-makers, and service providers (see World Development Report, 2004 and the key "accountability triangle" for public sector organizations shown in Figure 4 below).

The **second** point is that for any organization, governance is characterized by three elements: **i) the manner and the criteria by which authority/command over resources (material, human and financial) is defined; ii) the way information is generated and used within the organization; iii) and the way incentives for its members are structured.** This includes both intrinsic incentives, such as status and reputation, as well as extrinsic incentives, such as financial factors. **In any organization these three elements together determine the level of accountability, the pressure to be rule-compliant and perform well. Any reform to improve poor governance performance needs to improve all three dimensions.**

Defining the scope of the study

So, what is the "boat" studied here? Savedoff (2003) argues that: *"Governance can be analyzed at the broadest level in terms of political actors who contest and collaborate to establish each society´s particular public policies. Governance can also be analyzed at a secondary level in terms of the forms of these specific public policies, that is, the resulting rules, institutions, laws and enforcement mechanisms. However, governance can also be analyzed **at the level of particular organizations**, for example, the governance of a social security institute, a district health system or a hospital"* (Savedoff, 2003: p.4).

This study is not about measuring governance *in the health system*[19] but measuring governance (or "the quality of management", as argued above) in *health service facilities*. It is a street-level approach. The level of institutional analysis is micro (public service providers) and to a lesser extent meso (regional, oblast level), but certainly not macro (state or government level). This is easily reflected in the choice of the research methodology based upon surveying doctors, nurses and health staff at various health centers and in-depth interviews with local officials (local health administrators, chief doctors and chief information system officers; see Methodology section).

Governance and Corruption

Governance and corruption. Governance and corruption are often intertwined in the public discourse. Corruption can be defined as: *"misuse of public office for private (financial) gain."* From this definition and the previous definition of governance, it is clear that corruption - unlike governance - has an ethical connotation, in the sense that whether or not to engage in corrupt practices is ultimately an ethical decision. However, it is also clear that when governance systems are malfunctioning the extent of corruption tends to be more pervasive. Systemic corruption is rooted in poor governance, and in any organization corruption can be considered a symptom of poor governance policies and practices. In turn, just as in a human body fever tapers off as infection recedes, in any organization corruption opportunities and corruption are reduced when its governance improves.

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[19] Instead, an analysis of the quality of governance (government) in the health system in Ukraine would require considering the stewardship capacity of health authorities to steer the entire health system, including the ability to develop inter-sectoral actions and cross-cutting policies and engaging with key non-health stakeholders; the ability to formulate and implement health policy; the quality of information and data in the country, and the uptake of evidence to develop intelligence in policy making; the quality of the country´s regulatory framework; etc.

Why study governance? Governance in the results chain

Good governance is needed to make services work, as Figure 3 below illustrates. For example, in any given country, delivering high quality health, education or other services effectively requires sufficient human and financial resources, adequate and timely supplies, but it is also conditional on having sound governance systems.

Figure 3. Good governance is one essential element of effective service delivery
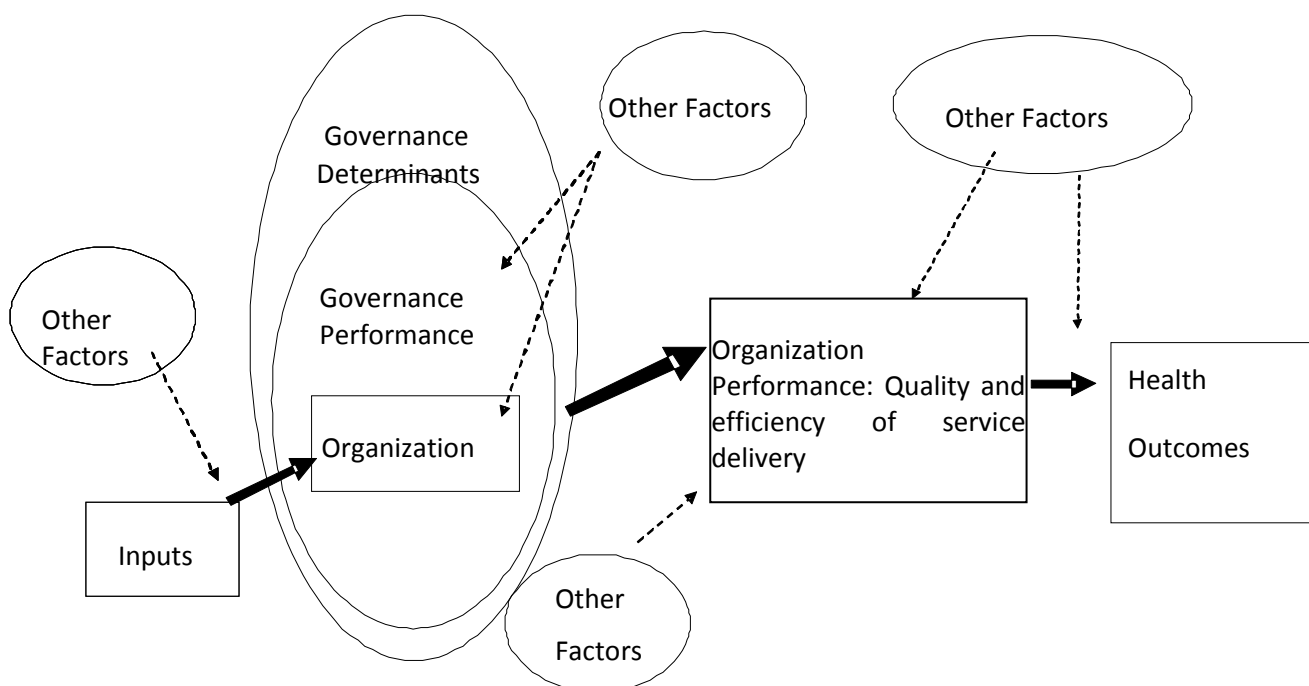
Source: Savedoff (2009)

The above figure clarifies that there is a complex set of "links" in the results chain that connects inputs to outputs and outcomes. Corresponding to each junction in the complex results chain, several exogenous factors may play a role in determining the strength of the causal link. For example, even where health system performance is relatively good, health outcomes may still be poor because of poor individual behavioral factors, or high pollution, or extreme income inequality and deprivation.

Most governance functions belong to the "missing middle" in the above results chain. Governance indicators are part of the set of intermediate service delivery indicators, referred in the literature as the "middle", because they identify critical "links in the results chain" which transform specific inputs (material and financial) into performance and outcome indicators.

Yet these links are also "missing" because, unlike inputs and outputs, they have not yet been measured with standardized tools. In other words, there is a disconnect between our ability to measure inputs and final outcomes, for which the literature has established standardized tools[20], and

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[20] Such as Demographic and Health Surveys to measure outcome, and Household Budget Surveys or Living Standard Measurement Surveys to measure financial protection

the exploratory nature of the measurements we can use for these "missing middle" indicators[21]. As a result while it is, for example, relatively easy, at least within industrialized countries, to track countries over time according to their main human development outcomes, such as their students' learning outcomes using the Program for International Student Assessment (PISA), or their infant mortality rates (see WHO World Health Statistics, 2012), it is impossible to know where the same countries stand in terms of their HR management policies and practices in the public sector, or whether they have improved over time. It cannot be known which country has the best information management system and why, or best procurement system for medicines, or which country follows good practice in informing patients about the quality of services or in promoting parents' participation in management of schools. For all these important questions, the literature does not provide us with evidence-based answers. Nor can we use standardized assessment tools to measure these governance dimensions across sectors and across countries in any consistent way. There are only a few exceptions to this (for example, the PEFA for assessing the robustness of the budgeting process).

In addition, we know that these "missing middle" indicators are important, but we do not have firm, quantitative evidence on the impact of each of them on final service delivery indicators. There have been attempts to empirically relate poor governance determinants/performance with poor organizational performance and final human development outcomes, but in the absence of micro studies with experimental design, to date these attempts have been tentative[22].

De jure and de facto

***De jure and de facto*.** Within governance dimensions, Kaufmann and Kraay (2008)[23] and Savedoff (2009) distinguish between "governance determinants" and "governance performance" dimensions**.** The former are policies or rules (*de jure* governance arrangements), for example the human resource policies/rules that establish hiring, rewarding, sanctioning and promotion criteria for teachers and doctors, while the latter are *governance practices*, which capture the extent to which governance policies work in reality (*de facto*). For example, how the rules for hiring, rewarding, sanctioning, and promoting doctors and teachers are enforced in practice, and how effective they are in attracting and retaining qualified applicants.

This study focuses both on *de jure* as well as *de facto* governance indicators. By contrast, indicators of organization performance, such as the level of out-of-pocket informal payments in health, or workers' absenteeism rates, or frequency of drug stock-outs, or length of waiting lists, or percentage of hospital infections and other indicators of quality are not the focus of the study. Empirically linking organization performance and outcome indicators with upstream governance indicators is also outside the scope of this work.

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[21] Besides the studies cited on page 1, there are only several attempts at developing "Governance Rapid Assessments", including: "Health Human Resource Policies in Latin America and the Caribbean: Rapid Assessment Tool on Policies of Performance Management – Indicators", World Bank, 2011.

[22] For example, some studies have tried to link a country's child mortality with its aggregate Policy and Institutional Assessment ratings, and have found a negative correlation.

[23] Kaufmann, D. and A. Kraay (2008), "Governance Indicators: Where Are We, Where Should We Be Going?" The World Bank Research Observer, 23(1):1-30.

The governance functions the study investigates

The key governance functions for public sector service providers. As explained earlier, the study analyzes governance **from the viewpoint of public service providers** using a framework shown in Figure 4 (adapted from the World Development Report, 2004: Making Services Work for Poor People). Service providers are shown in the low-right corner of the triangle within the figure, and one can see that for public sector service providers (such as government schools, hospitals and clinics), governance arrangements are defined by the way a number of relationships are organized; between citizens/clients and policy-makers, between citizens and service providers, and between policy-makers and service providers. On the one hand, health service providers' conduct is influenced by their relationship ("compact") with policy makers ("supply-side" governance functions), mediated by several layers of hierarchical relations in the executive branch of government. This compact is prescribed by public sector management arrangements, which define functions such as planning, budgeting, budget execution, financial management and audit, information management, procurement, and human resource management rules and practices. On the other hand, providers' conduct is influenced by their relationship with citizens ("short line of accountability", or "demand-side" governance functions): specifically, by citizens' ability to access information, to participate in local decision making, to monitor services and to take advantage of transparent and fair redressal mechanisms.

Figure 4. Governance from the point of view of service providers
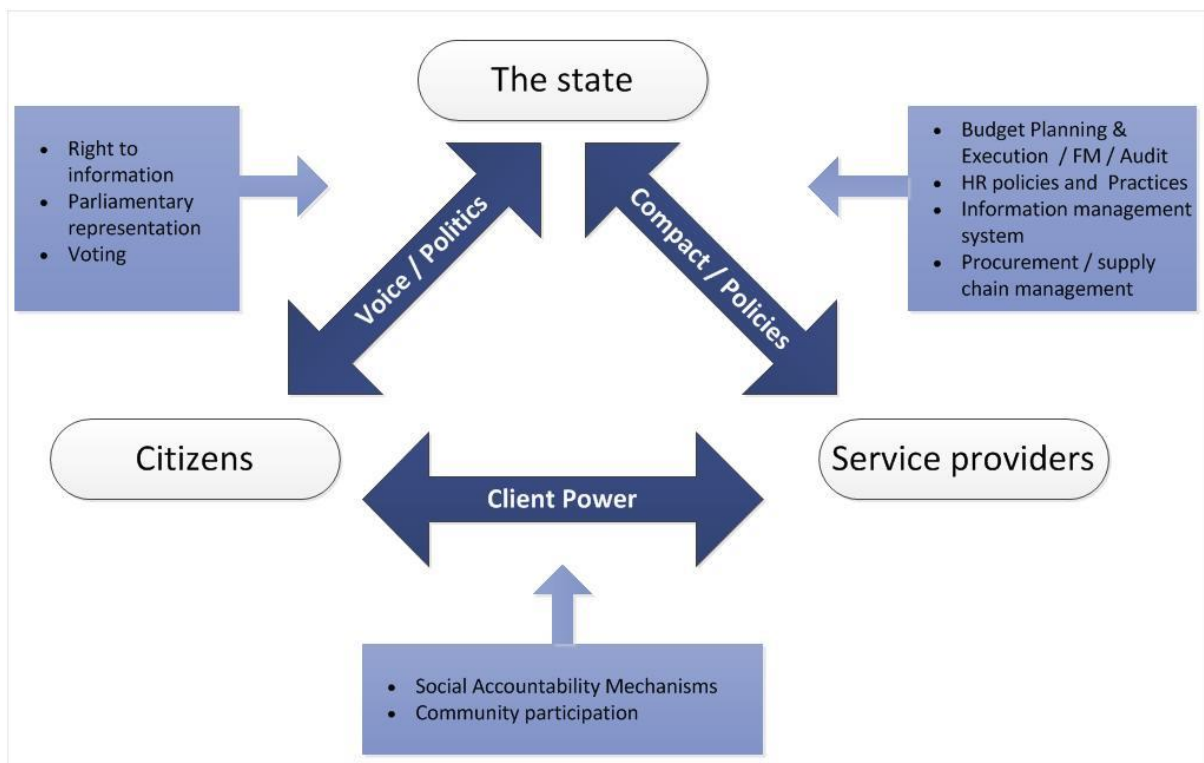
The study assesses the following governance functions in the compact between health care providers and policy makers: i) HR management systems and practices; ii) information management systems and practices; iii) planning, budgeting, and FM systems and practices; and iv) procurement systems and practices.

Its findings are complementary to those of a recent study, supported by Global Integrity, which has looked into the "demand side" governance functions in Ukraine. That study has highlighted problematic performance of the health sector in terms of patients' information, social accountability, and community participation in organization of service delivery in the health and education sectors in Ukraine. In addition, it pointed out that there is a wide gap between *de jure* provisions and *de facto* realities. For example, there are laws and regulations forcing central and local authorities to share information on budgets and on performance in both health and education sectors, but *de facto* these rules are largely not enforced and complied with. In addition, the study found that compared to Kenya and Macedonia, Ukraine has a less organized community of civil society and not-for profit organizations holding government accountable for their performance, and protecting patients rights.

For each of the above four dimensions the study proposes several sub-functions. For example, within the HR management function, the study identifies key sub functions: i) recruitment; ii) career management; and iii) retention of qualified staff. In turn within the hiring sub function, the study identifies five relevant indicators: i) public disclosure of vacancies; ii) transparency in appointment procedures; iii) competitive selection of applicants; iv) relevance of merit-based criteria for hiring new staff; and v) job description. In addition, the human resource management chapter assesses issues of ensuring adequate career management procedures, system of rewards and penalties, staff turn-over, training and continuous education.

The budgeting indicators described in Chapter 4 draw upon PEFA indicators, assessing how budgets of healthcare facilities are guided by strategic plans, quality of budget preparation process, predictability of funds, management of service delivery funding, and process of internal and external controls and audit. In addition, the chapter looks at selection and appraisal criteria for capital investments, and private sources of revenue.

The information management chapter assesses the process of information gathering, validation, and use of information for medical and managerial decisions.

In total, the study identifies 40 indicators within the four relevant governance dimensions (for a full list of the indicators, see Annex 1).

Figure 5 summarizes the key questions the study seeks to address for each of these functions.

Rationale for the choice of sub functions and indicators. The choice of these functions and of the indicators has been dictated by the following criteria: a) *broad consensus in the literature*: following the literature, human, material, and financial resource management functions have beenincluded. These are generally considered critical for health service providers' performance, and essential to an effective health system and ultimately to good health outcomes; b) *measurability*: measurability of different indicators/dimensions have been chosen accordingly. In addition, the study has had to be selective, to keep the length of the questionnaires manageable, and the study scope realistic given its overall budget. For example, dimensions of private sector regulation and contracting out have been omitted, since they do not yet appear to be relevant in the health sector in Ukraine.

Figure 5. Main questions addressed[24]

1. Human resource management	Are vacancies transparently advertised? Is hiring generally conducted competitively and according to meritocratic criteria? Are job descriptions used to hold staff accountable? Is there a performance appraisal system? How is it organized? How does career management system work? Compensation and sanction mechanisms? Is training useful? Are salaries paid on time? How frequent is turn over of staff?
2. Financial resource management	Is planning evidence-based? Is the planning cycle linked with budgeting? Is performance based budgeting used? What are rules for budget allocation? Is there a project appraisal process for capital investments? How does the cash management system work? How are FM controls/audit perceived at facility level?
3. Information management	How is the system of collection, validation and use of information organized? Is there information on performance? What is the M&E capacity at local and central level?
4. Procurement	Do local governments use specific manuals and SBDs for drugs and equipment? How frequent are open tenders for drugs and/or equipment? How long does it take to go through procurement process? Is there a complaint/grievance system; Is there a quality assurance system for drugs? How strong is procurement capacity?

Methodology

Overall approach

The study included both a desk review of existing laws and regulations, as well as face-to-face in-depth interviews, to be able to investigate both *de jure* governance determinants, as well as *de facto* governance performance, or real life practices.

The study methodology is based on: (1) A survey of doctors, nurses, other health workers and hospital administrators on practices and procedures both de jure and de facto; (2) interviews with government officials engaged in the health sector administration at central and local levels, and other sector experts; (3) a desk review of the normative and legal documents disciplining HR management, planning, budgeting and FM, information management and procurement functions and sub-functions; and (4) other assessments such as PEFA carried out recently in the country.

The sample for the interviews was chosen using snow ball and convenience sampling. Many of the questions on governance can be perceived as sensitive and generate non truthful responses. The team mitigated the risk of not getting truthful answers by: a) choosing interviewees first among good personal contacts, in oblasts where we knew personally the Head of the Health Administration, or

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[24] Financial Resource Management includes: budgeting, planning, financial management and audit arrangements.

we could count on at least some key respondents whom we trusted; b) by having several "probing questions" for the sensitive items, where the same question is asked in different ways, so that we could cross check consistency in the interviewees' answers; c) by presenting interviewees with hypothetical scenarios, and engage them in a way they could feel less defensive and more likely to report truthfully, because their personal circumstances may not seem at stake; d) by emphasizing the confidentiality and anonymity of the interviews, and conducting them at home whenever possible; e) by making sure interviewees know that the Ministry of Health authorities support the study, and having the latter's official endorsement of the study communicated directly by the Ministry to the local authorities.

The interviews were carried out in 39 facilities at different levels. Ukraine is organized in oblasts/ regions; in turn each oblast is divided into rayons and municipalities[25]. Health facilities can be owned by central government (Ministry of Health or other ministries), or oblast, or rayon, or municipality/city governments[26]. In this context, the team interviewed personnel and managers in 37 facilities subordinated to oblast, rayon,[27] and city governments, as well as in two facilities subordinated, respectively, to Lviv Railway and Ministry of Internal Affairs.

Sample units. The *s*ample units consisted of physicians, nurses, chief doctors of the facilities as well as representatives of human resource, financial and health care information / statistics departments; and heads or vice-heads of regional administration bodies. Table 3 presents a summary of the total number of people interviewed in each category.

Table 3. Sample for face-to-face interviews

	Doctors	Nurses	Chief nurses	Other facility staff	Chief Doctors	Rayon health adm.	City health adm.	Oblast health adm.	Budget/ accountant officers	HMIS Center specialists
number of interviews	41	16	12	2	See below	3	1	7	See below	5

Note: Facility executives interviewed for HRM Module = 17; Facility executives interviewed for PB Module = 21; Facility executives interviewed for ME Module = 13; in total, 25 of them were Chief Doctors

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[25] Ukraine has cities that are subordinated to oblasts ("oblast-significant" cities) as well as cities subordinated to rayon's administration ("rayon-significant cities"). This has a direct influence on the structure of healthcare facilities and budget authority, as well as the rules of budget formulation (according to the Budget Code). For instance, with regard to the budget process rules, oblast-subordinated cities have direct inter-budgetary relations with the central budget based on a formula (for equalization transfers only; see Chapter 3). Rayon-subordinated cities are still in the system of the so-called "budgetary nested doll" inherited from the Soviet era. For such cities, the rayon budget is a higher-level budget.

26 There are 24 oblasts, plus (i) the Autonomous Republic of Crimea, and (ii) two independent cities, Kyiv and Sevastopol.

27 Interviews were done in four oblast of Ukraine: Poltavska, Vinnyzka, Luhanska, Lvivska as well as in Kyiv city; 9 cities Lviv, St. Sambir, Luhansk, Alchevsk, Vinnytsya, Jmerynka, Poltava, Lubny, Kyiv. In each oblast interviews were done in oblast center and in one of rayon centers.

The questionnaires presented both closed as well as open-ended questions. The latter were used to collect individual "stories", which, whenever possible, were checked with supporting evidence. However, the team tried to include as many closed-ended questions (either, "yes" or "no" questions, or multiple choice questions), to allow comparability of responses across different respondents, and to allow also a quantitative analysis of the information, in spite of the non-representativeness of the sample.

The indicators, as well as the instruments for state, oblast, rayon, and facility level analysis were initially developed by the Bank's in-house team, in consultation with various experts, based on previous work done in Brazil to measure governance indicators by La Forgia *et al.* (2007), and other public sector management diagnostic instruments developed over the last few years by PREM and HD Networks. Then, together with the consulting firm that was selected (FISCO and Kiev International Institute of Sociology (KIIS)) the indicators and the instruments for information collection were finalized, and field tested. The study included four questionnaires: one for doctors, nurses and chief nurses; one for local health administrators (central, oblast and municipality/rayon health administrations); one for Chief Doctors; and one for Health Management Information System officers, and four modules (HR management, Planning/Budgeting and FM, information management and procurement). All the instruments developed for this report (questionnaires, desk studies, as well as the detailed "mapping" from the desk study and questionnaires to the indicators' ranking; see explanation below) are available upon request.

Indicators used for assessment of governance in Public Procurement were developed on the basis of OECD and WHO instruments and localized for particularities of Ukraine's healthcare sector. Governance indicators proposed by this study for Public Procurement represent a combination of criteria applied by the OECD for assessment of national public procurement systems (OECD Methodology for Assessing Procurement Systems (MAPS) (OECD 2010)) and those recommended the WHO for analysis of public procurement in the pharmaceutical sector (WHO Instrument for Measuring transparency in public pharmaceutical sector (WHO 2009)). We have built on these two sets of indicators, modifying them in the following way:

- **We refracted the OECD national-level indicators through the lens of facility-level governance.** The four pillars of the OECD assessment framework focus on national procurement systems. Therefore, just like PEFA, they are not directly applicable to analysis of procurement at the facility level. However, they offer a useful framework by outlining key governance outcomes which must be achieved at the national scale, including via appropriate governance at the facility level. The set of indicators used in this study is much narrow than the one used by the OECD. The OECD indicators encompass our indicators: high performance against our criteria would be only one contribution towards achieving nation-wide effectiveness based on the OECD four pillars.

- **We borrowed a range of WHO indicators for the pharmaceutical sector.** The WHO toolkit raises some of the issues which are specific to procurement in healthcare, where medications represent a significant share of all purchases. We incorporated these specific criteria into our indicator set (such as, e.g. the need to make sure that determination of the amounts of pharmaceuticals to be purchased is based on objective quantification methodology to avoid manipulations and oversupply of unnecessary drugs).

Scoring Methodology

Scoring of multiple dimensions within each Indicator

Most indicators in this study are multi-dimensional. The assessment proposed in this study is structured against 40 multi-dimensional indicators. Each indicator contributes to describe a certain sub-function relevant for a governance assessment, represented by 2-4 specific dimensions. For example, Indicator HRM-3 "Competitive selection of applicants for medical positions" (a sub-function within "Hiring" function in HRM domain) covers three dimensions:

> Is there a legislative requirement for competitive selection of applicants and what are the rules for running such competitions?
> How often is there only one applicant for one post?
> What procedures are used if there is more than one applicant for a certain position? Are there any informal rules that determine these procedures?

Each of the dimensions is reflected in a specific question addressed by this study, either through the survey or via desk analysis of the legislation. For example, to assess the country's progress against each of the three dimensions listed above, the following instruments and assessment benchmarks have been used:

Table 4. Scoring multiple dimensions- mapping from desk study and questionnaire into the relevant governance indicator

Dimension	Assessment instrument	Benchmark
Is there a legislative requirement for competitive selection of applicants and what are the rules for running such competitions?	[Desk Study] What are the legislative requirements for competitive selection of applicants for healthcare workers?	Desk study of national legislation

How often does it happen that there is only one applicant for one post?	A. Survey question (close-ended) [HR1.6_u_one.cand] How often does it happen that you have just one applicant for one position - estimate the share of all vacancies for last year?
	
	   All vacancies/ Almost all vacancies
	   Up to ¾ of vacancies
	   Up to ½ of vacancies
	   Up to ¼ of vacancies
	
	B. Never/ almost never
		% Chief Doctors who say that at least ¾ of vacancies are filled with some competition

What procedures are used if there is more than one applicant for a certain position? Are there any informal rules which determine these procedures?	Survey question (open-ended, segment-coded) [HR1.7_u_select.proced] What procedures are used if there is more than one applicant for a certain position? Are there any norms/regulations, which determine these procedures?	% Cases when Chief Doctors were able to explain procedures or rules used if there is more than one applicant for a post

Scores. This approach to analysis of multi-dimensional indicators draws on the structure of the Public Expenditure and Financial Accountability (PEFA) assessment framework. Building on this similarity, this study has applied the PEFA **scoring scale/approach** to measure governance performance on a four-point ordinal scale (A,B,C,D) for each of the separate dimensions, and combined these grades into an overall assessment of how well the healthcare system is functioning against each multi-dimensional indictor. As with PEFA, this study includes detailed benchmarks and guidelines outlining grading for each of the dimensions. In the example of "Competitive selection of applicants" discussed here, benchmarks and scoring guidelines are provided below.

Table 5. Example: Scoring For indicator "competitive selection of applicants"

Dimension	Assessment guidelines					Assessment result	
	Benchmark	A	B	C	D	Result	Grade
[Desk Study] What are the legislative requirements for competitive selection of candidates for healthcare workers?	Rules for selection of health workers	Clear rules for competitive selection	Rules require competition but guidelines for the selection process may be weak	Rules do not require competition but provide some guidelines on situations with more than one candidate	No legislative requirement for competitive selection and no rules for choosing between multiple candidates	No legislative requirement for competitive selection and no rules for choosing between multiple candidates	Grade D
Survey question (close-ended) [HR1.6_u_one.cand] How often does it happen that you have just one candidate for one position - estimate the share of all vacancies for last year? ☐ All / Almost all vacancies ☐ Up to ¾ of vacancies ☐ Up to ½ of vacancies ☐ Up to ¼ of vacancies ☐ Never/ almost never	% Selecting Option 4 or 5 (confirming that one candidate per post happens either never or in up to ¼ cases).	>75%	50-75%	25-49%	<25%	6.7%	Grade D
Survey question (open-ended, segment-coded) [HR1.7_u_select.proced] What procedures are used if there is more than one candidate for a certain position? Are there any norms/regulations, which determine these procedures?	% Able to explain selection procedures if there is more than one candidate	>75%	50-75%	25-49%	<25%	33.3%	Grade C

Scoring of individual dimensions was different for questions based on desk analysis and for questions based on the survey. As shown in the table above, the desk assessment of laws and regulations was based on qualitative benchmarks. These qualitative benchmarks specified particular requirements to the legislative framework which would allow the system to qualify for each of the Grades on the 4-point scale. In contrast, for all of the survey-based dimensions, assessment was quantitative, with numerical thresholds as criteria for each of the Grades. These thresholds were universal across all indicators, dividing possible results into 4 possible ranges with a 25% step (0-24%; 25-50%; 51-75%, 76-100%) and applied based on the following principle:

For dimensions which reflected a <u>positive attribute</u> of the governance system, higher Grades required higher thresholds;

For all dimensions with reflected a <u>negative attribute</u> of the governance system, higher Grades required lower thresholds.

Table 6. Scoring thresholds

Dimension type	A	B	C	D
Positive attribute (the more; the better)	>75%	50-75%	25-49%	<25%
Negative attribute (the less; the better)	<25%	25-49%	50-75%	>75%

Combining scores for individual Dimensions into an overall Indicator score

Aggregation of individual scores. Aggregation of scores to identify overall scores for each multi-dimensional indicator was also inspired by the approach used in the PEFA. The way individual Grades are combined into the overall Indicator Grade depends on the nature of that indicator. The scoring approach distinguishes between two types of indicators:

Type 1 Indicators (with "The weakest link"): Indicators for which performance in one of the dimensions may significantly undermine good performance on other dimensions and, therefore, represents the "weakest link" *(assessed with Method 1);* and

Type 2 Indicators (with equally important dimensions): Indicators for which progress in separate dimensions is equally important and does not necessarily require equally good performance on other dimensions *(assessed with Method 2).*

Method One

The overall Grade for Type-1 Indicators is based on the Grade achieved by the dimension representing the "weakest link", with some further calibration. However, deciding which of the dimensions is "the weakest link" is done differently here than in the PEFA. In PEFA, the weakest link is automatically ascribed to the dimension which received the lowest score. In this study, the "weakest link" dimensions for all Type-1 Indicators were identified "manually", as the key dimension for determining the indicator, based on the nature of the governance functions in question.

For example, Indicator HRM-1 "Public disclosure of vacancies" covers two dimensions (1) "Importance of personal connections in learning about new vacancies" and (2) "Extent to which health workers consider lack of transparency of the health job market to be a problem and barrier to effective hiring". The weakest link for this Indicator is the second (latter) dimension. Essentially, the first question is whether the job market is working, and the governance function is to ensure that there are no significant barriers for qualified applicants to finding appropriate positions. Whatever Grade is received for Dimension 2 becomes the overall Grade, which is then calibrated to take into account performance on other less critical dimensions.

Differences with PEFA in Method 1. As in PEFA, the grade achieved by the "weakest link" dimension may be calibrated by adding a "+" or a "-", depending on the results of applying Method 2 to the other dimensions: so, if overall score is higher/lower than the weakest link, then we upgrade/downgrade the weakest link grade with +/-. Unlike in PEFA, our approach also allows to "downgrade" the overall Grade, adding a "-". This is important for our scoring because of the "manual" selection of the weakest links: unlike in PEFA, our approach makes it possible to arrive at a situation where the most critical dimension would get a Grade which is higher than other dimensions (given that it is not identified based on the lowest Grade). In such cases, it is important to use downward calibration to reflect further issues in other dimensions. At the same time, this approach also means that if a Type-1 Indicator receives "A" on all dimensions, it should be scored as only "A" rather than "A+".

Method Two

When all dimensions have similar weight for the overall result, the individual scores should be averaged. This was done in exactly the same way as in PEFA:

– Individual dimensions were assessed against the A-B-C-D scale;
– Averaging of the resulting set of Grades was conducted based on the PEFA "Conversion Table" (see below). Essentially, this table specifies an "average" Grade for any possible combination of the A-B-C-D Grades for 2-,3-, and 4-dimensional Indicators.

In the example of this section ("Competitive selection of applicants") was assessed with Method 2. Individual Grades for this Indicator equaled D, D, C, implying an overall score of D+.

Scoring: conclusions

At the end of the scoring process described above the study assigns a Grade (A-B-C-D, with + or – "adjusters") to each indicator. Such grading (**explained in detail in the Annex)** is meant to show which of the different governance sub-functions seem most dysfunctional and require priority attention (Ds), and, by contrast, which seem to perform fairly well in the health system in Ukraine (As). Distinction between C and B cases were the hardest to spell out.

The study proposes a color coding of the Results (blue=A; green=B; yellow=C; red=D, with a shading of the colors to indicate for + or -). Just as in a car dashboard, such color coding is meant to "alert" the policy makers ("the driver") of "malfunctionings " which require urgent intervention and repair.

Limitations

The study sample is not nationally representative, both in the way it was selected and due to the small numbers of interviews. In rating each of the dimensions the study aimed to go beyond the constraints of the PEFA "expert-assessment based" methodology, and to substantiate empirically its conclusions, in the best way possible. Hence, rather than simply bringing a few experts around a table to do the scoring, it was decided to run a survey. However, for the reasons explained earlier (financial constraint, the need consider confidential and specific information, building upon personal connections and trust by the interviewed health workers), the study could not carry out a quantitative survey with a statistically representative sample. It was decided to use a combination and qualitative and quantitative information, using the qualitative information to "present individual

real life stories", but analyzing the data quantitatively in order to grade the different governance indicators[28].

However, quantitative findings and therefore the indicators' ranking should not be taken at "face value", but rather as suggestive of general results. It is worth repeating that the study methodology does not bring about statistically representative results, but rather only *empirically-informed expert-based results.* These results propose a picture of several governance sub functions in the health sector in Ukraine, which can be used as a basis to engage in an informed discussion with government counterparts and all other interested stake-holders on strategies for improvement.

Figure 6. Conversion tables for Method 2 (from PEFA Secretariat, 2011)

Conversion Table for Scoring Method M2

Scores for individual dim.		Overall score M2
2-dimensional indicators		
D	D	D
D	C	D+
D	B	C
D	A	C+
C	C	C
C	B	C+
C	A	B
B	B	B
B	A	B+
A	A	A

Scores for individual dim.			Overall score M2
3-dimensional indicators			
D	D	D	D
D	D	C	D+
D	D	B	D+
D	D	A	C
D	C	C	D+
D	C	B	C
D	C	A	C+
D	B	B	C+
D	B	A	B
D	A	A	B
C	C	C	C
C	C	B	C+
C	C	A	B
C	B	B	B
C	B	A	B
C	A	A	B+
B	B	B	B
B	B	A	B+
B	A	A	A
A	A	A	A

Note: It is of no importance in which order the dimensions in an indicator are assigned the individual scores

Scores for individual dim.				Overall score M2
4-dimensional indicators				
D	D	D	D	D
D	D	D	C	D
D	D	D	B	D+
D	D	D	A	D+
D	D	C	C	D+
D	D	C	B	D+
D	D	C	A	C
D	D	B	B	C
D	D	B	A	C+
D	D	A	A	C+
D	C	C	C	D+
D	C	C	B	C
D	C	C	A	C+
D	C	B	B	C+
D	C	B	A	C+
D	C	A	A	B
D	B	B	B	C+
D	B	B	A	B
D	B	A	A	B
D	A	A	A	B+
C	C	C	C	C
C	C	C	B	C+
C	C	C	A	C+
C	C	B	B	C+
C	C	B	A	B
C	C	A	A	B
C	B	B	B	B
C	B	B	A	B
C	B	A	A	B+
C	A	A	A	B+
B	B	B	B	B
B	B	B	A	B+
B	B	A	A	B+
B	A	A	A	A
A	A	A	A	A

Source; PEFA Secretariat, 2011

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[28] Similar combination of qualitative and quantitative methodology has been used by several studies, including: i) Ahuja, R., and G. La Forgia, 2012, Measuring Governance in the Health Sector: A toolkit for Assessing Public Sector Management Functions in Government Health Agencies, Delhi, India, World Bank (draft); ii) Belli, P., Shahriari, H, and G. Gotsadze, 2004, Out-of-pocket and informal payments in the Health Sector, Evidence from Georgia, Health Policy 70 (2004); and by several publications measuring decision space and decentralization; see for example, Mitchell, A., Bossert T., 2010, Decentralization, Governance and Health System Performance: Where you stand depends on where you sit, *Development Policy Review* 28 (6).

Chapter 2: Summary of study findings

Cross-cutting themes

The financial, regulatory and administrative framework of Ukraine's health care system retains all the core features of the Semashko integrated health care model. Developed in the Soviet Union in early 1920s, this model is based on highly centralized system of publicly owned medical institutions, financed and regulated by central authorities **through uniform rules and rigid vertical command**. Only very few decisions are delegated down the hierarchy. However, over time the level of deconcentration has increased, and at present the system *de jure* looks quite fragmented, with different levels of government (central, oblast, rayon, municipal, etc.) and different agencies within the same level (for example the several agencies responsible for communicable disease prevention and control vertical programs) holding some responsibility for financing and managing health services. In addition, there are dimensions of services for which there is no flexibility, such as staffing norms and schedules, or budgetary allocation, or requirements on data collection and reporting. For other dimensions, such as individual recruitment, performance assessment, and provision of incentives to staff, Chief Doctors (the managers of individual facility) have significant power and flexibility.

At every layer of this system, and in spite of an enormous body of regulations, accountability is weak. The emphasis is mainly on compliance (with the existing plethora of rules and regulations. concerning planning, budgeting, data collection, etc.), rather than performance. Figure 7 illustrates this point. When asked if they evaluate spending efficiency, several Chief Doctors (CDs) were puzzled. They reported being completely "straight-jacketed" by the current staffing, budgetary, and data reporting norms/rules, and that resources are so scarce and so entirely committed because of these norms/rules, that any evaluation of their spending efficiency would be useless.[29] In most other cases, spending efficiency was understood as ensuring that expenditures are kept within required minima. The identification of required cuts and savings were not in any way linked to analyzing benefits and results of alternative expenditure allocations.

External audit and oversight by professional and consumer associations is virtually non-existent. Overall, medical workers provide their services with little external, bottom-up oversight of their performance. There is a lack of public access to medical statistics. There is widespread tolerance of informal payments by patients. At the same time, facility managers use in-house systems of positive stimulation, such as training and professional development opportunities, open to staff whose performance is internally assessed as successful.

As for human resources (HR) management, the study found a few seeming contradictions. CDs cannot use the best combination of human resources to achieve results (they are very much constrained by the existing staffing norms), and they assume personal responsibility for maintaining high levels of discipline in the execution of central policies, which include comprehensive reporting of medical data based on centrally imposed benchmarks. However, they can establish in-house rules of the game (for example in the area of staff selection, job descriptions, and performance assessment, utilization of out-of-pocket financial flows, and also much public procurement).

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[29] In general CDs described their budgets as highly efficient because of the extent to which their allocations were tight in the first place. Not having to make any cuts and living on the minimum was understood as leaving no space for a discussion of efficiency in expenditure. *"There is no point in evaluating efficiency: our funds are so small, we spend them on the most important things anyway."*

CDs do have absolute power in some of these areas. However, there are certain rules of this game: e.g., that almost everyone stays in the same job, that monetary payment is symbolic, that staff needs to contribute with part of their income to finance some facility recurrent expenses.

Within facilities, health workers "invest" to obtain their positions in return for opportunities for stable employment and under-the-table income. Several of those interviewed reported they had to pay to secure a job, and to retain their positions, and also needed to maintain their discipline and their loyalty to their line managers.

Figure 7. Is there an established practice for evaluation of spending efficiency? (% responses by Chief Doctors)
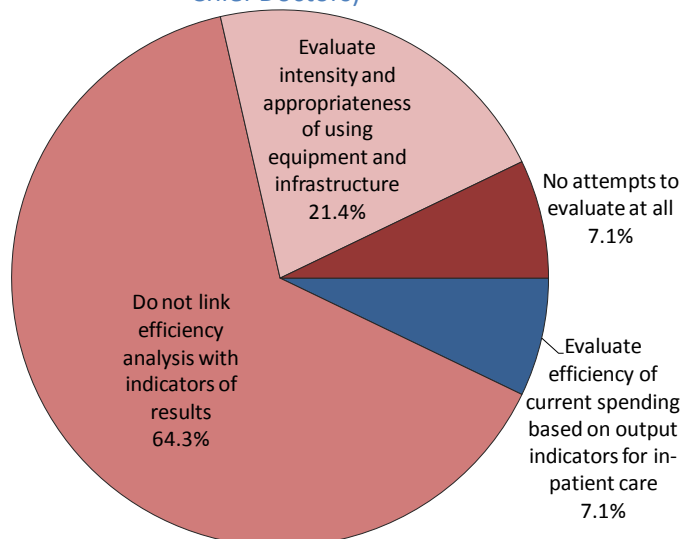
However, the study also found several cases of quite robust internal personnel monitoring systems. The question is, again, what are the purposes towards which these personnel monitoring systems are employed? Are they meant to provide incentives for good performance, or simply compliance with existing rules, regardless of their significance or rationale? Strong "in-house" control instruments need to be used to guarantee better long term career prospects for higher achievers, and we found that this is not always the case. However, the fact that CDs in many situations seem to be doing a relatively good job in keeping the hospital afloat could provide a good basis for future reforms. If the reform agenda is towards greater autonomy for provider facilities, together with greater accountability for performance, this study shows that Chief Doctors could run the system successfully.

The chapter on information management clearly illustrates that the health system does have well-established, albeit inefficient, processes for data collection, but the use of this data is limited at all levels, including, frontline service provision, facility management and local strategic healthcare planning. Collected data is not always realistic, useful, or trusted. Most of this data is not really used for decision making. Individual electronic patient records do not yet exist in most facilities.

Altogether in terms of study findings the picture emerging from the report is a worrying one, although there are some areas of strength the government can capitalize on. The sector seems to be in a low equilibrium trap. The health personnel are "at the mercy" of the Chief Doctors, the CDs are under the constraint of strict and unrealistic budget and staffing norms, the Treasury is constantly worried about theft and misappropriation and hence does not let go of input norms, the Ministry of Health (MoH) requires detailed data so that it can claim to exercise oversight, but does not use it de facto and cannot trust it either, the patients supposedly get free health services as guaranteed by the Constitution, but *de facto* need to pay "under" or "above" the table for almost everything.

In this environment, everyone seems to be trying to "survive", rather than to improve the functionality of the existing system. As a result, the interviews returned a picture of a healthcare system that is highly static with almost no mobility between positions and facilities, and with almost no initiative to introduce new management, or budgetary, or information management practices. When a new central regulation is introduced, such as those concerning Program Based Budgeting, everyone adjusts to the new requirements without changing the substance of established routines. The HR arrangements are usually maintained through informal incentives and rules, including personal patronage, favoritism or even literal dynasties with high entry barriers. People tend to work in the same positions where they started their careers until they retire or die.

In addition to the above overarching findings, the study provides an in-depth analysis of four key service delivery functions, namely HR management, planning and budgeting, information management, and procurement. These findings are presented in respectively, Chapters 3, 4, and 5, respectively. The 6th chapter, on procurement, is still been developed and will be available by the end of June.

Here we present a brief summary of findings for each of the other three governance functions.

Human Resource Management

Lack of transparency and competition in hiring

The job market in government-funded health facilities is opaque: vacancy information is not publicly disclosed, and people mostly learn about available positions through private connections. Lack of information about vacancies is considered one of the top-three barriers to effective hiring by most health workers, and most frequently health professionals learn about new vacancies via personal connections[30].

Recruitment and promotion decisions are made almost exclusively by the Chief Doctor (CD). While frequently Heads of relevant Departments are also involved in the selection process (for example they may propose applicants or be consulted on his/her qualifications), the final choice is still made personally by the CD. As was stated by one respondent, "*appointments are made by the Chief Doctor and it all depends on his whims*". The overwhelming role of Chief Doctors in the selection process is implicitly endorsed by the current legislation, which does not require consultations for facility-level appointments:

– Situations in which there are more than one applicant per post are not addressed and not regulated. Essentially, current legislation assumes that appointments are based entirely on the simple qualifying examinations, using the documents which should be supplied by all applicants who apply for healthcare jobs.

– Most of the Chief Doctors and administrators who responded said that competition for positions is very rare. Some of them said they never faced such situations even after more than 20 years. A significant proportion of appointments are made through direct allocation of graduates and interns by healthcare authorities. In other cases, there is usually only one applicant. Moreover,

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[30] Even if it is not through connections, health workers would usually learn about any available positions by arranging personal communication with the HR department or the Chief Doctor of specific hospitals. Frequently applicants search for jobs simply by visiting particular facilities and asking about vacancies either in the HR department or talking directly to the CD.

applications are frequently "supply-based": doctors or nurses often apply for jobs not so much in response to advertised vacancies but rather because of their own changing circumstances (such as relocating to another town). Such prospective applicants address their enquiries to the Chief Doctor and, if vacancies exist, they become single applicants for available positions.

- Only a third of all Chief Doctors were able to explain what procedures they use to choose between applicants if there is more than one. Most administrators found it difficult to answer this question or admitted that there are no procedures and rules. Of those who were able to explain their approach, most focused on the checks of qualifications and previous experience.

Some respondents mentioned competitions organized for healthcare positions by the relevant municipal administration. Notably, doctors and nurses interviewed in the same cities shared a skeptical view on the transparency and effectiveness of these competitions, doubting that they always result in fair and merit-based appointments.

Figure 8. % Choices of top-three barriers in hiring
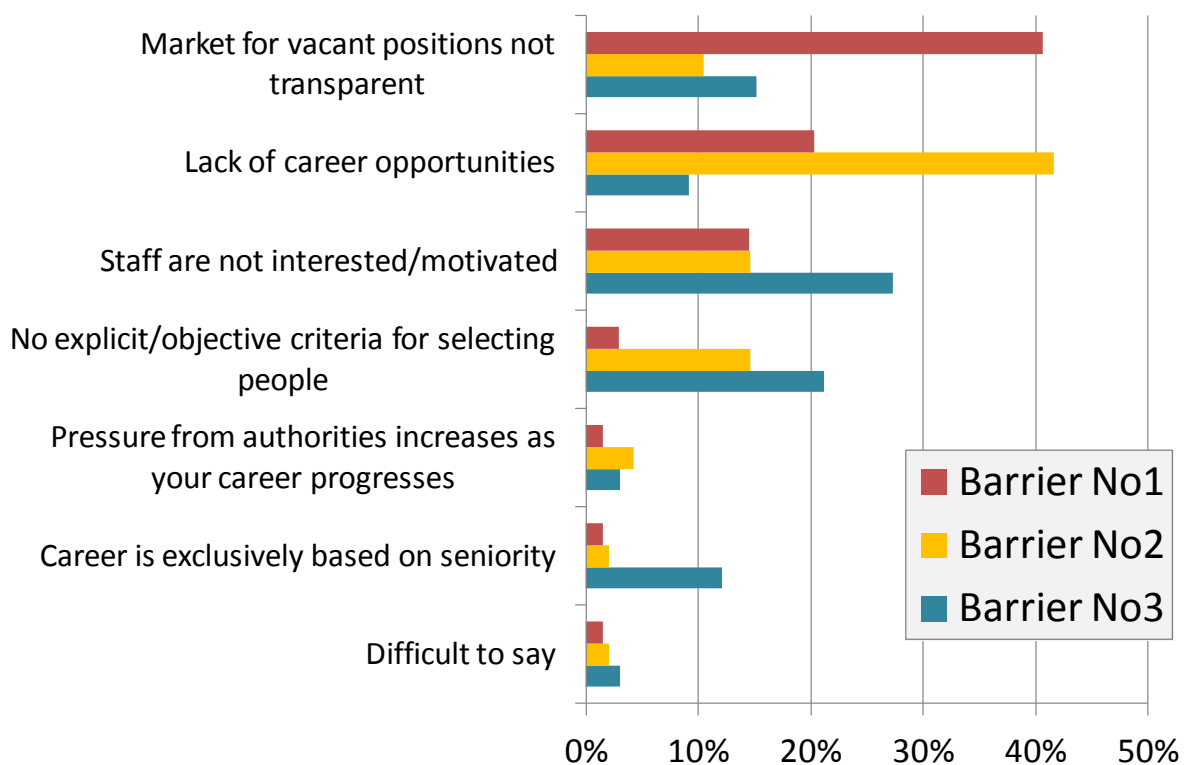
Patronage plays a decisive role in medical appointments, especially for attractive positions.[31] In a majority of cases, respondents explained that it is nearly impossible to get a job without connections, even though professional qualities might help to ensure that a particular person would be selected from several "recommended" applicants. *"To be honest, getting a job requires some connections, some support, and sometimes an informal payment. Getting a job without these additional means is very rare and only happens when, for some reason, the hospital urgently needs to fill some positions, for example, if it has to open a new department".*

Figure 9. Views on importance of merit-based criteria cross-tabulated by position	Figure 10. Views on importance of merit-based criteria cross-tabulated by facility level
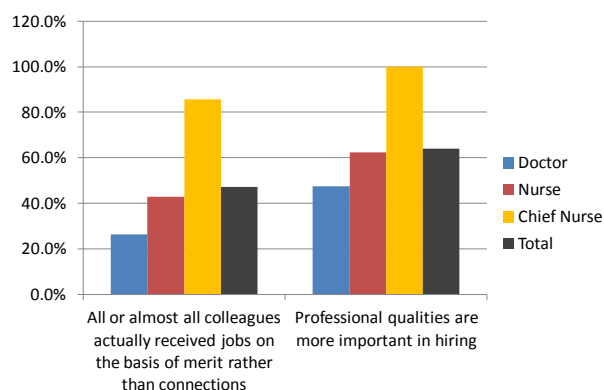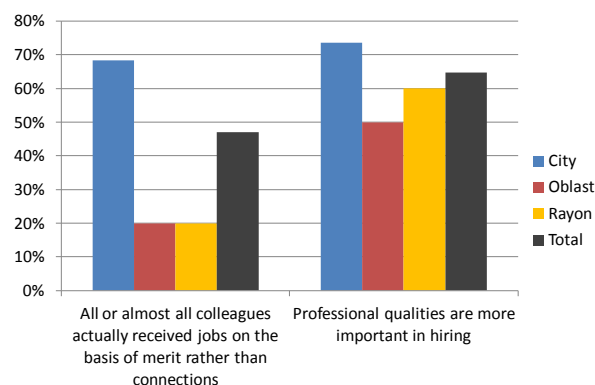
Other responses indicate that the healthcare system is characterized by an overall high degree of "compartmentalization" with extensive groups of people connected personally. Descriptions of recruitment procedures by doctors and nurses contained many references to the pervasive scale of connections and significant entry barriers into these circles. *"We have these big dynasties here; the father is a surgeon, the son is a surgeon etc, and everybody knows them, and know the decency of the father, and that the sons are always like their fathers".*

Static employment structures and limited professional mobility

The career development system in Ukraine's healthcare system offers limited opportunities for professional growth. The only real career advancement for a doctor is if he/she takes up managerial responsibilities (implying a significant change of career direction), while other career growth opportunities within the medical field are less visible and appealing.

A majority of doctors and nurses admitted that they have no interest in pursuing currently available career opportunities, claiming that current opportunities are either unattainable (44.4%), or not appealing (19.4%), or non-existent (8.3%): *"Moving anywhere within the facility is impossible. Mostly, people work their whole life in the positions they start in – and they remain there until they retire. There is no career growth. But no one is really bothered by this in any way."* Another quarter of the respondents explained that for most doctors their career is not important because they are interested in other aspects of their work (higher income, more patients, private practice etc.). Only 2.8% described career growth as an important goal towards which most health workers aspire.

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[31] Although the official salary of doctors in Ukraine only slightly differs depending on their position and specialization, out of pocket income depends directly from the doctors' field of expertise. For example such specializations as dentist, gynecologist, and surgeon are considered to be attractive, as these doctors are in big demand. Unattractive positions are those like therapist, phtisiologist, etc.

Figure 11. Attitudes of doctors and nurses to the current career opportunities
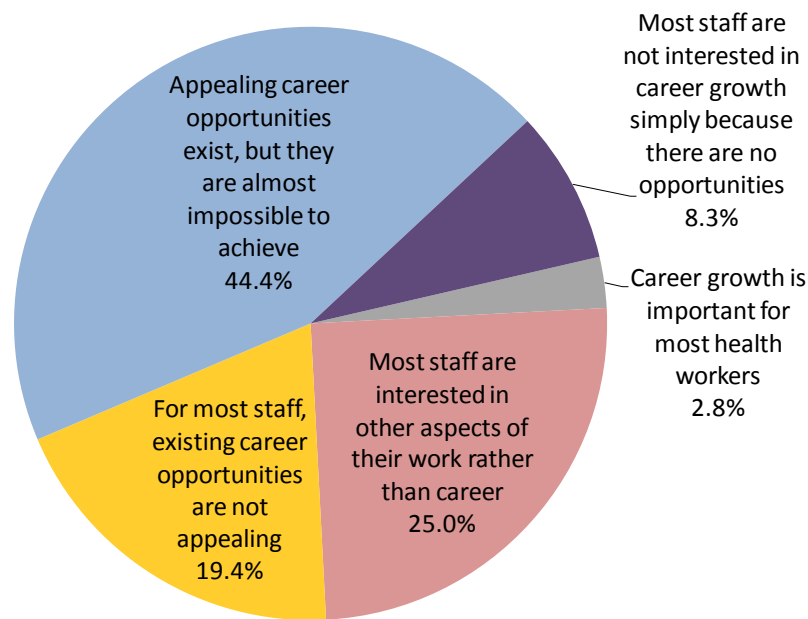
Turnover rates for all major types of medical staff are also extremely low. Actual annual turnover rates quoted by the interviews were negligible, in the range of 4-8 percent, much lower than the national turnover average of 29.75% across all sectors, according to official government statistics.

Figure 12 Average reported annual turnover rates for major types of health workers for 2012 (responses by Chief Doctors)
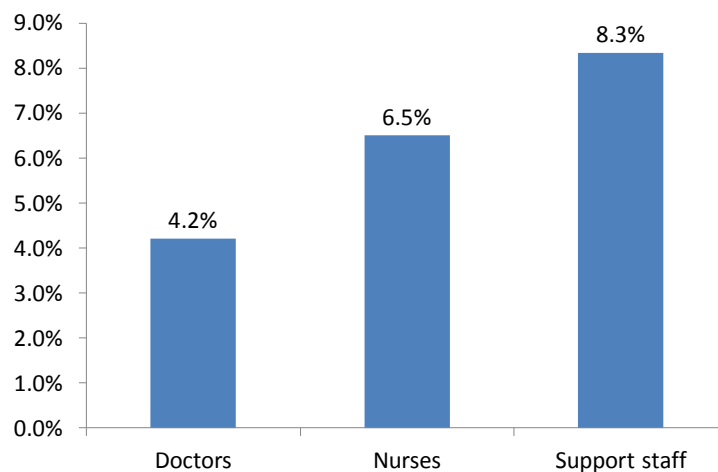
As Figure 12 indicates, the lowest level is reported for the doctors (4.2%), a somewhat higher level for nurses (6.5%) and the maximum amount – for the support staff (around 8.3%). While this low mobility minimizes direct and indirect costs of finding potential replacements, such low levels of professional mobility are also highly alarming, because they show that medical professionals find it very uncomfortable to ever leave their positions. Even more dangerously, very low turnover can be a symptom of other hidden benefits enjoyed by remaining in the same organizations: workers may have to "invest" in their positions and these "investments" maybe lost (they are "sunk costs") if they resign.

This finding resonates with the statements by many doctors about the need to make diverse and regular contributions to the operation of their facilities and to invest in establishing good relations with the facility management. Moreover, the study found that benefits of staying in the same position and not moving are much higher for doctors as compared to other health workers such as nurses.

The risks of low turnover are not recognized by the healthcare managers, who generally consider it to be a positive sign of stability. Of all the Chief Doctors interviewed for this study, only 21.4% were able to provide estimates of turnover rates in their facility for doctors, nurses and the support staff, in spite of well developed personnel registration system.

Day to day personnel management systems within facilities

Managerial practices of in-house day-to-day operations governed by the Chief Doctors and involving facility staff are in the majority of facilities visited rather robust. Most facilities use effective in-house systems of staff accounting (there are no ghost workers, and absenteeism and moonlighting are rigidly controlled[32]), performance assessment, training and development. Robust facility-level staff accounting systems are a useful tool for facility managers. However, they can be used for good as well as for questionable purposes.[33]

- **A majority of facilities use a combination of formal and informal evaluation systems, which are perceived by the employees as generally useful**. Most doctors and nurses confirmed that their organizations use a range of useful measures to assess staff performance. To an extent, this is linked to the need for both the facility and the staff to gain formal acknowledgment of their satisfactory performance to maintain their professional certification level (the facilities need to be accredited every 3 years, and the health workers need to be re-certified every 5 years).

- However, facilities often use additional in-house performance indicators and monitoring systems, as well as informal feedback channels such as facility conferences, individual discussions and mentoring. Most of the staff (83.3%) found these systems useful because of the learning opportunities they provide (a majority of doctors receive their reward in the form of increased accessibility to training opportunities), as well as because of the impact on individual and collective morale.

- Most of the interviewed doctors and nurses believe that good performance is generally rewarded in a relatively fair and transparent way. Only 21.2% of interviewed doctors and nurses expressed highly negative attitudes to the current system of positive incentives: 7.6% stated that achievements are not rewarded at all, 9.1% believed that criteria for rewards are arbitrary and opaque, without clear links to good performance, and 4.5% admitted that it was difficult for them to explain what criteria their management is using for the provision of rewards (see Figure 13). In most cases, doctors and nurses explained that rewards are given for regular good performance and for extraordinary achievements. Two thirds of the doctors and nurses interviewed agreed that heads of their facilities encourage department heads to praise their teams and to incorporate various intrinsic rewards into positive stimulation systems.

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[32] Interviewed facility managers felt very confident about their knowledge of possible moonlighting or staff working elsewhere during their regular working hours. In all cases (100%) Chief Doctors stated that their facilities use detailed registers of all workers which allow them to closely monitor moonlighting and dual practice. As a rule, these systems included personal identification numbers for all doctors and other medical workers. Importantly, almost all managers said that they believe they would always know if any of their employees was combining jobs and working elsewhere.

[33] On the one hand, doctors and nurses find it nearly impossible to quietly combine jobs at the cost of their regular hours. This helps to reduce the risk of resource outflow and ghost-working. However, there was some evidence that since facility managers have strong control over these systems, they may actually abuse them for their own benefit (for example, deliberately arranging ghost-worker positions for doctors who have political patronage).

- Most respondents identified some relationship between performance and rewards, but the strongest link was through informal evaluation and through informal, "soft" stimulation. In 78.8% of cases, doctors and nurses reported that performance evaluation systems used in their facilities have at least some impact on the rewards they receive (on salaries, training opportunities, promotion chances or any other opportunities and benefits), but informal evaluation seems to have much stronger impact. Informal rewards include: an opportunity to take a day off when needed, flexibility in choosing vacation time and a chance to take it during the summer, good attitude, authority, prestige, letters of recognition and letters of gratitude. In many cases, respondents also mentioned a stimulating opportunity to participate in local (municipal and oblast) competitions for the title of best specialist (doctor or nurse).

Figure 13. What are the usual reasons for positive stimulation? (% Responses by Doctors and Nurses)
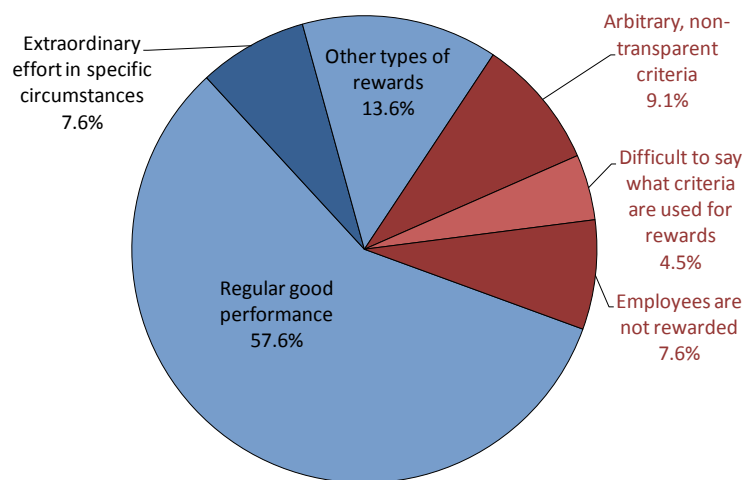
Training opportunities are limited but highly appreciated

The study found that most facilities use whatever opportunities are available to them to ensure regular training for their staff, even though the scope and quality of this training is limited. The majority of doctors and nurses interviewed for this study have received more than one form of regular professional training, and most of them stated that it had a significant impact on their work.

- **The main training program covers mandatory professional training required as a core eligibility requirement for 5-year recertification to receive "qualification categories"**. Interviews confirmed that this mandatory training is duly attended by all professionals with qualification categories (91.4% of all doctors and nurses). Most health workers provided positive feedback about this training and found it very useful. However, compared to facility-based and external events, mandatory state training received the highest number of critical comments.

- **On top of mandatory recertification training, almost every facility runs a range of internal training and development activities**. These activities include workshops, seminars, shadowing schemes, lectures and presentations. Participation in such activities was confirmed by 88.6% of doctors and nurses. In comparison to state courses, internal training was found to be much more relevant: about a half of the doctors and nurses said that the content should be fine-tuned, the other half said that the content was entirely adequate to their needs.

- **A majority of health workers also reported attending external training.** These courses included a range of conferences, seminars and workshops, mostly held outside of the facilities. A significant share of these events appear to be organized and sponsored by pharmaceutical companies, but doctors and nurses also mentioned other distinct training and courses funded by other sponsors (for example through fellowships) or by the staff themselves.

- **Apart from training sponsored by pharmaceutical companies, staff need to secure funding for all other external professional development activities**. In approximately one quarter of cases, respondents paid for their additional training themselves, and in one third of cases they were able to attract other external funding sources such as scholarships. Facility management is generally supportive to their staff attending self-funded external training but such goodwill may be used as an opportunity for positive stimulation (some of the travel costs may be co-funded) or punishment (if the person is refused required academic leave).

- **While training is highly valued, it is not sufficient.** Generally, existing training programs seem to be less relevant for professionals with higher and narrower specialization. Among the respondents, doctors were generally more skeptical about the quality of existing training compared to the nurses. In interviews, respondents explained specifically that, many courses and conferences were either too broad, or too narrowly focused. Moreover, many doctors stated that the only way to achieve really good quality training is to seek training abroad, because domestic medical education was perceived to be outdated and irrelevant.

- **One popular way of achieving professional development is to moonlight in more "advanced" facilities.** As in high-income countries, doctors in Ukraine frequently use opportunities of additional employment not only for immediate income maximization, but for achieving more strategic payoffs, such as gaining new knowledge and experience from working in more advanced facilities. This is one reason why facility managers in Ukraine express no concerns over the impact of moonlighting and often find it very useful.

Low official pay levels and their diminishing importance

Respondents estimate that, on average, current salaries of doctors represent only one third of the level needed to retain and sufficiently motivate qualified professionals (see Figure 14**).** The average ratio between current doctor salaries and the estimated amounts which respondents believe would be sufficient to hire well-motivated and highly qualified staff to doctor-level positions is 31.5%.

The estimated competitiveness of salaries for nurses and support staff is somewhat higher but still less than 50% of the market level. Estimated ratios between current salaries and market level remuneration for nurses and support staff are respectively, 35.8% and 42.6%. For these professions, responses were generally more positive, with larger shares of health workers estimating current salary ratios as being in the range of 25%-50% and 50-75% of the market.

Respondents strongly advocate making salaries more sensitive to differences in qualifications and more results-oriented. While many doctors and nurses wish their salaries were higher, the most popular appeal was not so much to increase salaries, but rather to change the way they are defined. Most respondents believe that current salary system is not effective because there is a weak link to performance and to differences between positions, experience, education and other professional merits. Linking remuneration levels to some indicators of results would be an immediate and very important step for increasing staff motivation. However, respondents often clarified that rules of such results-based calculation should be very transparent and clear to all, because the risks of abuse are high.

Figure 14. Estimated ratios between current and desirable wages (% of responses by doctors and nurses)
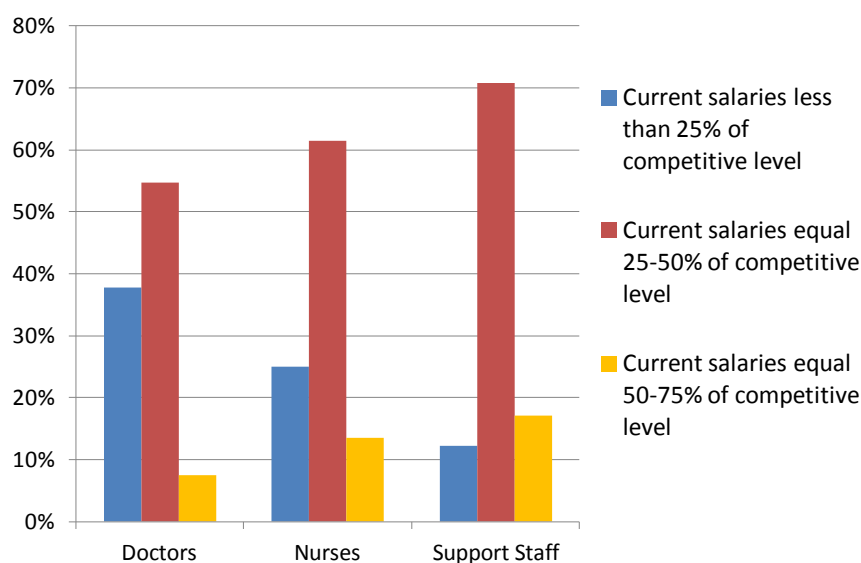
Many health workers do not consider official salaries to be a factor in professional decision-making. A very large number of health workers believe that low salaries as such do not affect their professional decisions or the quality of existing service provision. Doctors and nurses explained that, at present there is a widespread attitude of resignation about the poor salaries of medical staff and that, as a result these very low levels have no impact on the way people do their jobs. In some cases, this is explained by the lack of alternative employment opportunities. However, most usually this relative complacency points at the presence of under-the-table incomes which are more important than official salaries.

The diminishing importance of official income is supported by the fact that many doctors find it more important to have access to good equipment and offices, than higher formal salaries. As one of the doctors stated, *"Stalin said, give doctors a symbolic payment, and let them earn the rest. And this principle operates to this day. Sure, official salaries must be decent, but it will never happen in this country, it is simply unrealistic."* When asked to assess the effectiveness of the current remuneration system, many doctors explained that salaries as such do not really matter, and that it is more important in their view to be able to use good equipment and quality medical supplies: *"Of course salaries should be increased; but we also need good equipment. We need, for example, high quality chemical agents for our labs. Because we have three laboratories and they each produce different results, our patients get confused."* The fact that many doctors prioritize equipment as a more important factor than salaries is also reflected in the answers of Chief Doctors on the question on what is normally considered "good working conditions" among their employees. Access to reliable modern equipment received the highest priority (82% of responses), compared to only 55% respondents mentioning adequate salary.

Detection of mistakes lacks clear rules and external judgment

The majority of respondents stated that systems for detecting and punishing poor performance were effective, but many were skeptical. Most doctors and nurses consider existing systems for detecting and punishing poor performance relatively effective, with most mistakes revealed and current punishment methods usually helping staff to correct errors and modify approaches.

However, a significant share of respondents were skeptical, saying that mistakes are identified either rarely (25.8%) or never (3.0%). *"It doesn't work at all here. Because our system is based on the concept of medical corporativity and loyalty of employees. We don't take our problems outside. Unless it gets so big that they will show it on TV."*

While respondents could name examples of problems and their related sanctions, they found it more difficult to outline clear rules for identification and treatment of such cases. Only half of doctors and nurses interviewed were able to refer to a specific government policy describing the general approach to identification and dealing with poor performance. Some said that *"It is all individual"*, *"It all depends on the Chief Doctor and the resulting discussion"*, and that *"the choice of the concrete form of punishment is arbitrary because all cases are different".* Many respondents were certain that some document must exist *("The management MUST have some document, surely nothing is done without an underlying document in our system")* or even named departments or units who would have it (*"This document is available from the Unions Office / HR department / Legal department etc."*). However, only in few cases could interviewees actually explain a clear, universal and consistent rule which was applied in their organization. **Less than a quarter of doctors and nurses felt that medical staff are not in any way protected from mistreatment and unjustified punishment, while about half feel somewhat unprotected.** Notably, one of the biggest risks is the probability of a complaint by a patient. There are essentially no regulations which would protect doctors in such cases or which would allow appeals to third parties for an external opinion.

Planning, Budgeting, and Financial and Performance Management

Central mandates: inconsistent but diligently applied

Most of the public spending on healthcare in Ukraine is delegated to sub-national budgets. Local governments are the key players in the country's public healthcare system, spending over 80% of its public budget. This means that the key spending units responsible for these programs are sub-national administrations rather than the line ministries. While central ministries (which are themselves key spending units) do provide some services directly (via some central programs), these expenditures are much less significant. Local budgets receive a considerable share of funds through transfers from the central government, as Figure 15 indicates.

Equalization transfers that include healthcare funding are allocated across local budgets based on demographic variables (mostly population-based).

While funds are spent at the local level, the decisive authority is not with local governments. There is a sharp mismatch between administrative and financial responsibilities at the local and regional level. Local administrations have very little discretion in allocating funds and administering programs. Decision-making (including facility-level budgeting) is subject to a rigid vertical structure of input norms imposed by ministerial orders. Local governments are requested to respect staffing norms and finance vertically protected recurrent spending items on a priority basis. This includes public wages, which absorb the large majority of their budget envelope for the health care sector.

Rules for preparing facility budgets in Ukraine are elaborate, strict, and input-based. As stated by one of the Chief Doctors, *"The key thing you need for budget planning – is time and lots of tedious, diligent work."* Budget requests must comply with a range of regulations, covering precise rules, for example, governing the number and type of staff which can be employed, exact salary levels, and other types of possible expenditure items. There are detailed instructions (norms or formulae) for how these should be defined, based on the facility input statistics, such as the number of beds and patient visits. In these calculations, facility executives must also follow detailed templates and steps, involving considerable administration, which are explained in Box 9 in Chapter 4.

Figure 15. Consistently important role of sub-national budgets in Healthcare spending (2004-2012)
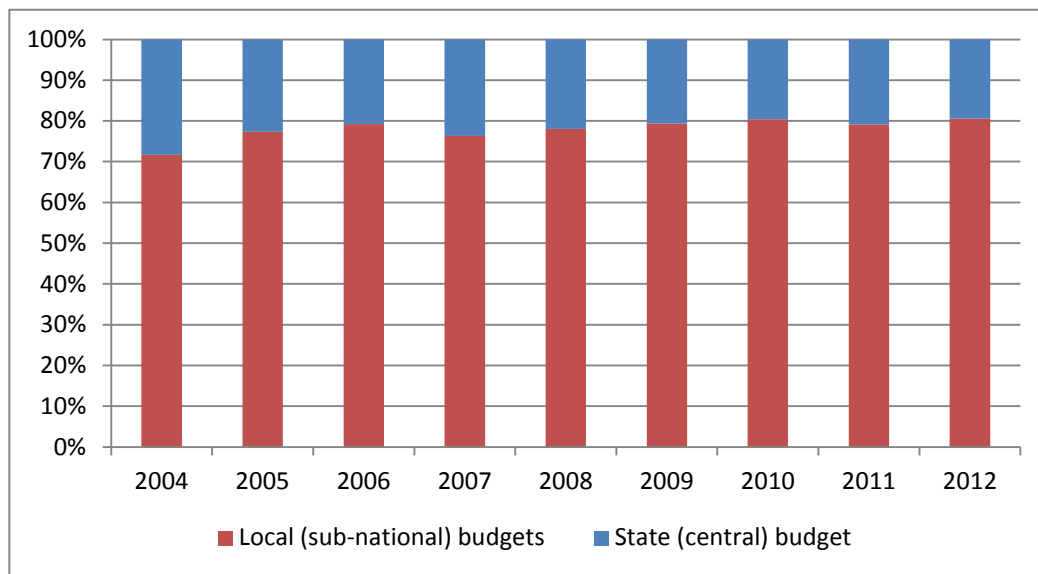
Source: State Treasury of Ukraine

Figure 16. What share of mandatory expenditures usually falls within available budget ceilings? (% Responses by Chief Doctors)
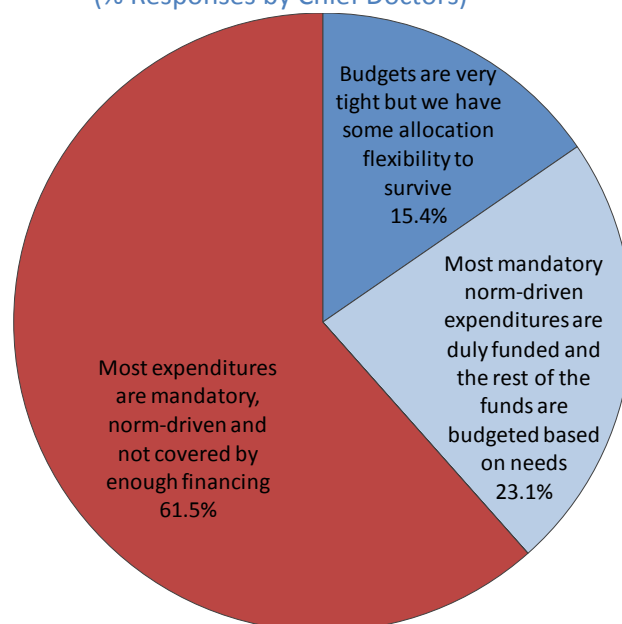
Healthcare facilities find themselves at the frontline of the "mismatch" between available resources and service delivery mandates, absorbing the resulting "unfunded" costs and, where possible, shifting them on to the patients. Administrators need to not only present their budgets, respecting impossible norms, but also find a way to actually provide services within their budget envelopes.

Faced with unfunded mandates, all facilities need to find some way to reconcile imposed norms and mandates for service delivery with their fiscal reality. Facility managers are personally responsible for submission of legally accurate budget requests which comply with all existing requirements. While there is no formal guidance on how to achieve this, the dominant approach is to use creative templates which reflect all requirements but also calculations which "transform" imposed expenditure and service delivery norms into actual norms within the budget ceilings. In addition, pervasive resource deficits at facility level prompt administrators to search for alternative ways to resource their service provision. Funding shortfalls are often collected through personal contributions by doctors and/or patients.

At all stages of budget planning and execution, expenditures are monitored and controlled by the State Treasury Service, a central executive authority. Facility executives agree that that the system of Treasury controls makes it impossible to commit outside the budget appropriations, which is a good practice. The State Treasury cross-checks budget commitments when the budgets are designed. It also monitors budget ceilings in the monthly breakdown, thereby coordinating cash flow forecasting and management at the level of each individual facility. Once the budgets are approved, the State Treasury undertakes several rounds of cross-checks for each of the payment requests against budget appropriations, approved expenditure lines, and monthly ceilings, before the funds are released. Compliance with these requirements for all of these verifications is strictly enforced. In general budget execution practices are robust, as PEFA found (see Box 1) and as also confirmed in our study.

Figure 17. Average deviation of allocations from approved budgets and actual spending from received allocations
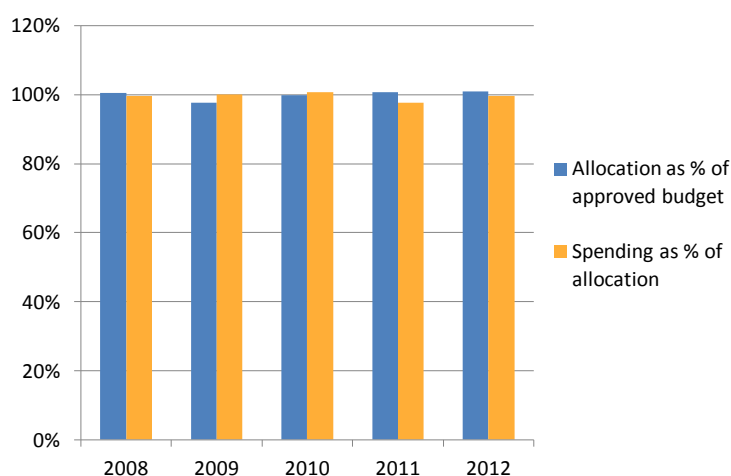
All facilities are also subject to controls and audits from several agencies (see Chapter 4). The prescriptions of these audits are usually followed up. The overwhelming majority of respondents listed a range of follow up actions from the inspections they are subject to. 92.3% of interviewed Chief Doctors stated that some follow-up took place. The range of measures usually follows the procedures specified in the legislation. Some of the recommendations made by the inspections are questionable, and they are not always mindful of the available funds for implementation of recommendations. In several cases, these recommendations actually led to visibly negative results (for example, based on outdated central regulations, facilities were requested to apply inappropriate chemicals to modern equipment, which was then damaged as a result, or to invest in highly cost-inefficient purchases: see Chapter 4).

Facility budgets and cash flow forecasts are generally credible, even though cases of changes and delays are growing. During the last decade, Ukraine has made a dramatic progress away from multi-

year arrears in the public sector at the end of 1990s. With the economic and fiscal recovery which began in 2000, arrears were gradually repaid and essentially ceased to exist. While the Government reported no new budget arrears during the 2008-2010 economic crisis, fiscal pressures in the economy have built up. Official statistics on public wage arrears are not publicly available,[34] but healthcare trade unions reported growing delays during 2012. Most facility managers interviewed for this study confirmed that they are able to secure due funds according to the agreed budget appropriations within the monthly ceilings. However, in 23.1% of cases respondents mentioned that in recent times they had experienced delays in payments (the survey took place in autumn 2012). In their experience funds were released only for protected spending lines, while payments for any other activity were "blocked". In one case, the facility faced a 2-week administrative delay in payment for the technical inspection of an ambulance which was servicing two acute care departments, making them essentially non functional for emergency aid services. Moreover, even within protected spending lines, interviews revealed covert episodes of incomplete funding of due remuneration. Even though all salaries are formally paid out at the moment, some respondents shared alarming stories about disguised arrears (such as being sent on compulsory unpaid leave while still having to work).

Significant cost of regulatory compliance

Central legislation imposes detailed rules for budget planning, execution and monitoring, which are frequently inconsistent, and leave almost no managerial flexibility to Chief Doctors and other senior administrators. National regulations for facility-level budgeting are diligently complied with even if they impose significant administrative and financial costs. Facilities consider it a priority to demonstrate compliance with central mandates, both in terms of budget management and sector-level instructions.

At all stages of budget management, existing rules require meticulous paperwork and involve significant personal responsibility of the involved executives.

– Preparation of budgets based on "straight-jacketing" spending norms within limited ceilings involves significant paperwork. CDs complained about lack of time and motivation to invest in strategic budgeting. CDs also complained about poor motivation for planning as such. They explained that planning takes almost all of their time but has little meaning: *"all the planning is based not so much on what we want to achieve but on whatever we get to spend"; "there is no leeway to make major decisions such as buying new equipment or reconstructing facilities"*.

– The system of Treasury monitoring and control is cumbersome, results in delayed funding and imposes extreme administrative burden on facility managers. Only a few Chief Doctors said that they spend less than 5% of their time on tasks and problems related to the State Treasury, especially on payment requests verification and approval. A majority spend about 15-30% of their time of these issues, while some report allocating 30-50% or even more of their time only on these tasks. Notably, Treasury controls cover all types of revenues and expenditures of the facilities, including their own revenues such as rental payments for sublet property. This sometimes makes it difficult for the facilities to use even these theoretically more flexible sources of financing.

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[34] The State Statistics Committee has a lot of detailed medical statistics on its website, and the State Treasury does publish some information on budget execution. However, none of these bodies (or any other source) publishes data on public wage arrears. The specific statistical information which is missing is data on public wage arrears.

- Facility audits are a significant burden, and almost half of the managers believe that audits may be disruptive and ultimately damaging to service quality. A majority of CDs (68.8%) still think that the current pressure they experience because of various inspections is excessive. Reviews by the State Financial Inspection (SFI), a central internal audit authority, are particularly lengthy (taking 1-1.5 months), during which time some of the CDs said that they had to spend their full working day (and work overtime) dealing exclusively with the inspection-related tasks.

No links between resources and results

In the last decade, the Ukrainian Government has implemented extensive reforms to transfer the country's overall general budget to a performance-based budgeting (PBB) principle. The rules for budget preparation in Ukraine have been consistently modified since 2001 to incorporate the principles of linking expenditures to indicators of results. Over this period, the Government has designed detailed regulations for budget preparation and implementation based on "programs" – activities governed by a joint purpose with some performance measures. Applying this program-based budgeting principle was made mandatory for all central budget expenditures in 2010 (although de-facto the application began much earlier, in 2002). Local budget expenditures (which comprise most healthcare spending) began to adopt the PBB principle in 2007. There should be a full transfer to PBB based spending by 2014.[35]

However, superimposing PBB on the top of an input-based budgeting system makes it difficult to truly link inputs to results, even where program-based accounting is duly implemented. The PBB should be based on accountability and achievement of results, but because of continuous attempts at controlling inputs rather than results, the PBB budget formulation risks of becoming a tokenistic exercise. The PBB system in Ukraine coexists with a wide range of rigid line-item regulatory requirements, such as detailed spending norms for individual expenditure items and spending priorities mandated by the central ministries. Our study clearly shows that these line-item requirements dominate the process of budget preparation, even though, in the end, the resulting budget totals are grouped into programs and approved in the program-based classification breakdown.

Program-budget accounting is perceived by the majority of facility administrators as an additional layer of bureaucracy rather than a useful management approach. Given the need to comply with expenditure norms and protected spending requirements, facilities find it difficult to meaningfully apply results-oriented budgeting principles.

Almost no Chief Doctor interviewed by this study appeared to be aware of the core objectives behind results-oriented budgeting, even when their facility was already operating under PBB. When asked what share of their budgets was designed by result-oriented programs as opposed to pre-defined formulas, negotiations or some other method, not a single Chief Doctor said the program-based principle underlies any part of their spending decisions at all. An overwhelming number of managers said that they define their expenditures by a precise input-based formula (64.5%). The rest said that some sort of formula dominates their calculations but they have a smaller share of the budget allocated by some alternative principle: either through an incremental adjustment to historical trends for similar budget lines or by keeping a small share of the budget flexible for any needed discretionary spending. These responses were given even by those Chief Doctors who use PBB accounting in their facilities during the budget process.

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[35] MoF Order No 805 of 02.08.2010 "On Approval of Key measures for introduction of Program-based method in planning and implementation of local budgets" clearly describes the sequence of PBB introduction and commits to full transfer of all local budgets to PBB by 2014. According to MoF, hundreds of local budgets are already "using elements of PBB". This is not confirmed in our study (see Chapter 3), even if two oblasts in our sample were precisely the ones where the PBB experiment was supposed to begin (Lvivska and Luhanska).

Nature and scale of private payments

Ukraine's healthcare system is mostly tax-funded, but with a considerable share of out-of-pocket payments, both formal and informal, consistently measured above 40 percent of total health expenditure, or approximately 3 percent of the country GDP by all household based surveys conducted over last ten years (see State Statistics Service of Ukraine, 2011). Ukraine's healthcare is funded from the general budget even though proposals for mandatory social insurance have been debated for several years and it is outlined as a strategic goal in the current healthcare reform strategy. The size of Ukraine's private healthcare market is marginal, both in terms of provision and in terms of private insurance funding. Voluntary private insurance covers less than 2% of the population, and many of the insured services are still provided by the public health facilities given the extremely small size of the private provision.

The legality of fee-based healthcare services is subject to an on-going constitutional debate. The possibility of formally charging patients directly at the time when they receive services in the public medical facilities has been debated since 1996. Fee-based services are allowed by a range of current regulations (including the Budget Code), but they contradict Article 49 of the Constitution, which states that all healthcare should be free of charge.

Any funds raised by the facilities must be fully accounted for in their reports, and clearly earmarked; off-budget revenues are not allowed. The study found that all facilities routinely collect private payments which they have to formally reflect in their fiscal reports; the Budget Code allows facilities to receive and spend additional *"Own Revenues"* but these must be fully accounted for within the Facility's Special Fund[36]. Moreover, the *Budget Code* clearly classifies possible sources of *Own Revenues* and exact types of *Own Expenditures* which could be covered from respective own sources. These stringent regulations increase the attractiveness of not reporting private payments.

More than a half of the interviewed Chief Doctors stated that formal private payments represent one of the three biggest items of their own-source revenues. Although fee-based services are not always the primary source of revenue, they are always significant and often outpace any other types of own revenues such as rental payments. Specifically, "additional services" have been chosen as the biggest own revenue by the highest percentage of Chief Doctors. Charity contributions did not feature highly in most facilities, but some did use them extensively, for example, facilities which provide services for children are not allowed to provide any fee based services, and charity contributions are used as an alternative way of accepting and accommodating private payments. For most formal fee-based medical services, pricing mechanisms are usually transparent and universal within oblasts (approved by relevant oblast administrations).

Although budget-funded facilities are required to account for all their financial flows on the Treasury accounts, at least some of them use additional entities to accept other private payments. A significant share of the facilities visited in this study ran separate, off-budget entities which enabled the collection and use of some of the private contributions. These entities were usually registered as charity funds, with separate accounts in commercial banks. For many facilities, the scale of such off-budget operations may be very substantial (sometimes larger than the overall facility budget).

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[36] The *Special Fund* of the facility budget includes a list of revenues and expenditures which are clearly defined by the legislation. The revenues must be clearly earmarked for a specific purpose and expenditures must fully coincide with the respective revenue sources and their authorized purposes. Any actual expenditures from the *Special Fund* can be made only within actual receipts of respective earmarked revenues.

Most facilities regularly collect informal private contributions to facility operations from their staff (about a third of the official monthly wage). These are most likely passed on to the patients. 58.8% of the interviewed doctors and nurses admitted that they have to contribute some personal funds informally to support facility operations. In our sample, the average size of the latest contribution was remembered as UAH 592 (median – UAH 100, mode – UAH 50), but individual cases ranged from a minimum of UAH 2 to the maximum of UAH 10,000. This average monthly contribution of UAH 592 represents 32.9% of reported average official wage of doctors and 43.8% of reported average wage of the nurses. In 61.3% of cases, the payment was a regular contribution, rather than a one-off payment. Some of these contributions were in cash, while others were collected in the Charity Funds operated by the facilities (in one case, it was a monthly UAH 5 contribution to the Fund by all employees). Most usually, collections are used to buy stationary and various supplies (instruments, bandages, tests, etc.), as well as for refurbishment and reconstruction of the facilities. However, in many cases the purpose of raising the money is not entirely clear.

The above evidence points at the fact that doctors and other medical workers first collect from patients, and then have to share their revenues obtained through patients' OOP with the hospital administration.

Information Management

Elaborate multi-layer systems for generalized medical reporting

Data collection and processing in Ukraine's facilities is fairly well organized and follows a standardized pattern. The national regulatory framework for medical data collection in Ukraine is elaborate and detailed. Precise forms for primary and generalized statistical reporting are highly standardized and regulated centrally by the MoH. There are also strict guidelines for how the forms should be completed and processed.

Overall, the MoH uses 246 mandatory forms and templates for primary recording and generalization of medical statistics. Generalized statistics are compiled in the MoH Center for Medical Statistics (CMS) through several reporting lines, which involve sub-national offices of the CMS and local healthcare authorities, but also other organizations such as Sanitary and Epidemiological Service (which tracks data related to particular infections, vaccinations, environmental public health risks) and the Medical Investigation Service.

Interviews confirmed that these universal guidelines are diligently applied. The overwhelming majority of Health Management Information System (HMIS) specialists stated that the statistical information they produce is standardized according to national requirements, and only some mentioned difficulties relating to the complexity and lack of clarity of these requirements. Moreover, in line with the current guidelines, medical statistics are collected for aggregation at the national level.

Poor cost-efficiency of data collection process

Medical information gathering in Ukraine is achieved at a substantial cost. Half of the facility statisticians believe that data processing requires excessive paperwork which is one of the key barriers to compiling good quality data.

Computerized systems are almost never used at the level of primary data collection. As a general rule, primary medical records (medical cards of individual patients) are paper-based, but generalized statistical reports are standardized and generated automatically with the help of specifically developed software "Medstat." In order to produce these generalized reports, some facilities may

choose to use electronic means of keeping primary medical records which can then be transferred onto automatic systems for generating the statistical reports. However such cases are rare.

Facility staff, including doctors, spend a disproportionate amount of their time on paperwork related to statistical reporting. Many of the statistical specialists believe that the workload exceeds their capacity and makes it nearly impossible to manage tasks effectively. Moreover, more than half the interviewed doctors and nurses said that they too find statistical duties excessively time consuming and the format inconvenient. On average, doctors and nurses reported that they spend 8.5 hours a week on data recording and processing (i.e. about 1/5 of their work time). A popular example of unreasonable workload related to collection of data is the use of "statistical slips". These paper summaries of key data for individual patients are used for primary data collection. In many facilities, the data are aggregated by manually sorting the slips (for example sorting the slips by types of diseases rather than using software applications and in-build automatic filtering). This is often delegated to doctors and nurses. It requires significant time, and is very difficult to verify.

Facility HMIS staff are frustrated both by the lack of hardware as well as by problems with current MoH IT applications used for generalized reporting. Most of the facilities say they wish they had more computers, but many are also concerned about weaknesses in the software they currently use for the production of the standardized reports. Some are experiencing problems because some necessary applications are not available on the MoH software, while others explain that existing applications are not always compatible and relevant.

In many cases, HMIS specialists believe that the focus of their MIS tasks is misplaced: effort is inefficiently spent on unnecessary activities. Less than half of the statistical specialists in the facilities think that the tasks which take most of their time are those which also make the biggest difference. The task which takes most time is the organization of the data collection process, even though this task is not always perceived to be conducted well.

Data distortions as a result of inefficient collection and incorrect incentives

Although healthcare authorities use multiple mechanisms for data verification, facility level specialists (health workers and statisticians) are not certain about the quality of the data they compile. Units responsible for data consolidation meticulously scrutinize reports before they are submitted, frequently inspect facilities and conduct numerous training activities for the statisticians. Failure to have statistical reports approved, or being accused of producing poor quality data entails severe formal and informal institutional sanctions. This creates significant leverage for the statistical authorities over the facilities. At the same time, it does not always ensure high quality. In fact, some facility specialists believe that CMS scrutiny prompts facilities to distort the real picture. A quarter of the statistical specialists at the facility level said that their data is never or rarely objective (and only half of the facilities said that it is always objective).

While most doctors and nurses believe in the primary records they produce in their facilities, they often do not trust generalized medical statistics. A quarter of all doctors and nurses said that they would rather not rely on this data.

− Many health care workers believe that distortions originate from the need to maintain imposed benchmarks in healthcare statistics. *"It is the statisticians who deal with all the health problems in Ukraine. It is they who reduce mortality. Whether some indicators go up or down, all depends on what the statisticians write and sign. These trends are often not true in reality, but they are true in the statistical reports."*

− But distortions also occur because of highly inefficient data collection systems (paper-based primary records and initial aggregation; inconvenient formats). Since most primary data entries

and initial aggregation are not computerized, data collection is highly unreliable. Moreover, doctors and nurses complain that many forms are outdated and inconvenient, which makes it difficult for them to accurately register primary data. The current forms request redundant information. For example in-patient medical cards include a field which must classify the patient based on his/her occupation into "categories" which separate "blue-collar" and "white-collar" workers. At the same time the forms may allow basic medical information such as diagnosis to be readily recorded. For example, statistical slips attached to the in-patient cards of patients released from hospitals contain only a tiny section for description of full medical diagnosis of the patient.

Poor fit of data with the decision-making process

Use of data is limited at all levels, including, frontline service provision, facility management and local strategic healthcare planning.

– **Healthcare staff involved in actual provision of services rarely find collected data useful because it is either not relevant or not reliable.** Only in less than half of the interviewed cases did doctors and nurses find the data they are asked to collect useful, relevant and reliable enough to be used in their practical work. A majority of the health workers consider data collection to be a burden on their time imposed for the purposes of nation-wide analysis. They consider the data are not useful at the level of service delivery. The data are mostly irrelevant because they fail to inform doctors about the patient's individual history in other facilities (before, during and after the treatment they provide). Such horizontal exchange of data between facilities is strictly limited and the data which might be shared are often classified.

– **Facility managers are limited in the choice of which statistics to use because they have little scope for managerial decisions in the first place** (apart from monitoring of compliance with input-based norms). Examples provided by the interviewed executives show that Chief Doctors often do not properly use the internal statistical service because they believe that they do not have sufficient discretion to make managerial decisions. For example they do not have sufficient flexibility to reallocate funds to acknowledged priorities or to create necessary incentives. At the same time, in-house administrative data are routinely used for planning against input-based norms such as utilization of bed-days. Given that many of the facility operations are dependent on performance against input-based norms (such as numbers of occupied beds), these statistics are vital for routine planning and reporting. In other words, facility managers need to track how well they are doing against these norms to provide reports but also to maintain operations in volumes which would allow them to request sufficient funding.

– **Although collected data are used in local health plans, such statistics are not sufficiently integrated into the local political decision-making process, and are not always realistic.** The survey confirmed that local healthcare strategies usually include up-to-date medical statistics generated with the help of the CMSs. Examples of indicators used in some strategies include immunization targets, TB check-up targets, or indicators related to maternal and child mortality or cancer detection. Where data are used, many but not all of the CMSs stated that these targets are realistic vis-a-vis current actual levels for the respective indicators. Explanations provided by the CMSs were not confident, sometimes casting doubts over their own projections. Moreover, unlike the CMS, facility level statisticians are not always as confident about the statistics used for local healthcare forecasting. Notably, only 30.8% of the interviews with the CMSs showed that statistical data are shared not only with the administrators but also with local politicians, trying to tangibly influence local priorities.

Poor fit of data sharing systems to address non-communicable diseases

A range of specific diseases – mostly contagious but also including cancer – are tracked separately through the system of specialized regional dispensaries. Most of the primary medical statistics are consolidated at the level of statistical units of central rayon and municipal hospitals, before being sent on to the oblast offices of the CMS. However, a range of "specialized" medical reports (on dermato-venerological diseases, HIV/AIDS, cancer, TB etc.) go through a network of specialized facilities, "bypassing" central rayon and municipal hospitals.

As a general rule, there is no two-way exchange of information about patients between the facilities, even for conditions where such exchange is critically important (for example for patients with cancer). If a patient is dismissed from the facility or dies, the facility issues a Discharge Summary which is handed to the patient in person or a close relative, after which this policlinic or hospital does not receive any further information about this patient. If a patient is first detected with a communicable diseases or cancer, and then transferred for further monitoring to a specialized dispensary, the first place where the patient sought care will not receive any further information about this patient.

Most doctors complain that lack of horizontal data exchange significantly complicates their work. A majority of the doctors explained that the nature of the information they collect differs from what they actually need for their work: "*morbidity data and data on the consequences of the treatment*". However, these data are unreliable or strictly confidential (not accessible). While doctors have full access to indicators they don't trust and appreciate, "*useless, meaningless data*," they are in need of information which is "*classified and impossible to get*." Many of them admit that making data accessible would require a considerable change in the way data are collected and shared; data need to focus on other aspects of service delivery and should be shared horizontally via new computerized systems of medical system exchange. Examples of data gaps include:

– **Information on personal medical history before admission**: allergic background; life history; family medical history;

– **Medical information collected during the treatment**: tests undertaken in other facilities; nature and results of parallel treatment in other facilities; information on whether the patient is HIV-positive and/or has other diseases which affect treatment and safety of medical staff, but which the patients have the right to keep private;

– **Personal medical history after release from facility:** Development of diseases monitored by specialized dispensaries; treatment results; medical data which cover services provided by facilities of 1st, 2nd and 3rd level; data on surgeries undertaken by other facilities; further check-up results.

Procurement

Operating under relatively advanced provisions of the 2010 Public Procurement Law (PPL), most facilities undertake large procurement through transparent competitive procedures. At the facility level, PPL provisions are robust and routinely applied. Interviews showed that procurement officers comply with the PPL diligently, with all purchases above the PPL threshold[37] (that is, apart from small-value purchases) made through competitive tenders, with

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[37] UAH 100 thousand for procurement of goods (UAH 300 thousand for construction) and UAH 1 million for procurement of works

due publication of all information, absolute compliance with the Tender Committee decisions and regular audits. This discovery is supported by the fact that some of the interviewed procurement specialists were rather annoyed with having to comply with the new regulations and complained about the additional effort it imposes on them.

Without clear rules for small-value procurement, it is often conducted in opaque ways and is vulnerable to sub-optimal choices of suppliers. As would be expected under the current PPL, procurement below UAH 100 thousand is done without any specific rules. In most cases decisions on such purchases are made ad hoc and often *"based on established practice"* (implying contracts with traditional suppliers)*.

While facilities do comply with the PPL, their procurement suffers from severe shortcomings which echo the loopholes in the PPL itself. There are several significant weaknesses in the organization of the tenders which are likely to distort tender results and generally reduce quality of provided medical services:

- **No separation between the functions of Procurement Office (PO) and Tender Committee (TC).** The PPL does not assume that preparation of tenders and management of contracts should be separated from the function of choosing the suppliers and deciding on awards. In fact, it treats the PO and TC as one, and this is how it is organized in practice. The Tender Committees of the facilities thereby include staff who are responsible for at least two or three of potentially conflicting roles (e.g. calculating amounts of drugs to be purchased, preparing technical specifications, qualification requirements and, at the same time, choosing suppliers). The current organization of Tender Committees also places disproportional tax on the worktime of the involved specialists (since it does not absolve them from their regular duties).

- **No understanding of Conflict of Interest, as a concept or as a situation to be handled.** There are no explicit definitions of what represents Conflict of Interest and no rules on how to handle it (no templates for a declaration of COI by the procurement specialists, no specific rules for reporting of the COI etc). Respectively, no interviewed procurement specialist was familiar with the idea as such, and intuitive understanding of the Conflict of Interest was highly misguided.

- **Excessive amount and depth of inspections by authorities whose mandate is not directly related to procurement.** Procurement is subject to numerous intrusive audits by a range of bodies which sometimes includes police and security services. Not only does it come at administrative cost to facility executives, but also raises concerns on true incentives for such disproportionate attention.

- **Highly inefficient information management systems.** Even though information is diligently recorded, it is usually paper based, difficult to aggregate and almost impossible to use for real-time management of contracts. Information on suppliers (past performance, quality level) is especially weak. One reason for this is that facilities have little leverage to use supplier information in practice: there are no blacklists and no opportunity to remove poorly performing suppliers from future tenders.

Facilities are dissatisfied with the quality of medical products procured centrally and with the mechanisms behind centralized procurement. Centralized procurement via national targeted programs is criticized for low quality and inadequacy to hospital needs. At the same time, hospitals do not feel in power to refuse such supplies. Moreover, procurement of some supplies at facility level (notably, equipment) is overseen by a centrally established state enterprise whose mandate is opaque and involves highly conflicting interests (such as marketing and sales of particular equipment, their technical maintenance, development of standards and evaluation of compliance to these standards).

What can be improved? Policy Recommendations

What can be improved? The literature on health system performance assessment speaks about defining expectations, measuring goal attainment in terms of outcomes; tracking changes in the health system and non-health system resources used to achieve these outcomes; estimating efficiency in resource use; and evaluating the way the functions of the system influence observed levels of attainment and efficiency. Explicit measures to improve the situation need to ensue, as improved organizational effectiveness can be generated through new management structures and incentives.

In Ukraine, clearly first-order issues include: how to better finance institutions and to incentivise personnel; as well as how to better deploy human resources and to ensure the correct skills-mixes. **Two of the key issues at the root of some of the imbalances uncovered in the report appear to be: the way resources are allocated, as well as the excessive and not always rational body of regulations in the system**.

The study confirmed what we already knew from the PEFA assessment (see Box 1) that one key weakness in Ukraine PFM system is **the lack of a link between strategies and budgets and between budgets and outcomes**. So the answer would presumably be Program-based Budgeting (PBB). Yet, as chapter 4 shows, if the new PBB system being introduced in Ukraine coexists with a wide range of rigid regulatory requirements, such as detailed spending norms for individual expenditure items and spending priorities mandated by the central ministries, it is likely to fail. These requirements, determining line-items according to the economic classification of expenditure, dominate the process of budget preparation, execution, and monitoring. And little attention is being given to promoting the rational overall use of resources or to cost-efficiency (see Figure 7).

Abolition of the "spending norms" should be introduced with a change to the payment system, away from historical expenditure, inputs, and line item allocations. A new payment system based on cases treated, corrected by their severity, would completely change the budgetary process, basically eliminating the bottom up discretionary negotiations on the budget based on existing inputs (reviewed in Chapter 4), and would introduce a new, objective, formula as a basis for determining each facility's relative budget, thus providing greater flexibility also during the budget execution phase.

One key reform which the study findings would support is towards greater **autonomy of providers.** Hospitals and other medical facilities should be "grouped" together in a network and managed professionally by management with appropriate qualifications, empowered to take decisions, and held accountable for ultimate quality and efficiency of services delivered, rather than by the compliance with hundreds of minute regulations, many of which seem redundant or irrational. In other words, facility managers should *progressively be freed from micro-management of their staffing, budgets, data, etc.*; such managerial autonomy would have two essential dimensions:

(i)   the ability to organize the production of services, including appointments/dismissals, staff working hours, remuneration, capital expenditures, medicine purchase and stock management, etc. with some flexibility, within general principles to be determined by framework regulations;

(ii)   the ability to retain savings, and managerial responsibility in case of cost overruns.

However, greater autonomy needs to be accompanied by greater accountability for results. In other words, there needs to be accountability for performance and financial results. To establish such accountability, reforms should design a new governance structure for hospitals, with clear and separate management and control power by, respectively, a Chief Executive, and a Hospital Board. Using the current legal framework for State Owned Enterprises may not be appropriate for the health sector.

Finally, greater accountability requires a better information basis, so that key information on each facility's performance can be trusted, and used for decision-making. New investments in Information Technology, together with profound changes in the way the flow of information in the system is produced and circulated, are critical elements to empower managers, and allow them to take greater initiative in the management of their facilities.

The matrix on the next page summarizes the rankings for all the individual indicators, the main issues uncovered by this study, and the main study recommendations.

Matrix summarising key findings

Domains and Indicators	Grade		Main Issues	Policy Recommendations
Human Resource Management				
Recruitment				
▪ Indicator HRM-1. Publicizing vacancies	Grade C	🟡	- Extremely rigid staff schedules determined at national level by facility type; - No clear ethical norms and standards of medical practice; - Opaque advertisement of vacancies; non-compatible recruitment are norm.	- Abolish MoH Order No 33 of 23.02.2000 "On staff norms and typical staff in healthcare facilities"; - Approve new legislation with Draft Code of Ethics of Ukrainian Doctor; - Establish transparent mechanisms for advertisement of vacancies and new legislation for selection process when there are competing candidates. Legislative requirements should also require competitive selection as norm.
▪ Indicator HRM-2. Transparency of appointment procedures	Grade C+	🟡		
▪ Indicator HRM-3. Competitive selection of candidates	Grade D+	🔴		
▪ Indicator HRM-4. Importance of merit-based criteria for hiring new staff.	Grade C+	🟡		
▪ Indicator HRM-5. Job description	Grade A	🔵		
Personnel management				
▪ Indicator HRM-6. Opportunities for career progress	Grade D+	🔴	- Lack of opportunities for career progress; - Mandatory recertification procedure for professional qualification category does not have enough impact on staff salary and grade	- Modify *Unified Qualification Requirements* for each category of workers in healthcare facilities as defined by the *Reference Book of Professional Qualifications* (Volume 78, Healthcare). New regulations should empathize specific skills requirements for each position, not only minimal qualifications; - Revise doctors and nurses career progress by revising the *Reference Book of Professional Qualifications* (Volume 78, Healthcare), approved by the MoH Order No 117 of 29.03.2002. Allow greater facility level flexibility in managing career progress. Provide career-long incentives by opening up promotion opportunities at all levels, but particularly for medical doctors; - Allow more flexibility in setting number of staff and levels of salary at facility level; - Revise *Standing Procedures on Certification of Doctors*, approved by the MoH Order No. 359 of 19.12.1997.
▪ Indicator HRM-7. Career progress procedures	Grade B	🟢		
▪ Indicator HRM-8. Day-to-day performance assessment	Grade A	🔵		
▪ Indicator HRM-9. Positive stimulation	Grade B+	🟢		

Indicator	Grade	Status	Findings	Recommendations
▪ Indicator HRM-10. Timely payment of salaries	Grade A	🔵 (blue)		
▪ Indicator HRM-11. Training	Grade A	🔵 (blue)		
▪ Indicator HRM-12. Sanctions	Grade C+	🟡 (yellow)	- Doctors and nurses feel unprotected against unfair punishment. Currently, the rules for appeal are the same as for any individual labor dispute as outlined in Chapter XV of the UCLL	- Establish specific redress procedures for health sector workers, by building up Article 150 of the UCLL which grants all employees the right to appeal against disciplinary measures.
Retaining qualified staff				
▪ Indicator HRM-13. Levels of pay in public vs private sector	Grade C	🟡 (yellow)	- Salaries are extremely low and largely independent of performance	- Make salaries more sensitive to differences in qualifications and more results-oriented
▪ Indicator HRM-14. Turnover	Grade D	🔴 (red)	- Extremely low turnover of staff	- Establish new rules that force staff to rotate to different positions and/or facilities at least every so many years. Improve transparency of internal market vacancies.
Planning and Budgeting				
Policy-based budgeting				
▪ Indicator PB-15. Strategic guidance	Grade A	🔵 (blue)		
▪ Indicator PB-16. Links between strategic plans and facility budgets	Grade C+	🟡 (yellow)	- Rules for preparation of facility budgets in Ukraine are elaborate, strict and highly input-based.	- Provide facilities with only two budget allocations, under recurrent expenditures: one for salaries and one for all other recurrent expenses. Move towards DRG-based payments for hospitals. - Link planning and budgeting by: a) providing certain budget envelope to guide the planning process; b) leaving greater flexibility in the allocation of resources at facility level.
▪ Indicator PB-17. Staff engagement with the strategic planning process	Grade C+	🟡 (yellow)	- Staff is informed, not consulted. In several cases, main objective seems to seek financial contribution from staff.	- Establish mechanisms so that professional staff can be involved in the planning and budgeting process in a meaningful way.
▪ Indicator PB-18. Capacity for strategic planning and budgeting	Grade C+	🟡 (yellow)		
▪ Indicator PB-19. Results-oriented budgeting	Grade D	🔴 (red)	- Without changing other budgetary rules, introduction of PBB will not change or improve budgetary process.	- Provide facilities with only two budget allocations: one for salary and one for everything else. Move towards DRG-based payments for hospitals.
▪ Indicator PB-20. Clarity and consistency of budget preparation guidelines	Grade C	🟡 (yellow)		
Capital budgeting				

Indicator	Grade		Comments	Recommendations
▪ Indicator PB-21. Criteria for prioritising investment projects	Grade B	🟢	- The planning and the priorities for capital investment seem rudimentary but robust.	- Develop national guidelines for capital project appraisal and oblast level capital expenditure plans, with three years timeframe
▪ Indicator PB-22. Project approval and selection	Grade C+	🟡		
Budget execution and management of funds				
▪ Indicator PB-23. Predictability and availability of funds	Grade A	🔵		
▪ Indicator PB-24. Spending flexibility and transparency of adjustments	Grade B	🟢	- Procedures for actual in-year adjustments in their budgets take a lot of time.	- Simplify procedures for in-year budget adjustments.
▪ Indicator PB-25. Authorisation of funds and commitment control	Grade C+	🟡	- Treasury controls are effectively imposed to avoid unauthorized spending, but the system is bulky and imposes extreme administrative burden on facility managers	- Simplify procedures
Audit				
▪ Indicator PB-26. Scope and nature of audits	Grade C+	🟡	- Audit is too focused on compliance and not enough on performance	- Strengthen internal audit process; strengthen performance audit. Reduce number of agencies who can audit any given health facility; - Establish a process of quality improvement, which would include quality audit.
▪ Indicator PB-27. Administrative burden associated with audits	Grade C+	🟡		
▪ Indicator PB-28. Extent of follow-up	Grade B	🟢		
▪ Indicator PB-29. Redress policies	Grade C	🟡		
Revenue collection and financial risk pooling				
▪ Indicator PB-30. Significance of formal own revenues and expenditures	Grade C+	🟡	- Revenues from paid services are significant. Yet, there is no agreed discipline or acceptance of these payments.	- Reduce the distance between what the state promises and what it is able to provide: clearly define legal co-payments for health services according to regulated prices, with clear categories exempted (chronically ill and poor patients) and with upper limits to the maximum amounts any patient can pay every year.
▪ Indicator PB-31. Extent of unreported revenues and expenditures	Grade C+	🟡		
Monitoring and evaluation				
Data collection				
▪ Indicator ME-32. Division of responsibilities and coordination	Grade B	🟢	- Information "originators" do not find the information useful or accurate. They are not motivated to collect information carefully.	- New standards and processes need to be designed to make information flows seamless. Information collected should be first useful to those who are asked to collect it.
▪ Indicator ME-33. Availability, frequency and standardization of data	Grade A	🔵		

▪ Indicator ME-34. Quality of information	Grade B+	🟢		
▪ Indicator ME-35. Cost-efficiency of data collection process	Grade C+	🟡	- There are huge numbers of data collection requirements (over 200 different forms in the health sector as a whole)	- Rationalize data collection requirements; merge and/or increase coordination among different vertical programs and data collection requirements.
▪ Indicator ME-36. Capacity for data collection and statistical analysis	Grade C+	🟡		

Use of information

▪ Indicator ME-37. Use of statistics by healthcare professionals	Grade C	🟡	- Although most healthcare staff have easy access to collected data, they rarely find it useful.	- Create new information management systems based on the needs of grass-root users of those systems rather than the reporting requirements of higher level institutions.
▪ Indicator ME-38. Use of information in managing healthcare facilities	Grade B+	🟢		
▪ Indicator ME-39. Use of information in local strategic management process	Grade C	🟡		
▪ Indicator ME-40. Transparency of performance information	Grade C+	🟡	- Information on performance is not publically available or easily accessible.	- Make statistics on relative performance of different facilities publicly available to citizens.

Procurement

Regulatory guidance

▪ Indicator PR-41. Transparency and clarity of regulatory guidelines for public procurement in healthcare	Grade B+	🟢		

Procurement cycle

▪ Indicator PR-42. Methodology for determining quantities of pharmaceuticals to be purchased	Grade C	🟡	- Amounts of procured drugs are often impacted by subjective decisions, creating space for payoffs from supplieyrs and distorting the composition of procured pharmaceuticals.	- Release rigid norms for per-bed calculation of expenditures, thereby removing financial incentives for their selective application within limited facility budgets; - Introduce a legal requirement for a transparent and objective methodology to calculate procured amounts of pharmaceuticals.
▪ Indicator PR-43. Functionality and independence of the Tender Committee	Grade C+	🟡	- Functions of TC and Procurement Office are not separated (and this is not required by the PPL), which creates conflict of interest.	- Introduce legal requirement to separate the functions of Tender Committee and Procurement Office.

▪ Indicator PR-44. Objective criteria for Tender Committee membership	Grade D+	🔴	- PPL criteria are generic and even as such they are not known or understood by the procurement specialists	- Introduce clear rules for selection of Tender Committee members with explicit specification of requirements against conflict of interest, professional merit and periodic rotation
▪ Indicator PR-45. Compliance with Tender Committee decisions	Grade A	🔵		
▪ Indicator PR-46. Appeals	Grade A-	🔵		
▪ Indicator PR-47. Procurement information system	Grade D+	🔴	- PPL requires to select bidders with lowest price and does not allow to use black lists of underperforming suppliers	- Introduce a possibility and clear rules for creating black lists of suppliers whose previous performance was below agreed benchmarks.
▪ Indicator PR-48. Contract administration for procurement of pharmaceuticals	Grade C	🟡	- No rules for regular sampled laboratory checks of the shipments (facilities check only packaging and documentation), which promotes counterfeit	- Introduce rules for regular sampled checks of shipments to identify counterfeit pharmaceuticals with due packaging and documentation.
▪ Indicator PR-49. Contract administration for procurement of equipment and medical supplies.	Grade B	🟢		
▪ Indicator PR-50. Procurement audit.	Grade B	🟢	- Procurement-focused audit is excessive and often used as leverage to influence tender results	- Clarify audit rules and require that audit results must be publicly available
Integrity and transparency of the procurement system				
▪ Indicator PR-51. Ethics and anti-corruption measures	Grade D	🔴	- Complete lack of understanding of the concept of conflict of interest and absence of implementation procedures.	- Strengthen the legal definitions of conflict of interest and introduce clear rules and procedures to enable procurement specialists to effectively handle conflict of interest situations.

Conclusions

The study proposes a new methodology to shed light on key governance policies and practices in the health sector in Ukraine, and how they support or impede service delivery and performance. The study highlights core gaps in the current governance policies and practices in (human, material and financial) resource planning, management, monitoring, and links these gaps to the underlying distribution of authority, capacity, incentive structures and accountabilities. The results obtained are systemic (i.e., tracking indicators and developing scores for each function), and will be used as a strategic information tool to engage government on health sector reforms.

The study's value added is that it proposes a set of specific, implementable recommendations on how to improve the public sector management system in the health sector in Ukraine along each of the functions studied (see next Chapter), and at the same time contributes to a new, more rigorous methodology to measure public sector management performance, which in future could be applied in other sectors and other countries. By these means, the study also aims to reduce the current fragmentation within the World Bank as well as within the research and policy communities in the measurement and assessment of public sector management/governance issues.

The open question is whether the methodology chosen can lead to empirically sound results. As explained, the methodology proposed presents a combination of qualitative and quantitative features. The sample size is not statistically representative, and the "scoring" exercise is based on the team's joint assessment of the different responses to the questionnaire and desk reviews, according to a clear mapping from the questionnaire responses/desk review findings to the final scores, as highlighted in the previous sections. At the same time, most questions are "closed", not open-ended, and thus allow an objective assessment of the frequency of each particular response in the sample. In other words, the methodology proposed has a more solid empirical foundation than PEFA, and at the same time extends it to other dimensions of governance which are critical in the HD sector, such as HR management. **However, the limited sample size imposes a severe constraint on the validity of the results obtained. Specifically, the key constraint that has limited the validity of comparable studies on governance in the past, namely the fact that there are several sensitive questions, for which some respondents may be reluctant to answer truthfully, may have affected the results of this study as well**. This problem is acute when there is a large disconnect between formal rules and reality, and respondents may be tempted to repeat to the interviewers just what the rules prescribe, rather than telling them how things work in reality, unless they strongly trust the interviewers. To mitigate this risk, the team started interviewing doctors, nurses and administrators with whom one or more of the team members had a personal connection, to maximize probability of truthful reporting.

The study then expanded the sample based on the recommendations of the first people interviewed. This approach can reduce, but not eliminate the possibility of untruthful responses. In addition, the information from the survey was complemented with experts' opinion, and with an in-depth review of existing laws and regulations.

In spite of all of the above, the findings should be seen only as suggestive of underlying realities: specifically, ratings should be seen as approximating realities but always with an up-ward bias towards more positive results than real ones, since we cannot rule out that some respondents reported untruthfully, because they did not want to be held responsible for their misgivings, or did not trust the interviewers, and ended up describing a more rosy reality than they should have.

Another "limitation" of the study is that it is explicitly focused on governance at the level of service providers. This is only one of the three angles of the accountability triangle (Figure 4). It is a particular sub-system within the broader healthcare system and for that matter, the public

administration system. Governance of adjacent sub-systems is very important, but it is deliberately covered in this study only in so far as it impacts service providers. For example, we scored the indicator PB-19 (on capacity for strategic planning and budgeting) quite well. However, for strategic planning at the service provider level, availability of framework regulations, reliable macroeconomic and demographic data, are exogenous variables. The point of the Indicator was to measure "in-house" capacity within the hospitals to engage in meaningful strategic planning process. It does not mean that other aspects of the healthcare system are not important. As such the governance aspects measured by the indicators are only a small part of the full picture. However, they help to reveal individual symptoms which, taken together, can point at the primary diagnosis.

It is hoped that this study will generate a debate within the "community of practice" of researchers and policy-analysts interested in studying governance issues. As the focus of development assistance shifts towards tackling governance issues (for example through Results-based operations), as opposed to simply financing inputs[38], it will become more imperative for the International Community, as well as counterpart ministries and administrations, to agree on a common metric and methodology to assess progress. It is hoped that studies such as the one presented here can be repeated, **in order to further develop and consolidate the study methodology and results.**

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[38] This is because more and more evidence shows that what really matters for final results is not so much the amount of resources invested in a specific sector, but really intangible factors such as the quality of management, the quality of the information for decision-making, or the overall regulatory and incentive environment and how strong are accountability mechanisms towards citizens and service beneficiaries.

Chapter 3: Human Resources Management

Introduction

Civil servants and regular employees

There are two broad types of health sector workers in Ukraine: civil servants and regular employees:

1) Those employed as civil servants or as officers of local self-government (staff of MoH, Autonomous Republic of Crimea (ARC) MoH, and departments of healthcare, except staff not employed as civil servants such as technical workers, accountants, etc.);

2) Those not employed as civil servants or officers of local self-government (all staff of healthcare facilities, and staff of healthcare authorities not employed as civil servants).

While the first type of healthcare workers fall under the remit of civil service laws, the second type is regulated only by labor laws. Generally, the labor regime for healthcare facility workers is regulated by the same provisions that are applied to workers in other sectors. At the same time, there are a number of peculiarities. These include special requirements governing candidates for vacant healthcare posts (applicants should correspond to *Unified Qualification Requirements of the MoH*), special procedures for their recertification, special procedures for appointment of healthcare facility managers, etc. These peculiarities are described in detail in the sections below.

Process of filling the vacancies

Staff Schedule

Every employer in Ukraine, including healthcare facilities, operates on the basis of a "staff schedule." The *Staff schedule* is understood by Ukraine's legislation as a "document which defines, for a given enterprise, institution or organization, its structure, staff and their fixed salaries by specifying the names of all posts, numbers of employees for each of these posts, and the fixed salaries for the respective posts"[39]. The Staff Schedule only lists the types of posts and their respective fixed salaries, while the number of working hours for each post is defined in detail by Ukraine's Code of Labor Laws (UCLL).

Budget-funded entities must follow strict rules in developing and approving their staff schedules. All organizations, except those funded from the budget, can define their Staff Schedules independently (according to Article 64 of Ukraine's Economic Code).[40] However, all organizations which receive public funding (including medical institutions) must follow precise rules for developing their Staff Schedules, coordinating them with the Ministry of Finance, and having them approved by the level of government which owns the organization (for example, a oblast hospital would have to seek approval from oblast health department) on an annual basis. Moreover, on top of generic rules for all types of budget institutions (defined by the CoM and the MoF), individual line ministries may impose sector-level requirements on Staff Schedule. In the case of healthcare sector, the MoH strictly regulates the content of Staff Schedules as explained below.

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[39] Letter of the Ministry of Labor and Social Policy of Ukraine "On Staff Schedule", No 162/06/187-07, issued 27.06.2001.

[40] Ukraine's Economic Code, No 436-IV, approved 16.01.2003, current edition – 30.10.2012.

The typical form of a Staff Schedule, for any given year, lists the names of all types of positions of the budget-funded entity, grouped by all its components/units. For each type of position, the Staff Schedule specifies: the number of expected posts (employed people) per position, the fixed salary for each position; premiums and allowances for each position; resulting payroll fund for each position (monthly amount and annual amount).

The exact number of positions to be reflected in any Staff Schedule is strictly defined by the MoH Order No 33 of 23.02.2000 "On Staff Norms, and Typical Staff of Healthcare Facilities"[41]. Specifically:

- This Order provides staffing rules for 52 types of medical institutions (in 52 respective annexes). For each of these institutional types, the Annexes list precise types of departments allowed, number of posts, and precise Staff Schedules allowed per each Department /or number of beds. Certain structural units and posts are prescribed for cases when specific equipment is available (for example, for radiologist posts). To illustrate, an oblast hospital can have an Endocrinological Department, and it can hire one Endocrinologist per 20 beds. Certain specific posts are prescribed for particular departments, for example Proctology Departments must have 0.5 post of an Oncologist.

- The Order covers medical, pharmaceutical, educational, administrative, support and managerial types of posts for each type of healthcare institution. For example, for food handling staff, the Order prescribes hiring one employee responsible for peeling vegetables and potatoes per 50 beds in facilities with less than 500 beds, and and one employee per 55 beds in those with more than 500 beds.

- In the same way, the Order defines a minimum bed requirement to allow Departments to justify the creation of a Head of Department position, as well as other managerial posts (for example, the post of a Head of Admissions Office is allowed for hospitals with more than 250 beds).

- The Order does allow managers of healthcare facilities to propose changes to the Staff Schedule for certain Departments, and to introduce posts which would not be typical for that particular type of Department. However, these newly introduced posts should still be defined in Order 33, all changes should be within the defined payroll, and any changes should only be between types of posts within one category of staff (medical, pharmaceutical, administrative, and managerial).

- If new healthcare facilities are established which require types of posts not listed in Order 33, their staff structure should be defined with clearance from the MoH.

The process of developing and approving the Staff Schedule is closely coordinated with the process of development and approval of each medical organization's budget. The major principle behind this approach is that each budget-funded organization must ensure that the number of staff it plans to employ in a given year falls within its budget allocation. The Staff Schedule is approved annually together with the organization's Budget. The Staff Schedule describes the entire structure of the organization, including any units or posts which are funded out of its own-source revenues. Any changes to approved Staff Schedules must be introduced exclusively by using the same forms and the same process as defined for the initial approval of the Staff Schedules.[42] As a rule, each year the Staff Schedules of all budget-funded organizations are approved by the level of government which owns the organization. The hierarchy in this process is the same as that for approval of the organization's budget.

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[41] Ministry of Health Order No 33 of 23.02.2000 "On Staff Norms and Typical Staff of Healthcare Facilities".

[42] Cabinet of Ministers Resolution No 228 of 28.02.2002 "On approval of Procedures for development, consideration, approval and basic requirements to implementation of the budgets of budget entities"

Appointing new staff

There are no clear regulations for the process of appointing most staff (except managerial posts). Facility owners or authorized bodies fill their facility vacancies (as per the Staff Schedule) by concluding agreements with their respective staff members. Control over this process may happen only in cases when it is explicitly required by the facility statute, specific legislation, or by the regional healthcare departments at the stage of Staff Schedule authorization. Legislation specifies a control procedure for staff appointments and releases only for facility managers (Chief Doctors), and does not contain any such provisions for other types of vacancies.

In order to be hired for a medical post, candidates must comply with *Unified Qualification Requirements of the MoH*. *Unified Qualification Requirements of Ukraine's MoH* are formulated in terms of official credentials of the candidates, rather than their knowledge and skills.

- *Unified Qualification Requirements* for each category of workers in healthcare facilities and authorities (managers, professionals, specialists, technical staff) are defined by the *Reference Book of Professional Qualifications (Volume 78, "Healthcare")*, approved within the *Order of the MoH No 117 of 29.03.2002*.

- For each category of healthcare workers, the *Reference Book* defines key tasks and responsibilities (Job Description), and qualification requirements. In these definitions, only qualification requirements are formulated with clarity and precision, while required skills and responsibilities are defined in a rather general way. For example, qualification requirements for *Senior Nurse* include: undergraduate education (junior specialist) or basic high education (bachelor) in the field of "Medicine" with specialization in "Nursing"; completion of professional development training; certificate of acquisition or confirmation of a qualification category; and relevant work experience of at least 5 years. By contrast, requirements related to the knowledge and skills of the Senior Nurse are formulated in a generic way: she has to know current healthcare legislation and basic legal aspects of healthcare, labor law, guidelines and directives which define tasks and functions of medical facilities, rules for record keeping and reporting, principles of anti-epidemic *measures etc*. Requirements to qualifications, skills, and responsibilities of other categories of healthcare workers are formulated in the same manner.

Relations between the management and subordinates

Legislation requires each worker to have an employment contract and job description, but does not have any guidelines as to the content and level of detail of these documents. The *Reference book* defines most of these requirements in a very generic way. According to Article 21 of *Ukraine's Code of Labor Laws (*UCLL), key responsibilities and the scope of work should also be defined by the employment contract and by the rules of internal labor regime. But for these sources as well, no legal requirements exist for the level of detail to be specified in employment contracts, job description and related documents which guide the relations between the managers and their subordinates. The content and level of detail of such job descriptions depend on the decision of the manager. As the study will show, in fact it was found that job descriptions at the individual facility level are generally quite specific and binding (see Indicator HR-5).

Regulation of ethical issues for health service providers

The basic duties of medical and pharmaceutical workers are defined in the *Ukraine's Framework Law on Healthcare.* According to Article 78 of this Law, medical and pharmaceutical workers should protect and promote better health of people, provide timely and qualified medical care and treatment, provide free first aid to citizens in case of emergencies, maintain requirements for

professional ethics and deontology, and maintain confidentiality of private medical information. These duties are also reflected in the *Physician's Oath*, the text of which is approved by the *Order of the President of Ukraine No 349 of 15.06.1992. The Oath* is made by graduates of high education facilities of Ukraine. Prior to 2009, the *Physician's Oath* was the single document which declared principles of professional activities for doctors.[43]

In 2009, the MoH has developed and published on its web-site[44] for debate a *Draft Code of Ethics of Ukrainian Doctor*. This draft was approved by an All-Ukraine Meeting of Doctor Organizations in Eupatoria city (24-27.09.2009). However, the document was never approved as a legislative act which would make it compulsory for all healthcare workers.

Generally, the content of the draft *Code of Ethics* is compliant with the norms of the *International Code of Medical Ethics of the International Medical Association*. The draft *Code of Ethics* establishes a duty of the doctor to respect the honor and dignity of the patient, to keep private health information in confidence (clause 3.6. of the *Code of Ethics*), to pay sufficient attention and time to establish the right diagnosis and to help the patient in full, to avoid intrusion into private matters of the patient and his/her family (clause 3.3. of the *Code of Ethics*), to respect the right of the patient to chose his/her doctor (clause 3.5. of the *Code of Ethics*), to not request remuneration from the patient or his/her relatives if it is not required by law (clause 2.6. of the *Code of Ethics*), to not promote medicines and medical products for commercial purposes, to not collude with pharmacists and pharmaceutical representatives to receive unauthorized profit, to not accept benefits from producers and drug sales representatives for prescribing their products, to not create conditions for illegal benefits, etc (clause 2.7. of the *Code of Ethics*).[45]

Recruitment

Indicator HRM-1. Publicizing vacancies

Publicizing vacancies ensures that qualified candidates have an opportunity to apply. This is a precondition for employing the most suitable and qualified staff. Achieving a sufficiently broad pool of qualified candidates is unlikely where information about vacancies is only available through personal connections, rather than through public channels such as websites, publications, employment and professional organizations, etc. Moreover, even if vacancies are formally publicized, the way in which this is done may be limited or inaccurate, and so may fail to ensure fair competition. Because of the critical importance of advertising posts effectively and meaningfully this Indicator is scored by Method 1. The "weakest link dimension" is the actual perceived degree to which doctors and nurses consider closed and opaque job markets to be a major problem.

Scoring table (Method 1)			
Dimension	Source	Benchmark	Grade
Is lack of transparency over vacant positions (lack of freely accessible information on vacancies) perceived by health workers as one of the top-3 biggest barriers and problems in the hiring process? **[Weakest link dimension]**	% Doctors & Nurses who chose "Lack of transparency in the market of vacant positions" among top-3 biggest barriers and problems in hiring	54.3%	Grade C

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[43] See: http://www.apteka.ua/article/22890

[44] http://www.moz.gov.ua/ua/portal/Pro_20090324_0.html

[45] Code of Ethics of Ukrainian Doctor, approved and signed by All-Ukraine Meeting of Doctor Organizations in Eupatoria city (24-27.09.2009); http://health-ua.com/pics/pdf/19/30-31.pdf

How often personal connections are the key source of information about vacancies?	% Doctors & Nurses who state that personal connections is usually the key source of information about vacant posts	52.2%	Grade C
Overall Grade			**Grade C**

This study found that the vacancy market in Ukraine's publicly-funded health sector is highly opaque. 54.3% of doctors and nurses chose "lack of information about vacancies" – a core dimensions of this indicator – as one of the top-three barriers to effective hiring. Notably, this particular problem was chosen by the largest share of doctors and nurses (40.6%) not just as one of the top-three, but as the top recruitment problem. This is illustrated in Figure 18. Moreover, 52.2% of doctors and nurses stated that personal connections are the core channel by which professionals usually learn about new vacancies.

Figure 18. % Choices of top-three barriers in hiring
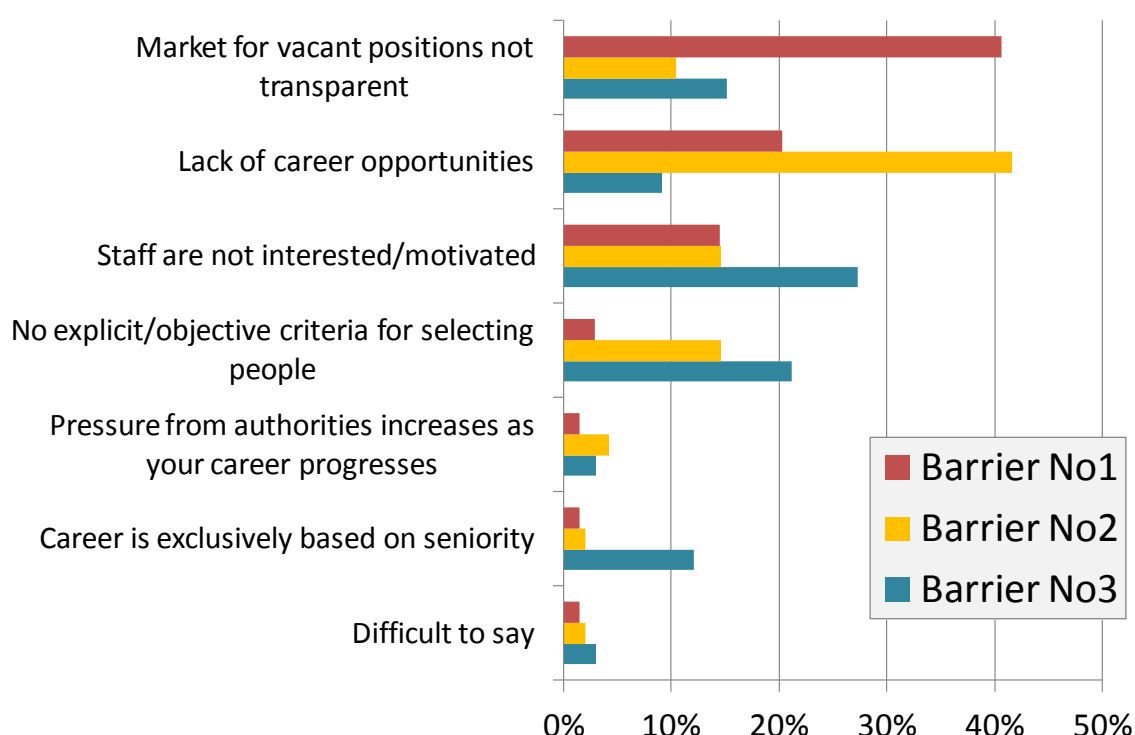
The primary importance of personal connections for learning about available posts is strongly supported by interviews. As illustrated in Figure 19, personal connections were selected most frequently as the key source of learning about vacancies in comparison to all other potential sources. Moreover, the second and third most frequent channels were personal communication with the HR department and the Chief Doctor (CD) of particular hospitals. Often candidates search for jobs by visiting specific facilities and asking about vacancies either in the HR department or talking directly to the CD. The explanations provided by doctors and nurses during interviews illustrate this.

- *"Usually when someone leaves a job, people tell each other and the information is spread through acquaintances."*

- *"Connections matter most, as well as ability to communicate – because this is the foundation of our profession. Learning about jobs in our city without connections is not possible."*

- *"One has to ask friends, colleagues, and visit HR departments."*

- *"We call it 'jungle telegraph' or spreading news by word-of-mouth. Colleagues transfer information to each other."*

- *"I was told about this job by the head of the department who knew me well, because we worked together previously for many years, so she offered me this job. She knew I had solid experience. When I was appointed to my previous job, I learned about the vacancy from a friend. She worked there and she told me that they had an open position."*

Vacancy searches using the Local Employment Center are more common amongst nurses than doctors. Apart from learning about jobs through connections and visits to facilities, 18.3% of respondents acknowledged the role of Local Employment Centers in providing vacancy information. The role of the Local Employment Center is described in **Box** 3. This organization has a mandatory responsibility for collecting all vacancy information and then helps to fill vacancies. The survey shows that this channel is used mostly by nurses rather than doctors. 25% of nurses used it to search for jobs as compared to 12.2% for doctors.

Figure 19. What is the key source of information about vacant posts? (%)
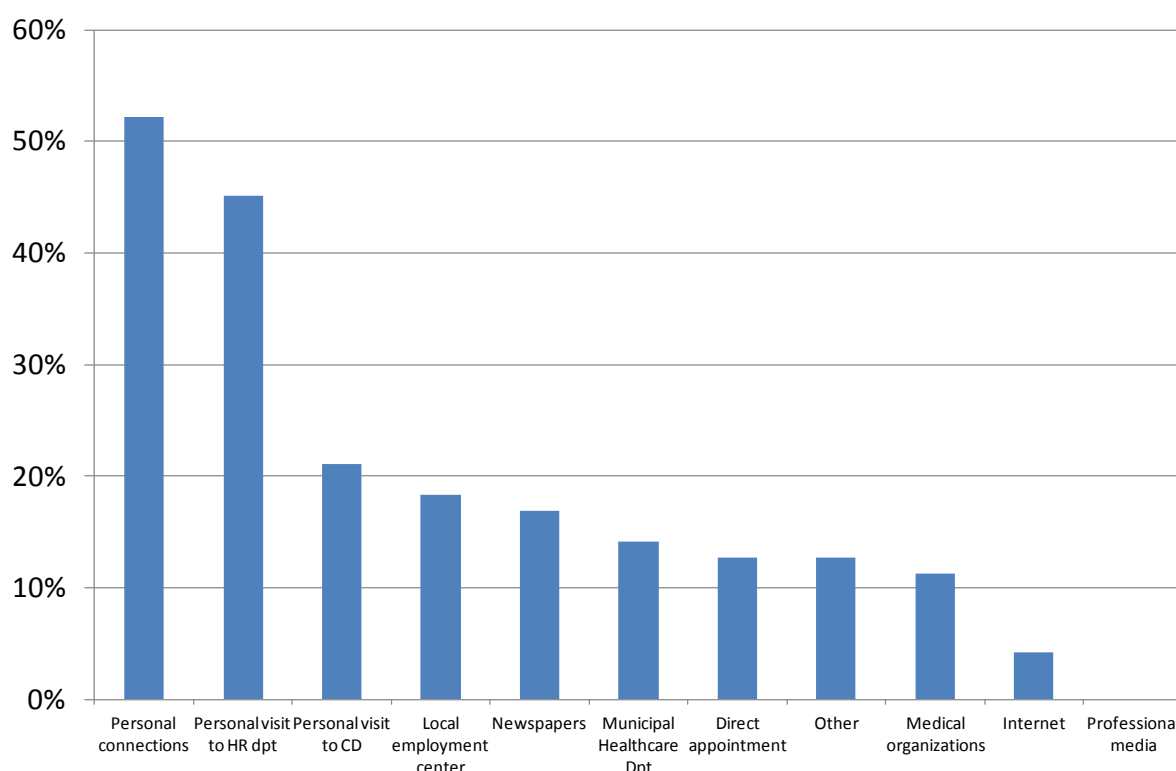
Indicator HRM-2. Transparency of appointment procedures

Open and transparent appointment procedures are a key means of increasing the quality of appointments. A transparent and accountable selection process ensures that choices of candidates are unbiased and objective, which in turn is necessary to hire the right people into the right posts. It also limits possibilities for discrimination and for offering jobs in exchange for personal favors. The minimum requirement for transparency is the involvement of a range of actors in the selection of candidates, so that subjective opinions are open to challenge. Because of the critical importance of a range of actors being involved, this Indicator is scored by Method 1, with the actual involvement of multiple actors used as a "weakest link" dimension. Transparency is further increased through good documentation of recruitment decisions, which might be used to conduct audit and external checks of hiring decisions.

Scoring table (Method 1)			
Dimension	Source	Benchmark	Grade
What are the legislative requirements for the range of actors to be involved in the selection process, for the selection criteria and for keeping records of the decisions made?	Desk study of national legislation	Rules do not demand plurality of actors but they include some selection criteria and record requirements	Grade C
How true it is that hiring decisions are made by only one person (Chief Doctor), without oversight? **[Weakest link dimension]**	% Doctors & Nurses stating that medical staff is selected only by the Chief Doctor	50.0%	Grade C
How often does the hiring process require candidates to submit a specified package of documents which shows the candidates' professional attainment and qualifications?	% Doctors & Nurses confirm that they have had to submit the specified document package when they were hired	90.1%	Grade A
Overall Grade			**Grade C+**

Appointment procedures in Ukraine's public health system are not transparent, largely because a range of actors are not involved in the selection process and because the role played by Chief Doctors is disproportionate. In the survey 50 % of doctors and nurses stated that hiring decisions in their facility are made exclusively by the Chief Doctor. Very commonly, heads of relevant departments are also involved in the selection process; for example they may propose candidates or be consulted on his/her qualifications, but the final choice is still made personally by the Chief Doctor. As one respondent commented: "*appointments are made by the Chief Doctor and it all depends on his whims.*"

Even where municipal and other local authorities are involved in the selection process, Chief Doctors may still retain significant control. In 10.9% of cases, respondents reported that in their cities medical appointments have involved municipal Health Care Departments. The latter are responsible for "placement" of recent graduates across health facilities. However, this hiring process was described by respondents as "*complex and painful*", given that graduates are usually initially appointed to economically depressed, generally less attractive or otherwise prioritized locations, and influencing this process is difficult. In addition, Chief Doctors retain significant control in the selection process. One respondent described how she had to pay a bribe to a prospective Chief Doctor to participate in the municipal competition even though this payment did not guarantee that she would actually win the position.

The overwhelming role of Chief Doctors in the selection process is implicitly endorsed by the current legislation. This does not require consultation or the involvement of multiple stakeholders in the selection of facility-level appointments. For the majority of posts in the healthcare sector,[46] hiring procedures are defined by *Ukraine's Code of Labor Laws (UCLL),* and further specified by the *Healthcare Framework Law* and secondary legislation by the Cabinet of Ministers (CoM)[47] and the Ministry of Health (MoH).[48] Essentially, these regulations describe the package of key documents which need to be provided by all hired workers and represent a set of minimum qualification

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[46] Not civil servants, which are those employed in the health administration at the center, oblast, rayon and municipal administrations. All other health workers are not civil servants.

[47] E.g., in terms of responsibilities of the Departments of Healthcare over provision of clearances for certain appointments and releases from posts.

[48] In particular, by the *Sector Rules for Internal Labor Regime*, approved by the MoH Order No 204-o of 18.02.2000.

requirements.[49]   In addition, the regulations describe the process of verifying the required documents and the steps for newly appointed employees to start work (checking the package, signing an employment agreement,[50] issuing an appointment order,[51] defining conditions by which the worker is allowed to start work,[52] and the requirement for a written record within the employment record book within 5 days after the commencement of work[53]). The UCLL states that an appointment order must be signed by the owner of the facility or the respective authorized body, but contains no requirements relating to the selection or decision-making process, such as the need to involve multiple stakeholders. Besides the UCLL, other secondary regulations endorse a central role for Chief Doctors in the appointment of new staff. Selection and appointment of facility staff is listed as the responsibility of the Facility Manager in the list of basic requirements to this post outlined in the *Reference book of professional qualifications (Volume 78, "Healthcare"[54])*. Moreover, the MoH has issued a *Typical Statute* for communal healthcare facilities,[55] which states that all appointments within the facility are the responsibility of its Manager, and which does not recommend any additional clearance for such decisions (Article 6). Exceptions to this approach do exist, but they are rare.

Notably, Chief Doctors themselves are appointed by the level of government responsible for the hospitals or other health facilities for which they are applying, and their appointment generally involves wider consultations and clearances. Most healthcare facilities in Ukraine are administered by sub-national governments, who act as "facility owners."[56] Notably, this rule covers not only local-self-government authorities (city and village councils) but also regional (oblast and rayon) governments, which run facilities which are jointly owned by villages, settlements and cities of respective rayon or oblast.[57] Chief Doctors of these local or regional facilities are appointed and dismissed by the respective Council, or its Executive Body. Specific procedures are defined by local regulations and may vary to a small extent across the country. In villages settlements and cities responsibility for appointing facility managers rests with the Mayor, although some cities (for example, in Izyum[58] or Sumy[59]) have further elaborated this general rule in their statutes to engage wider consultations with the local councils and administrations (but without specifying the process). In rayons and oblasts, candidates for managerial posts in facilities are usually proposed by the local State Administration (Head of Administration or key department) and must be approved by the local council.[60]

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49 These include: a passport or another personal identification document, employment record book, proof of professional education, proof of correspondence to the Unified Qualification Requirements of the MoH, and a health certificate (Second part of Article 24 of Ukraine's Code of Labor Laws, Article 74 of the Healthcare Framework Law).
50 Article 25 of the UCLL, part nine of Article 16 of the Healthcare Framework Law.
51 The order should specify the position (profession) according to Ukraine's State Classifier of Occupations or according to the staff schedule, as well as the terms of pay (clause 7 of section II of the Sector Rules for Internal Labor Regime).
52 These include: explanation of rights and duties, countersigned notice about terms of pay, rights, privileges and compensations, information about rules of internal labor regime and about union agreement, definition of his/her workplace, tools and instruments necessary for the work, safety, security, and sanitation instructions, including fire safety (Article 29 of UCLL).
53 Article 48 UCLL.
54 Approved with the Order of the MoH No 117 of 29.03.2002.
55 Ministry of Health, Order No 734 of 30.08.2010 "On Approval of Typical Statute of a Healthcare Facility – communal non-for-profit enterprise and of Typical Agreement on provision of medical services".
56 Article 17 of Ukraine's Law "On Local Self-Government".
57 Clause 10 of Chapter V of Ukraine's Law "On Local Self-Government".
58 Decision No 2255 of the 36th session of the 5th Congregation of the Izyum City Council (Kharkivska Oblast) approved 28.05.2008 "On Approval of the Statute of the City of Izyum in Kharkivska oblast".
59 "Statute of the City of Sumy", approved by the Sumy city council Decision No 893-MP on 26.10.2011.
60 Additionally, at the level of rayons, the candidates proposed by the Rayon State Administration must be cleared by the respective department of the Oblast State Administration.

Box 2. Cases of local decisions to introduce wider consultations over facility-level appointments

Although wider consultation over appointments within facilities is not required by the national legislation, there is some experience of such practices:

▪ It is possible for individual local governments (owners of the facilities) to establish additional requirements for Chief Doctors to have doctors and other health workers' appointments approved by local government, although such cases are rare. The requirement may be introduced through specific local regulations (e.g. via City Statutes) or within the Facility Statutes. For example, *Standing Orders* approved by the Stakhanov City Council to regulate the activities of its Municipal Hospital[61] (Clause 4.5) state that the Chief Doctor should appoint and dismiss facility staff and approve their job descriptions *"with agreement from the Healthcare Department of the Stakhanov City Council."*

▪ Professional journals include debates on the legal basis of attempts by local councils to require Chief Doctors to seek approval for their selections from the commissions of local councils. This suggests that these cases do exist. The National Journal "Healthcare Facility Management Practice" raised the subject in its 2011 Volume No 8[62] by asking the Chief Specialist of the Trade Union Federation of Ukraine to comment on the decisions of some rayon councils to require Chief Doctors of Central Rayon Hospitals to seek agreement to the candidacies of Deputy Chief Doctors from Healthcare Commissions of the Rayon Councils. The answer was inconclusive, but implicitly suggested that this is not in line with current regulations.

▪ National MoH regulations require authorization from local healthcare authorities for the appointment and dismissal of specific staff categories. For at least some healthcare workers, authorization of appointments and dismissal is required by MoH regulations. For example, the *"Typical Job Description of a Head of Department/Cabinet for Endoscopy"* approved by the Ministry of Healthcare Order No 393 of 11.07.2007[63] requires that such employees are appointed and dismissed by Chief Doctors *"with agreement from the Chief Non-Staff Specialist of the Healthcare Department of the Oblast (City) State Administration"* (Clause 1.2). Since there is no single document which would comprehensively describe detailed appointment procedure for all types of posts, it is difficult to conclude how many other posts have similar requirements.

At the same time, current legislation requires detailed documentation from new appointees, and formal qualification details. This requirement is diligently enforced. Ukraine's legislation qualifies for a Grade C, rather than a D, because there is precise legislative guidance in the UCLL, the Healthcare Framework Law and the Healthcare-specific secondary legislation relating to minimum qualification requirements for medical posts. This also covers verification procedures. The surveys also showed that these requirements are strongly enforced. And reporting from all groups of respondents – doctors, nurses and administrators – on their hiring experience suggested that the process was almost always fully compliant with the specified rules. In particular, 90.1% of doctors and nurses said that they had to submit a specified package of documents as part of their application. Moreover, 69% of doctors and nurses not only submitted the documents but also went through a formal interview.

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[61] Standing Orders on the 2nd Municipal Hospital of the Stakhanov City, approved by the decision No 321/29 of the 15th session of the 4th Congregation of the Stakhanov City Council on 11.04.2003.

[62] "Практика управління медичним закладом", № 8, 2011 (http://www.med-info.net.ua).

[63] "Typical Job Description of a Head of Department/Cabinet for Endoscopy" approved by the Ministry of Healthcare Order No 393 of 11.07.2007

Indicator HRM-3. Competitive selection of candidates

The best way to ensure merit-based appointments and to reduce risks of patronage and favoritism is to select candidates through open competition. In order to find the most appropriate and capable individuals, all potential candidates should have equal opportunity to apply and their suitability for the post should be accessed through an open and fair competition. Competitive examination of candidates differs fundamentally from simple checks of eligibility. Limiting examinations to whether the person is certified to do the job or has achieved certain minimum qualifications does not assure the selection of the best individual from several possible candidates. A necessary condition for competitive selection is that clear rules exist and are then implemented.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Is there a legislative requirement for competitive selection of candidates and what are the rules for running such competitions?	Desk study of national legislation	No legislative requirement for competitive selection and no rules for choosing between multiple candidates	Grade D
How often does it happen that there is competitive selection?	% Chief Doctors who say that at least ¾ of vacancies are filled with some competition	6.7%	Grade D
What procedures are used if there is more than one candidate for a certain position? Are there any informal rules which determine these procedures?	% Cases when Chief Doctors were able to explain procedures or rules used if there is more than one candidate for a post	33.3%	Grade C
Overall Grade			**Grade D+**

In most cases, hiring of medical staff in Ukraine is done without transparent competition and there is no legislative or regulatory requirement for competitive selection of health workers. In all three dimensions of this indicator this study has found little evidence that selection processes are open, equal and competitive:

- **National legislation contains no requirements or rules for competitive selection of staff in healthcare facilities.** Ukraine's labor laws and sector-specific regulations have no requirements regarding public disclosure of information about vacant posts in healthcare facilities (except provision of information to the State Employment Service, as described in **Box 3**), **or regarding open competitive procedures for filling vacancies**. Situations in which there are more than one candidate are not addressed and not regulated. Essentially, current legislation and regulations assume that appointments are based entirely on a simple examination of qualifications, drawing on the package of documents which need to be supplied by all candidates to be accepted to healthcare jobs (as described in the previous section).[64]

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[64] More discussion on legal qualification requirements – in the Indicator on importance of merit-based criteria.

- **This approach in the healthcare sector differs from the education sector.** The Ministry of Education addressed the absence of legal regulations for competitive selection of staff in 1993 by approving sector-specific *Procedures for Hiring and Firing of Pedagogical and Academic Staff to Education facilities in state ownership.*[65] These Procedures extended the regular labor law by providing the option for managers of educational facilities to agree contracts based on competitive selection of candidates. For academic staff, competitive selection became mandatory (which was also in line with the Law "On Education"[66]). Rules for selection of this type were then clearly specified, and typical contracts were duly established. This different approach in the education sector has some implications for the healthcare sector: medical facilities which act as training bases for Medical Education facilities (Universities) may employ medical staff working in academic posts (and selected on competitive basis).

- **As discussed earlier, hiring of staff for managerial posts has to be approved by upper-tier authorities, but there are no legal instructions on how such approvals should be granted if there is more than one candidate.** When candidates are considered for the position of healthcare facility manager/Chief Doctor, their candidacies should be approved with the owner of the facility or his authorized representative.[67] However, legal documentations do not provide guidance for situations in which there are multiple candidates, and where selection should be competitive. At the same time, competitive selection of candidates for managerial or other posts is not prohibited.[68]

- **The overwhelming majority of Chief Doctors report that in most cases they have only one applicant per post.** In only 6.7% of cases did Chief Doctors report that they usually (always or in more than three quarters of cases) had more than one applicant per post. Most of the responding administrators reported that cases of competition for posts are very rare; some of them said they had never encountered multiple candidacies even after more than 20 years experience in their positions. A significant portion of appointments are made through direct allocation of graduates and interns by healthcare authorities. In other cases, there is only one applicant. Moreover, applications are frequently "supply-based": doctors or nurses often apply for jobs not so much in response to advertised vacancies but rather because of their own changing circumstances (such as relocating to another town). Such prospective applicants approach the Chief Doctor and, if a vacancy exists, they become the single applicant.

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[65] Order of the Ministry of Education of Ukraine "On Procedures for Hiring and Firing of Pedagogical and Academic Staff of the Education facilities in state ownership", No 293 of 05.08.1993.

[66] Law of Ukraine "On Education", No 1060-XII approved 23.05.1991 (current edition – 18.10.2012).

[67] See previous Indicator.

[68] Only one such case was identified by this study: at least during 2012. Kirovograd Oblast State Administration ran a number of competitions for selection of managers of its communal facilities, including Healthcare facilities. Each competition was based on respective decision of the State Administration, but these are not accessible in public domain. In the healthcare sector, in March, competition was announced for the post of Chief Doctor in the Kirovograd oblast hospital by posting a respective advertisement on its website (http://kr-admin.gov.ua/start.php?q=News1/Ua/2012/01031204.html). The advertisement did not refer to any legislative requirements (as would be typical for official statements) and only listed selection criteria to the applicants (including such requirements as proposal of an original concept for development of the facilities in short- and long-run). Later, in August, another competition was announced for the posts of Chief Doctors simultaneously for three oblast Healthcare Facilities (Oblast Centre for AIDS Prevention and Control, Oblast Narcologic Dispenser, and Novomyrgorod TB Dispenser). According to some media statements, these episodes were related to a range of scandals which occurred in this particular oblast earlier in 2012, such as the revelation that the new Perinatal Centre which was opened in the oblast with participation of the President of Ukraine in fact had never started its work because respective funds were not included into the annual budget (http://gre4ka.com.ua/society/perynatalnyj-tsentr-v-kirovohradi.html). This and other episodes allegedly resulted in a range of dismissals in the healthcare management of the oblast (http://gre4ka.com.ua/society/na-kirovohradschyni-brakuje-holovnyh-likariv.html) and subsequent competitive selection of replacements for the vacated posts.

- **Lack of competition is reported both for attractive and unattractive posts and locations.**[69] Chief Doctors explained that hiring realities for attractive and unattractive posts substantially differ, but in both cases it is not done through competition. For unattractive posts/locations, finding applicants is difficult (for example one Chief Doctor said she was "ready to get to her knees to find good nurses"). By contrast, attractive vacancies are not widely advertised, which limits opportunities for competition.

    - For example, in one case the Chief Doctor complained that when doctors leave attractive posts, a prospective applicant is usually informed before the Chief Doctor finds out about such changes himself/herself, and the Chief Doctor learns about the future vacancy because a potential applicant contacts him expressing interest in the job.

    - In another example, a doctor explained that for attractive positions a separate approach ensures that vacancies are always available in case needed for "VIP" applicants. Certain posts are filled with friendly ghost workers (sometimes from the management), for example on a partial basis (25% of positions, 50% of positions). When there is a request to hire someone from those the Chief Doctor is loyal to, these ghost workers are fired, and a vacancy emerges for the individual concerned.

- **Only 33.3% of all Chief Doctors were able to explain the procedures they use when selecting from more than one candidate.** Most administrators found it difficult to answer this question or admitted that there are no procedures and rules. Of those who were able to explain their approach, most focused on the checks of qualifications and previous experience. Such CDs highlighted the need to collect references from previous employers; some expressed preference for middle aged applicants. However, 13.3% of CDs admitted that they relied on their subjective and emotional reactions to the applicants, because they trusted their intuition and experience of "feeling the people."

- **Some respondents mentioned competitions organized for healthcare posts by the respective municipal administration.** Some CDs described how the Healthcare Department of their respective municipal administrations organized open competitions to hire doctors for the municipal hospitals. In these cities, all facilities submit their requests for new doctors and these are selected by a selection committee organized under the Mayor but with participation of hospital representatives. Notably, doctors and nurses interviewed in the same cities shared a skeptical view on the transparency and effectiveness of these competitions, doubting that they always result in fair and merit-based appointments.

Box 3. The role of the State Employment Service

According to Ukraine's Law "On Employment", one of the roles of the State Employment Service (SES) is to assist employers throughout the country to find qualified staff and, thus, to assist the unemployed to find new jobs.[70] This mandate covers all employers working in the healthcare sector, including budget-funded facilities.

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[69] See footnote 27. Attractive positions are positions which allow greater collection of informal payments; unattractive positions are those in specialties and in departments where it is more difficult to collect informally.

[70] Law of Ukraine "On Employment" (approved 01.03.1991, No 803-XII, current edition of 18.10.2012; effective until 01.01.2013, to be replaced with a new Law of Ukraine "On Employment, approved 05.07.2012 No 5067-VI).

In order to fulfill its mandate, the SES collects information on all new vacancies from all registered employers, makes this information available to registered unemployed, and *"selects and directs workers of required qualifications to employers who demand them."*[71]

Collection of information on the open vacancies by the SES is clearly regulated. The Law on Employment requires all organizations, enterprises and institutions, regardless of ownership type, to submit data on their vacancies, as well as information on any restructuring plans, which may result in vacancies, to the SES. All legal entities have to register in the local Employment Centers, which are the local branches of the SES, as payers of the Ukraine's Unemployment Insurance Fund and to submit to these Centers their reports on current vacancies on a monthly basis (with penalties established for failing to register or to submit the vacancy reports). Compliance to these requirements is monitored by the Inspection for Control over Compliance to Employment Legislation.

At the same time, these laws do not set any rules for how the State Employment Service should select proposed applicants if there is more than one eligible candidate for the job. Although the current Employment Law will expire in 2013, it will be replaced with a new edition (approved 2012) which does not contain any clarifications on this matter.

Indicator HRM-4. Importance of merit-based criteria for hiring new staff

Hiring based on competence rather than personal favoritism is the foundation of a merit based and professional medical staff. Appointment systems may use diverse solutions for examining the professional qualities of the applicants. This can include safeguards against patronage and favoritism such as wide and transparent consultation and competitive selection. The ultimate indicator of the performance of the system is an estimation of how commonly appointments are guided by merit rather than by subjective factors such as personal connections, bribes or political patronage. In this study, this was estimated as a combination of two variables: frequency of merit-based appointments as perceived by doctors and nurses, as well as their view on whether merit usually matters more in the hiring process than other subjective factors (averaged by Method 2).

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
What is perceived frequency of merit-based appointments?	% Doctors & Nurses who state that all or almost all people they know received their job mostly because of their merits (knowledge, experience and other professional qualities) and not any other factors	47.2%	Grade C
Do health workers believe that professional qualities are more important during hiring process compared to connections and loyalty?	% Doctors & Nurses who state that professional qualities are more important than connections and loyalty in the process of hiring	63.9%	Grade B
Overall Grade			**Grade C+**

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[71] Clause "d" («д») of Article 4 of the Standing Orders "On State Employment Service", approved by Cabinet of Ministers of the Ukrainian Soviet Socialist Republic No 47 of 24.06.1991 (current edition – of 11.05.2006

Responses by Ukrainian doctors and nurses showed that patronage plays a decisive role in medical appointments. Against this, 63.9% of surveyed medical staff stated in their answers that professional qualities are more important during the hiring process as compared to non-merit factors such as connections or loyalty to the facility management. 22.2% believe merit and non-merit based factors are equally important, and only 13.9% state that connections matter more. However, only 47.2% of medical staff confirmed that almost all of their colleagues have actually received jobs primarily because of their professional qualities rather than through connections or other subjective factors. In many cases, respondents explained that it is nearly impossible to get a job without connections even though professional qualities might help to ensure that a particular person would be selected from several "patronage" candidates:

- *"Chief Doctors have to select qualified staff, but they create conditions under which they may choose someone they know and someone they would benefit from. Professional qualities matter, but there also has to be a connection; the Chief Doctor will select the best out of those people (s)he knows."*

- *"I do not know a single exception; all doctors I know received jobs through personal arrangements. All members of my family are doctors, so I know several people in this field, and I haven't heard of anyone finding a job without connections."*

- *"Professional qualifications matter only when quality has any importance and when there is competition. But here these things are not important, and everything needs to be done through arrangement. Everybody owns someone and then needs to repay it somehow."*

The importance of connections and patronage is greater for attractive posts. Figure 20 shows that health workers in relatively more attractive (doctor-level) positions are much more skeptical about the importance of professional qualifications in obtaining a job. Only 26.3% of the doctors claimed that almost all of their colleagues were hired mostly because of merit (compared to the 47.2% average, 42.9% for nurses and 85.7% for chief nurses) and only 47.4% of doctors believe that professional qualities matter more in the hiring process than connections, bribes and patronage (compared to 63.9% average, 62.5% for nurses and 100% for chief nurses). Notably, Chief Nurses – who are involved in hiring nurses themselves - were most optimistic about merit, stating in 85.7% cases that all of their staff was hired because of professional qualities and in 100% cases that professional qualities are more important than connection (thereby significantly distorting the average). The difference between merit-based selection for attractive and unattractive jobs is strongly supported by the interviews:

- *"To be honest, getting a job requires some connections, some support, and sometimes an informal payment. Getting a job without these additional means is very rare and only happens when, for some reason, the hospital urgently needs to fill some posts, for example, if it has to open a new department."*

- *"It depends on the position; in our facility it is very easy to be hired as an anesthesiologist, but impossible to be hired as a gynecologist – I don't know a single such specialist who hasn't used connections."*

- *"Getting a job without bribes and connections is possible only for low-prestige categories, such as emergency aid doctors, specialist in infectious diseases, primary care physicians, laboratory assistants, statistical specialists. In other posts, especially in state facilities, connections matter more."*

Oblast and rayon level facilities seem to give much lower priority to professional qualities compared to the municipal level. As illustrated in Figure 21, only 20% of staff from rayon and oblast facilities claimed that most of their colleagues were hired by merit (compared to 68% in the cities[72]).

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[72] A hypothesis to be tested in future research would be that better performance in municipal hospitals applies to service delivery dimensions as well, and that it is related to their stronger accountability to local populations. Municipal

Professional qualities were considered more important than connections by 60% at the oblast level and 50% in the rayons, in comparison with 74% in the municipal facilities.

Figure 20. Views on importance of merit-based criteria cross-tabulated by position
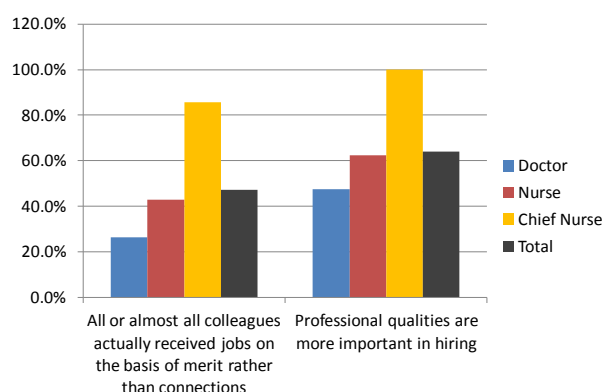
Figure 21. Views on importance of merit-based criteria cross-tabulated by facility level
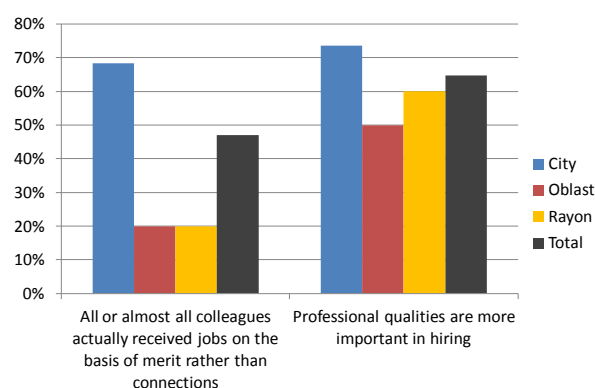
Several doctors explained that the way people obtain their jobs is almost never disclosed and discussed even amongst colleagues who are close friends. This could be one reason why responses to questions for this Indicator have received a high share of inconclusive or contradictory answers (which were excluded from calculations).

- *"Such issues are never discussed. Based on my experience, it is very difficult to find a job on your own."*

- *"Nobody ever says how they were hired; it is known by all that such issues are not discussed. I think that no one gets a job on his/her own, because we have a lot of competition in our city."*

- *"It is difficult to judge whether professional qualities matter more than connections because people do not disclose the details of their hiring process. Also, doctors tend to keep to the posts once they receive them."*

Other responses also indicate that the healthcare system overall has a high degree of "compartmentalization", with groups of people connected though personal patronage. Descriptions of hiring procedures by doctors and nurses contained many references to the pervasive scale of connections and significant entry barriers into these circles.

- *"We have these big dynasties here; the father is a surgeon, the son is a surgeon etc, and everybody knows them, and know the decency of the father, and that the sons are always like their fathers."*

- *"When you are on your own, you have no one to count on. But most of the people in our University do not even think about how they are going to find their jobs, they know that their connections will resolve everything. There are lots of people who pay for their degrees, and then they pay for their jobs, and they do not worry because they know that if there is any problem, they would pay for that too."*

- *"In the medical fraternity, everybody knows each other. Therefore, it is very difficult to separate cases when people find jobs with or without connections."*

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governments' Executive Authorities (Mayors) are elected, rather than appointed by central government, unlike oblasts and rayons authorities.

Indicator HRM-5. Job description

Clear, accurate and up-to-date job descriptions help employees to know what is expected and to deliver accordingly. To assess the quality of job descriptions, the minimum requirement is to check whether such documents even exist in written form. This is why this indicator is assessed by Method 1. For those employees who do have job descriptions, the quality of this tool comprises several key dimensions. First, it is not enough for job descriptions to be in place, they need to be used in practice. Secondly, when workers have to refer to their job descriptions, they should find them helpful in most cases. Finally, job descriptions need to be regularly revised to make sure that they reflect current job responsibilities and priorities, help to evaluate performance and establish individual career development goals.

Scoring table (Method 1)			
Dimension	Source	Benchmark	Grade
Do written job descriptions exist? **[Minimum requirement dimension]**	% Doctors & Nurses who have some type of written job description	97.2%	Grade A
Are job descriptions actually used?	% Doctors & Nurses (of those who have job descriptions) who actually referred to them after they were signed	82.6%	Grade A
Are job descriptions useful?	% Doctors & Nurses (of those who have job descriptions) who find them useful always or in most cases	76.5%	Grade A
Are job descriptions regularly revised?	% Doctors & Nurses (of those who have job descriptions) who state that these documents are revised at least once every 5 years	81.0%	Grade A
Overall Grade			**Grade A**

The HR management system in Ukraine qualifies for an exceptional Grade A for this Indicator. National legislation requires that all employees are supplied with an employment contract and a written job description, describing respective duties and responsibilities in line with the standard requirements established for all categories of health workers. In addition, according to Article 21 of the UCLL, key responsibilities and scope of work should be defined by the employment contract. Specifically for the healthcare sector, key requirements around knowledge, functional duties and qualifications of workers in healthcare facilities are defined within the *Reference book of professional qualifications (Volume 78, "Healthcare")*, albeit in a rather generic form. The existence of the job descriptions and the detailed requirements on their content are one of the key criteria which impact on whether the facility will pass regular state accreditation (described in detail in Box 5). The requirements include, among other things, a typical template for the job description, which must include description of tasks, rights, responsibilities, required knowledge and skills.

The survey results confirm overwhelming compliance with these legal requirements as discussed below:

▪ **Availability of written job descriptions amongst doctors and nurses was confirmed in 97.2% of cases.** Moreover in 56.3% of cases, respondents stated that their job descriptions were compliant not only with national legislative requirement but also with specific local regulations issued by their sub-national governments.

- **In 82.6% of cases, employees confirmed that they actually referred to the job descriptions at least once after they were signed.** Job descriptions seem to be "living documents", which are used in practice. In most cases, this was caused by the need to resolve controversial situations or work-related conflicts. However, some staff used job descriptions to check whether they were allowed to implement certain activities. Moreover, in some cases a description of duties was needed in the performance evaluation process for producing self-assessment reports.

- **Job descriptions seem to be more often used for resolving conflicts with patients rather than conflicts within the facilities.** Some examples of such episodes are listed below:

- *"There are situations when we need to protect ourselves and explain what responsibilities we are supposed to execute. For example, nurses have a duty to check medical cards of the patients before they see the doctor and to find out who referred these patients to the facility. Many patients object to this and insist that they can see doctors directly if they wish. It helps to be able to show them that it is the nurse's legal duty to prepare patients and doctors for the visit."*

- *"Sometimes patients disagree with preliminary diagnoses and refuse to accept that they have a certain illness. For example parents may not agree with a diagnosis made for their child because they don't want certain problems to be associated with their children. Some parents cannot accept that their child is disabled and they believe that the child is not sick, even if this is the case. In such cases, parents insist that we should not make a preliminary diagnosis but only list symptoms. But I need to prove that I do have the right to provide a preliminary diagnosis, and it is very difficult without the job description."*

- *"We sometimes have conflicts with mothers who refuse to show their newborns to the doctors. In such cases we can use job descriptions which show that doctors have the right to inspect all newborns within the first weeks of their lives."*

- **In 76.5% of cases doctors and nurses found their job descriptions useful.** The majority of doctors and nurses found their job descriptions useful. Job descriptions are perceived as a basic tool governing employment relations, even if this can increase the bureaucratic burden. However, some do complain that these documents are too formal, sometimes existing only on paper and are not relevant to the delivery of services and to the actual needs of the patients.

- *"I had a conflict with the management because they required me to be on duty in the Admissions Unit. This is outside the scope of my duties because I am a neonatologist. I tried to use my job description to protect my rights, but it didn't help, and I had to go on duty as requested."*

- *"We had a problem with a junior nurse who worked in the corridor and whose job description required her not only to make sure that the corridor is clean but also to help the patients if needed. She refused to do it initially, but after referring to the job description we were able to resolve this conflict."*

- *"Job descriptions are used not so much in conflict, but in other situations. For example we had a fire and the Prosecutors Office had to review the case. They looked at the job descriptions of all staff to see who was supposed to do what in such an emergency situation."*

- **In 81.0% of cases, job descriptions were regularly revised.** In 27% of cases, existing job descriptions were revised during the previous 5 years, and in a further 54% of cases they were revised as recently as during the previous year. However, explanations during the interviews indicated that not all of these revisions are meaningful and that sometimes even after revisions the content may remain essentially unchanged. As a rule, the nature of revisions is dictated by the issuance of some new national or local regulations which need to be reflected in the job descriptions of respective staff. *"Immediately when MoH orders arrive, they need to be reflected in the Job Descriptions".*

Personnel Management

Indicator HRM-6. Opportunities for career progression

Opportunities for career progression allow professionals to fulfill their potential by extending their skills, knowledge and responsibilities. Providing employees with a range of opportunities to take on more challenging roles and acquire new skills and professional experiences is one of the core factors required to stimulate continued learning, strong performance and high morale. Individual aspirations and values may differ, and not all workers may have leadership ambitions, or aspire to move up within their organizations. Professional growth opportunities in healthcare, therefore, embrace not only possibilities to advance up the administrative ladder but also scope to move to other posts and tasks which are in line with the employee's individual professional development aspirations. To assess the quality of career opportunities for this Indicator, this study used an average of two dimensions: the estimated scope of the existing opportunities and the degree to which it appeals and motivates medical staff.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Is there a sufficient range of opportunities for career progress in the medical profession?	% Doctors & Nurses who state that there is a sufficient range of opportunities	17.1%	Grade D
Do health workers feel motivated and encouraged by the existing career opportunities?	% Doctors & Nurses who state that career opportunities are non-existent, not appealing, or almost impossible to achieve	72.1%	Grade C
Overall Grade			Grade D+

The Career development system in Ukraine's healthcare is exclusively focused on acquiring over time managerial responsibilities, while opportunities for professional growth within technical positions are less visible and less appealing. Only 17.1% of the interviewed respondents (mostly doctors) stated, in their description of career progression, that there are a range of opportunities for professional growth within their organizations. The majority of the doctors and nurses (75.7%) explained that the only career development option they have is to apply for a managerial / administrative post (becoming a Chief Nurse, Head of the Department or Chief Doctor). This would imply a significant change of career direction.

- *"Those who are promoted to managerial posts usually become pure administrators, they distance themselves from practical medicine. Usually, people don't want that. As we say, 'we all studied for different reasons.' Someone wanted to be a director, while someone wanted to be a surgeon."*

- *"What career growth is at all possible in our healthcare? The question you are asking is formulated in a funny way and clearly not for our society. What career progression could there be for our nurse? At best, she might become a Senior Nurse or the Chief Nurse. But there is only one Chief Nurse, while there are hundreds of nurses."*

- *"The promotion episode I remember is when the Chief Nurse retired and was replaced. But if she had not retired, there would have been no promotion."*

Typically, the predecessor (previous Head of Department or Chief Nurse) may propose a candidate for replacement or have a voice in the selection process:

- *"Usually for such managerial posts we have a reserve list of candidates – about two people per post. Among other things, these 'replacement reserve' employees usually execute the duties of their current line manager in his/her absence. When we have to select someone for actual promotion from the reserve list, we usually ask the leaving manager himself to make a proposal. Besides, we need to get an agreement from the candidate himself. As a rule, there are not many people who wish to work on these managerial posts."*

A majority of doctors and nurses (72.1%) admitted that they have no interest in pursuing currently available career opportunities. Of those doctors and nurses who shared their insights about their level of motivation in career development, most believed that current career opportunities are not appealing to medical professionals. As shown in Figure 22, only 2.8% described career growth as an important aspiration for most health workers. Another quarter of the respondents explained that for most doctors, career progression is not important because they are interested in other aspects of their work (discussed below). However, the remaining doctors and nurses stated that current opportunities are either unattainable (44.4%), or not appealing (19.4%), or non-existent (8.3%):

- *"Moving anywhere within the facility is impossible, the only way to move is to move away – perhaps to other hospitals. Mostly, people work their whole life in the posts where they start – and they remain there until they retire. There is no career progression. But no one is really bothered by this in any way."*

Figure 22. Attitudes of doctors and nurses to the current career opportunities
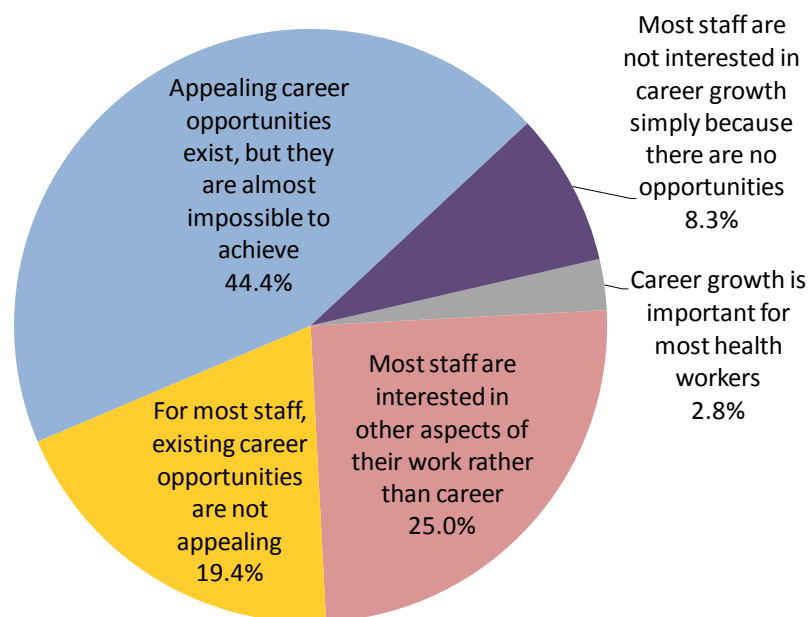
Health workers who believe that existing career opportunities are unattainable usually ascribe this to opaque and costly promotion procedures, especially at the highest category level. As illustrated in Figure 22, 44.4% of doctors and nurses stated that they consider it nearly impossible to ever achieve the few good career development options which are theoretically available:

- *"Every five years there is a chance to upgrade our specialist category, but it does not mean that it will actually be achieved. Receiving the highest category is nearly impossible. For some reason, in our city this process is captured by the oblast chief therapist, and it all depends on whether you are able to find your way to her and make her like you. Personally, I have the highest category, but I look at the young people now and I can see that most of them will never receive it. "*

- *"In career progression, what matters is special connections. I do not see any chances for career growth for myself. If I want a higher category, in my field which is endocrinology, I need to travel to receive training, and I have to pay for it myself – my expenses would not be covered. So, gaining all these new categories is very hard, and it is useless given that you would still return to work essentially for free."*

- *"Career progression is limited to upgrading categories. This involves attending training, which is supposed to be funded by the facility, but in our case, it is not covered. So, only those who have an opportunity to attend this training might consider any career options."*

- *"For recertification, some hospitals send their staff to our own oblast commission, while others like to send staff to Kyiv. The Chief Doctor decides whether he agrees to send you to Kyiv or not. And he can always explain his rejection by saying that he was unhappy with your performance. In such cases, there is nowhere to complain: it would be the same as peeing against the wind."*

- *"My good colleague has worked as a gynecologist for 30 years, with two jobs, and suddenly last year the municipal healthcare department did not approve her application for reconfirmation of her level of highest category. So where would she work now? Therefore, a lot of doctors in our city try to avoid getting these categories at all, simply to avoid the need to humiliate themselves in front of these recertification commissions, to not make a fool of themselves. Because in our city receiving the highest category is extremely difficult. I don't imagine what it takes to get it. The highest category is only confirmed for the managers, and I am sure it must be some kind of policy. This policy comes from city and oblast authorities to save on salaries or maybe with some additional goal, but they try to avoid giving highest categories. So, doctors don't even bother applying – it only adds 20-30 UAH to your wage but it exhausts your nerves. When you go through recertification, you can be a genius, but it would be still easy to fail you."*

- *"It is subjective and unpredictable. Last year, the Head of the city Healthcare Department rejected the application for highest category of a Department Head from one of our municipal hospitals. And after crapping right into his soul in this way, next year he suddenly gave him a title of a Distinguished Doctor of Ukraine, as if it helped."*

In a quarter of cases, doctors and nurses stated that career progression does not matter much because most health workers have other priorities anyway:

- *"If you ask any of my colleagues – nobody wants to become the Head of Department. Because the key professional goal is not career growth, the goal is to achieve some material benefits, ideally – to open a private practice."*

- *"For a doctor, to have a career means to have a lot of patients."*

- *"Categories are not important. What matters is that when you have more experience, you are more appreciated by the patients and you start having more of your own patients."*

- *"Do people want to have a career growth? It depends on how we define it. To be a good doctor is already a good career, because a good doctor will have a much higher income than others. He may be much more prosperous than his manager, and he would be also happier because he would not be bothered by all the administrative duties. Being a good doctor is the best career and it does not depend on your formal position."*

In the absence of opportunities for career progression, many health workers refer to informal career paths which they consider appealing. During the interviews, doctors and nurses described various alternative forms of career development which are not always associated with formal qualifications or even changes of posts:

- **Inclusion on the "reserve" of specialists for possible replacement of current managers.** It is a required practice for healthcare facilities plan for the possible retirement of managers by

selecting a "reserve list" of specialists to replace them. These workers may receive larger responsibilities and workloads, including opportunities to act in place of the managers when they are on leave.

- **Undertaking more duties without changing posts:** *"It all depends on a person. I love my job as a practical doctor and I am not interested in managerial posts. So, for me, a certain development is the fact that I am a rayon specialist responsible for all Chernobyl victims. Also, there is some development in gastroenterology, and if you have energy, desire to learn you can get new duties."*

- **Transferring to more demanding sectors with the same job:** *"Formally, there is almost no way for any career growth – if you are a nurse, you can only hope to become a Senior Nurse. But some of our nurses work as nurses-anesthetists, which are considered kind of more senior. To work like this, you need to go through training and then you can actually help doctors to administer anesthesia. These nurses have same formal salaries as others, but it is considered more prestigious. Moreover, their job is easier: once the surgery is over, they are free, while here at regular posts we have to attend patients 24 hours a day, and work not only as nurses but also as their mothers and sisters. Treat them, pamper them, clean them."*

- **Transferring to more respected departments in the same facility:** *"Our nurses are considered more qualified; they are requested by other departments because we are allowed to administer all procedures by ourselves, so we have these skills, unlike nurses in other departments. For example we can insert urinary catheters, we can use feeding tubes, we can do intravenous administrations properly which not everybody can do. For us all these medical procedures are daily routine."*

- **Transferring to more demanding facilities:** *"One possibility is to transfer to another facility which has an in-patient department, which would represent a career growth. However, to achieve this, you need to know about open vacancies in the first place, but this information is spread only by connections".*

- **Transferring to better equipped facilities with bigger opportunities:** *"We just had a new hospital opening after reconstruction. It became semi-commercial and it received a lot of good new equipment. Lots of staff left to work there, and it was a significant career growth for them. As for the rest of us, we just sit here on our old places."*

Indicator HRM-7. Career progress/promotion procedures

Transparent, competitive and merit-based consideration of candidates for promotion enables the selection of the most able professionals and increases confidence and motivation for all staff. To make sure that all posts are filled by the best possible candidates, employee advancement should be based on relative merit established through fair and open competition. Assessing whether promotion procedures are indeed helping facility managers to make the best personnel decisions is based on three dimensions, averaged by Method 2: 1) Transparency of criteria used in the process; 2) Low prevalence of patronage and favoritism; and 3) Importance of merit-based criteria.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
How explicit and objective are the criteria which are used for promotions?	% Doctors & Nurses who believe that lack of explicit and objective criteria for promotions is one of the three biggest barriers to career progress in healthcare	25.4%	Grade B

How strong is the impact of non-professional factors (political patronage, loyalty to the hospital management, connections) on the chances of career progress?	% Doctors & Nurses who select political patronage, loyalty to the hospital management, and personal connections among top-three strongest factors in career growth	32.8%	Grade B
Do health workers believe that professional qualities are more important for promotions compared to connections and loyalty?	% Doctors & Nurses who state that professional qualities are more important than connections and loyalty for career progress	63.1%	Grade B
Overall Grade			**Grade B**

Lack of explicit criteria for promotion within facilities is considered to be a major problem by around a quarter of the employees. 25.4% of doctors and nurses believe that the lack of transparent promotion criteria is one of the top-three biggest barriers for career growth. Doctors tended to consider this issue more problematic than nurses (28.2% of doctors ranking it in the top-three compared to 16.7% for nurses).

In many cases, employees believe that promotion choices are dictated by non-merit factors; most usually, loyalty to the facility management. 32.8% of the doctors and nurses believe that non-merit factors rank in the top-three issues governing career progression. These factors include political affiliations, personal connections and being loyal to the facility management (supporting and executing all their decisions without criticism). Among these three factors, loyalty seems to matter most frequently, as illustrated in Figure 23 (chosen by 23.9% respondents). At the same time, political affiliations are least important of the three (indicated by only 1.5% of respondents, along with personal connections):

- *"Recently in our hospital one girl was promoted to a better post in another department. It happened because she worked here for a long time, had a sufficient (highest) category and never created conflicts with the hospital management" (response by a nurse in a rayon hospital).*

- *"To be promoted, this person needs to have knowledge, experience, and be ready to execute tasks and not be prone to creating conflicts" (response by a Chief Doctor of a central rayon hospital and policlinics).*

- *"Loyalty and connections matter, because managers want to see people with whom they already have an established level of communication and with whom there will be no problems in the future" (response by a Chief Doctor of a city policlinic).*

Figure 23. % Doctors & Nurses selecting non-merit factors among top-three most important for career growth

Loyalty to facility management

17.9%

Connections

7.5%

6.0%

1.5%

Political affiliations
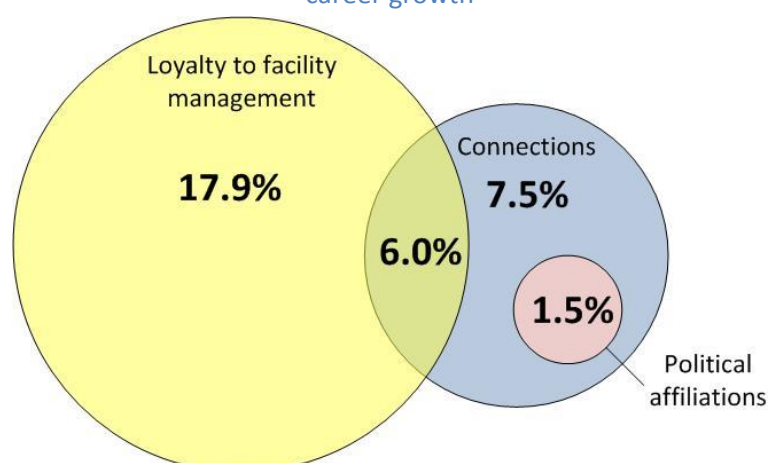
A significant share of respondents believes that professional qualities are still more important than subjective factors. 63.1% of doctors and nurses believed that professional qualifications matter more than non-merit factors, and a further 21.5% stated that merit is as important as connections, loyalty and political patronage. However, as shown in Figure 24, trust in the importance of merit-based promotions is much weaker among doctors as compared to nurses: only 51.4% of doctors believed that professional qualifications matter more than connections and loyalty, and 32.4% believed that non-merit factors matter at least as much.

Figure 24. Importance of merit-based criteria cross-tabulated by type of position
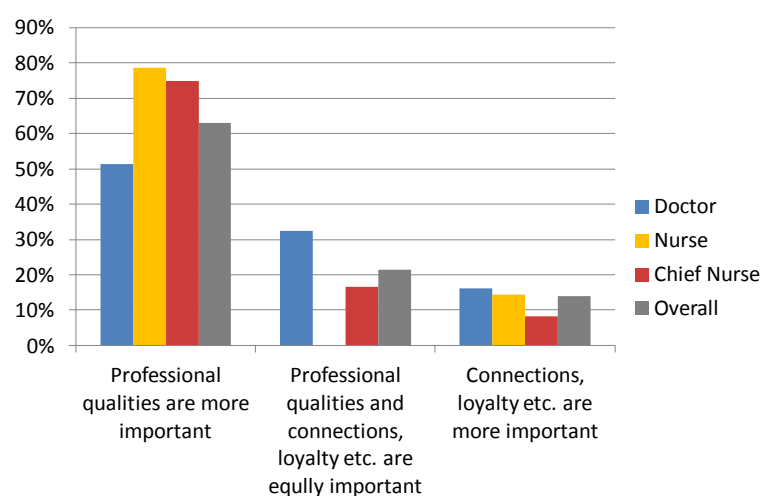
Several of the quotes link career progress to the mandatory recertification procedure (referred to as *"receiving a professional qualification category"*). As described in Box 4, at least every five years all medical professionals (doctors and junior specialists with medical education) have to go through this recertification procedure, which either confirms or upgrades their professional qualification category. The qualification category affects health workers in two ways:

1. **It is one of the key eligibility criteria for any medical post**. Unified Qualification Requirements for each category of workers in healthcare facilities and authorities (managers, professionals, specialists, technical staff) are established by the Ministry of Healthcare and described in the *Reference Book of Professional Qualifications (Volume 78, "Healthcare,"* approved within the *Order of the MoH No 117 of 29.03.2002).* This document

specifies that having up-to-date certification (confirming either as basic "Specialist Doctor" title or as one of the three higher categories) is required for all posts, but also lists specific positions which require highest category – such as Chief Doctors or their deputies.

2. **It impacts the level of fixed salaries**. Fixed salaries – or guaranteed wages before benefits – are defined for every worker of a health facility by multiplying a pre-defined minimum wage established by the CoM[73] by a series of coefficients which reflect the nature of the position and the qualification category of this employee (as will be discussed in more detail in the subsequent section).[74] For example, an employee occupying a post of a doctor-surgeon would have a pre-defined minimum wage increased by a coefficient in a range from 1.97 to 2.42. The precise size of such increase (the size of the multiplier) depends on the professional qualification: for example, this surgeon has no qualification category (i.e. s/he is simply "Specialist Doctor"), the multiplier would equal 1.97 (leading to a fixed salary of UAH 1, 653[75]), while a surgeon with the highest qualification category would have a multiplier of 2.42 (leading to a fixed salary of UAH 2 030, which is UAH 378 or 23% higher).

Most doctors and nurses interviewed in this study recognize the possibility of obtaining higher qualification categories but few consider these "category upgrades" as a sign of "career progression" as such (unless these categories can be used to secure a more senior position). Upgrades in qualification categories are described as necessary only in cases when health workers are interested in obtaining higher-level (administrative) positions but not strongly appealing in other cases. The impact of upgrading categories on the salary level is perceived to be negligible and not worth the investment needed to achieve the upgrade.

- *"All career possibilities have shrunk to the upgrade of qualifications. You can receive the highest qualification category, but then what would you do with it? You can seek a position as Department Head or Chief Doctor, but all these posts are occupied. There is no movement. In our department, all doctors have the highest qualification category, and they all sit in a career grave."[76]*

- *"I don't see what could possibly represent a career progression for a nurse. We are recertified every 5 years, and our qualification can increase, but we will still remain on the same post and with same responsibilities."*

- *"The only possible progression is to achieve a higher qualification category. Could this be considered career growth? I don't think so. It has no impact on the position and responsibilities. The system of career progression does not exist."*

- *"There are very few career advancements. Only your qualification category can grow and your title can change, but you have to work on this, you should go through the exams but also invest in the 'encouragement' of the recertification commission (here the interviewee was hinting at the need to bribe the recertification commission members), because this is critical no matter how well you do on your exams."*

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[73] The "minimum wage" in this case corresponds to the "size of the fixed salary of the hypothetical first band worker", defined by the CoM Resolution No 10 of 11.01.2012 "On increasing remuneration for workers of publicly funded facilities in certain areas" at the level of UAH 773 (starting from 1 January 2012), to grow to UAH 794 (starting from 1 April 2012) and further to UAH 839 (starting from 1 December 2012).

[74] The size of these coefficients are defined in a Unified Schedule of Bands and Coefficients for salaries of workers in publicly funded facilities, approved by CoM Resolution No 1298 of 30.08.2002, and way they should be applied is described in a joint Order of the MoSP and MoH No 308/519 of 5.10.2005, which approves Terms of Pay for Workers of Healthcare and Social Protection Facilities.

[75] Without benefits and at the level of the fixed salary of the hypothetical first band worker of UAH 839 defined as of 1 December 2012. This would be equivalent to USD 206 at current exchange rate (USD 1 = 8 UAH).

[76] "Pit, hole"

- *"This whole system is wrong. Categories influence our salaries, so they are supposed to stimulate us. But this stimulation is so paltry that we have no desire whatsoever to develop our careers. Think about it, my husband is a highly qualified specialist, while I am a primary care physician, our jobs are not comparable in complexity terms, but we have same salary levels. Therefore, to me, personally, career growth is not interesting at all."*

Box 4. Obtaining and raising qualification categories through 5-yearly recertification

The key method of performance evaluation in the health sector is *recertification* of staff, undertaken once every 5 years, including a preceding self-evaluation. The recertification procedure allows medical workers (doctors and junior specialists with medical education) to go through three major stages of professional development throughout their career: (1) initial certification, as a "Specialist Doctor" (2) attainment of a "qualification category" (second, first, or highest), and (3) upgrading the obtained "qualification category." Each of these stages requires separate "recertification" which can, respectively, take three forms:

▪ Recertification to define the level of knowledge and practical skills to assign (or confirm) the title of "Specialist Doctor";
▪ Recertification to assign a qualification category (second, first, or highest);
▪ Recertification to confirm a qualification category.

Primary certification (and assignment of the title "Specialist Doctor")

Certification to define knowledge and practical skills to assign (or confirm) the title of "Specialist Doctor" in concrete medical specialization is required for graduates from internship, residency, or postgraduate training, if they do not yet have a certificate of Specialist Doctor. After initial certification, each doctor has to confirm the title of Specialist Doctor every 5 years by going through a recertification process.[77] Primary recertification is also required for all doctors who discontinued medical practice for longer than 3 years, or those who applied to receive a higher qualification category but were rejected.

Primary certification and recertification is performed by the Certification Commissions established within the Higher Medical Education Facilities (III and IV accreditation level) and within Facilities for Post-Graduate Education.

Confirming and raising the assigned qualification:

When a doctor is re-certified every 5 years, (s)he can seek to achieve a higher qualification category. If the doctor fails to obtain a higher category, (s)he should confirm the title of Specialist Doctor.

After obtaining a higher qualification category, the doctor will go through recertification to confirm this category no less frequently than once in 5 years. Recertification to achieve a higher qualification category may be performed no sooner than one year after the previous recertification[78].

When applying for a qualification category, the candidate can request one of the three levels of qualification: Second, First, and Highest. Broad requirements for each category which are specified in the MoH Standing Procedures are limited to those who have acquired at least the minimum required years of experience for each of the categories.

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[77] Exception is made for pregnant women or women on maternity leave (Clause 4.2).

[78] Clause 1.10 of the Standing Procedures on Certification of Doctors, approved by the Ministry of Healthcare Order No 359 of 19.12.1997.

Indicator HRM-8. Day to Day Performance Assessment

It is impossible to improve the quality of services without having an effective way of monitoring it. Tools for staff performance evaluation may vary and could be based on a variety of data sources and types of measures (indicators). However, any effective system should ultimately help motivate health workers to provide better services for their patients and help the facility as a service provider to achieve its strategic objectives. To achieve this, performance assessment needs several vital components: it must include some link between performance results and rewards, it must be sufficiently transparent with public disclosure of results, and it must be sufficiently interactive, involving employees and the management at all stages of the assessment (setting goals, discussing the process, following up jointly on the outcomes).

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Is there a system of formal staff performance assessment with clear record of results?	% Doctors & Nurses who confirm that such system exists	83.1%	Grade A
Is there a complementary system of informal performance assessment (regular assessments and individual performance by the line managers, discussion of unsuccessful cases at departmental meetings etc)?	% Doctors & Nurses who confirm that there is some informal assessment system	84.5%	Grade A
How useful is the existing system of formal performance assessment?	% Doctors & Nurses who believe that the existing system is very useful or useful in most cases	83.3%	Grade A
Are existing performance assessment systems linked to reward levels received by staff (salaries, promotion changes, training opportunities or other benefits)?	% Doctors & Nurses who confirm the impact of performance on reward opportunities	78.8%	Grade A
Overall Grade			**Grade A**

A majority of the facilities around the country use a combination of formal and informal assessment systems, which are perceived by the employees as generally useful and influencing rewards. Ukraine scores a robust "A" for the performance assessment indicator, with most doctors and nurses confirming that their organizations use a range of useful measures to regularly assess staff performance as described below. As was revealed during the interviews, to a significant extent, this strong result is linked to two major factors:

1. **The need of all facilities to receive high scores in the process of 3-year mandatory state accreditation (see Box 5).** Since 2011, facilities are accredited based on a detailed list of performance indicators including staff performance and qualification measures (such as the number of surgeries conducted per specialist; the number of patient complaints; mortality indicators; etc), but also including reports on approaches to ensure quality (gathering of required statistics, consultations and meetings to discuss problems, patient surveys etc).

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[79] Healthcare Departments of the Oblast State Administrations, Kyiv and Sevastopol City State Administrations, and the Ministry of Healthcare of the ARC.

Respectively, most doctors and nurses interviewed for this study described a range of activities undertaken in their facilities to evaluate performance and to make sure that resulting data are available for accreditation purposes.

2. **The need for all medical professionals to collect a certain number of scores to qualify for 5-year recertification to receive a qualification category.** Since 2009, one of the minimum requirements for being considered for a recertification qualification category (described earlier in Box 4) is to collect a defined amount of performance scores during the period since the previous recertification. Scores are provided for 22 types of activities, including various types of training, managing interns, participation in research, participation in innovative treatment approaches, producing publications, making presentations to general public and media, and working in rural areas.[80]

A formal assessment system was reported in 83.1% of cases. A range of performance measures is collected regularly through formal procedures: provision of data and reports to line managers and the facility statistical specialists. While many respondents explained this process with the need to comply with the accreditation requirements, some have also referred to additional quality standards introduced by local healthcare authorities or the facility management itself.

- *"We provide quarterly reports to the statistical unit. This is to help them monitor the patient load: how many patients each of us must serve; for example they can calculate how many patients we served during the year and whether we achieved the plan. It is needed by the management. And if we underachieve, they can cut our salaries, for example by transferring us to 0.75% of a position. But if we overachieve, there is no impact on anything."*

- *"Yes, there is a methodology for monitoring performance which is established in the rules for facility accreditation. But it is hard for me to say how they calculate these indicators."*

- *"Sure, there are established quality standards for every specialization, and our managers collect these measures every quarter. The standards are established by the local healthcare authorities. We also have daily 15-minute meetings, extended monthly meetings, and this also corresponds to the description of control measures which are outlined in our job descriptions. For all these meetings, there are detailed records, all resulting notebooks with these records are duly stamped and stitched together. So, when the hospital goes through accreditation, all these documents are presented."*

- *"For performance assessment we have a system: it is a set of indicators which we need to achieve. There are really many of these indicators. All the check-ups we undertake, all indicators which describe the patients' visit, numbers of home-visits, plans for amounts of X-rays, plans for inspection for diabetes. Everything we do is based on indicators, and it all has to be executed."*

- *"There are lots of formal performance indicators: the number of diagnosed diseases, number of patients, number of deaths, etc, plus our reports during the staff meetings."*

- *"There are expert standards for care quality, for doctors as well as for nurses. So, we monitor how everyone complies with them, and if they don't, we reduce their scores. We look at everything: at what time they arrive and depart from work, how well they manage their records, assessing their professional qualities."*

The study also found cases of truly positive performance assessment systems, created by extra-ordinary Chief Doctors by their own initiative.

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[80] MoH Order No 484 of 07.07.2009. *"On approval of changes to guidelines on running examinations for recertification cycles".*

- *"We conduct anonymous surveys: asking heads of departments to assess the performance of management, and also asking patients to assess the performance of our staff."*

- *"We have ourselves developed performance standards. Each nurse receives scores for every part of her work: treatment, training, volunteer work, sanitary and prevention activities, the level of his/her care in provision of services. And in each of these components are other sub-components which are all evaluated. We also have a list of problems for which the scores are reduced: mistakes during treatments, complaints from patients, reprimands from management, ignoring safety regulations, errors in documentation etc."*

- *"Every year we develop individual plans which show what new skills we intend to master: for example taking cardiograms, prevention and promotion activities etc. The Chief Nurse gives us scores for achievements against these plans. Usually, the score is 'satisfactory'. Previously we were scored 'outstanding' or 'good', but now – always 'satisfactory', which is kind of highest these days."*

Box 5. Mandatory state accreditation of healthcare facilities

Once every 3 years, all healthcare facilities in Ukraine (public and private) must go through mandatory state accreditation. Accreditation certifies that the facility has sufficient conditions to provide quality services, maintains established standards of such services and employs staff formally qualified for their jobs[81].

Accreditation is conducted by working groups of designated experts, coordinated by accreditation commissions under healthcare authorities at central and sub-national level. It results in acquisition of one of three accreditation categories: Second, First, and Highest.

Starting from 2011, accreditation follows a set of new Standards and Criteria established by the Ministry of Health[82]. The Standards cover 25 domains of service provision: 10 generic areas of facility management and 15 service-specific areas: Facility management; Human resources; Management of facility units; Patient rights, responsibilities and security; Medical information service; Equipment maintenance services; Sanitary and epidemiological safety; Labor protection; Exploitation of buildings; Quality of medical aid; Primary medical aid; Emergency aid; Out-patient aid; In-patient aid; Surgery, anesthesia, intensive therapy; Motherhood and childhood services; Rehabilitation; Para clinic service; Laboratory diagnostics; Use of medications; Blood supply service; Post mortem services; Burn medicine; Transplantation centre; and Medical genetics.

Every facility is scored on its achievement on each relevant domain[83] based on a list of detailed sub-standards. After establishing scores for all domains, experts who lead the analysis calculate the result as compared to a theoretical maximum. This defines the accreditation level (90-100% leads to the highest category; 80-89% - first category, and 70-79% - second category).

In order to participate in the assessment, every facility needs to submit a set of documents which show its achievements against all standards and sub-standards. Apart from basic registration documents, this set of documents contains a range of reports which illustrate the structure of staff, indicators of their qualifications and performance, results from the provision of medical services for the three previous years and analysis of the quality of these services. All these reports follow an established template, which includes criteria for assessing quality of medical services.

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[81] CoM Resolution No 765 of 15.07.1997 (latest edition – of 15.01.2013) *"On Approval of Guidelines for Accreditation of Healthcare Facilities"*

[82] MoH Order No 142 of 14.03.2011. "*Standards for state accreditation of healthcare facilities*"

[83] Some domains may appear irrelevant to certain facilities, e.g. not all facilities would have an in-patient service.

In 84.5% cases, respondents described one or several additional informal assessment tools used in their facilities to monitor performance. Most facilities have established means of continuously monitoring performance, such as staff meetings, discussions and internal conferences:

- *"Our Head of Department introduced a new idea of having 5-minute staff meetings and little slips filled in by all doctors every week with key performance indicators: how many patients they had, how many tests taken. These slips help the Head of Department to compare how each of us is working, but also to plan our joint work."*

- *"Informal assessment happens mostly when there are some problematic cases. In all other cases, the key informal performance measure – is whether your patients are grateful."*

- *"We have competitions among departments. Another approach we use to check performance is to send Senior Nurses from one department to assess the work of nurses in another department and to see whether there are any mistakes with a fresh eye."*

- *"Every month we discuss achieved results against all indicators for the entire policlinic and discuss any problematic cases or mistakes, especially in the currently prioritized areas such as TB or oncology (late discoveries and other mistakes). In such cases, those who made the mistakes have to explain reasons in writing and to present at the staff meetings, and these explanations are then given also to the city Senior Pulmonologist or Oncologist. There is no single emergency which goes without discussion."*

83.3% of doctors and nurses believed that current performance assessment tools (either formal or informal) were in most cases useful. Most respondents praised current performance assessment tools for the learning opportunities it provides as well as for its impact on individual and collective morale. In only 10% of cases did doctors and nurses state that the system was not at all useful, and 6.7% more said that it was rarely applicable:

- *"It is very useful; it stimulates staff to be more responsible."*

- *"It helps because during the consultations and meetings, the Department Head can give some useful advice."*

- *"It is a strong psychological factor because it raises our self-esteem and our motivation to work better."*

- *"It is very useful because we discuss all difficult cases so that there are no mistakes in the future. Everything is discussed and everyone can give examples how he or she would act in a similar situation. I believe that this is very helpful."*

Most respondents identified some relationship between performance and received rewards, but while formal assessment had some influence on salaries, informal assessments had "softer" and less predictable impacts. In 78.8% of cases, doctors and nurses reported that performance assessment systems used in their facilities have at least some impact on rewards (on salaries, training opportunities, promotion chances or any other opportunities and benefits). Impact was reported both through formal systems (69.6%) and informal systems (64.3%), but the nature of this impact was very different, as demonstrated in Figure 25. Staff salaries seem to be affected most by formal performance assessments, but only in 33.9% of cases. This reflects automatic wage adjustment in cases when employees are promoted, when indicators such as surgical activity are increased, or bonuses are provided for strong performance. On the other hand, informal assessment seems to have a much stronger impact. Informally established achievements have more influence on promotion and training opportunities, and are rewarded in a range of ways, including: the opportunity to take a day off when needed, flexibility in choosing vacation time including during the summer period, and letters of recognition (letters of recognition and letters of gratitude; see next indicator). In many cases, respondents also mentioned a stimulating opportunity to participate in local (municipal and oblast) competitions for the title of best specialist (doctor or nurse).

Figure 25. Impact of performance assessment on employee rewards and development opportunities
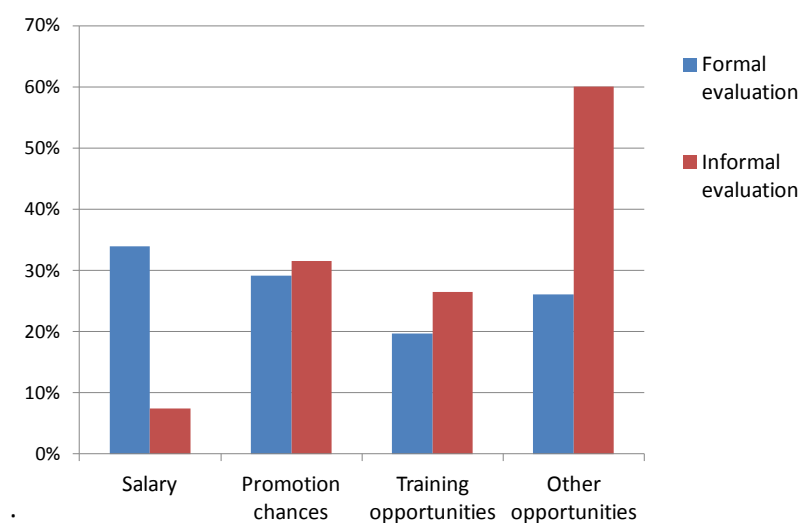
- *"There are no financial levers, but performance is discussed and visible. There is also a rating and it does matter. So, if there are reprimands, nurses do try to adjust and improve."*

- *"It doesn't impact our salary. But if there are problems, we can receive reprimands and not receive premiums for a year."*

- *"Those who show good results can participate in the competition for the oblast's best nurse."*

Even though most respondents confirmed the existence of elaborate performance assessment systems, some of them were skeptical about their impact. Dissatisfaction with current approaches was mostly based on the lack of a tangible relationship between performance systems and available opportunities, and doubts about whether or not performance assessment is transparent and reliable.

- *"It only impacts our internal conscience."*

- *"If we get real, checking statistical data in our specialty is impossible, and the data is fake. For example, if the daily norm for the number of visits is 15, one day I can have 60 visits, and another day I would have 13. In any case, I will just add these two people to achieve the daily target – I will just sit and write that down. Nobody will ever know. And perhaps this is bad. Because this is all simulation, it is not true indicator of quality."*

Indicator HRM-9. Positive stimulation

To work at their maximum, employees need to be certain that effort would lead to success and that failures can be survived and used for learning. Effective positive incentives – a system of rewards – is the core way in which managers can motivate staff to work better, to co-operate and to comply with rules. Positive incentives may include monetary and other material stimuli, such as pay raises and bonuses. However, in recent decades, approaches in Human Resource Management have shifted strongly towards recognizing equal and sometimes higher importance of "intrinsic", rather than "extrinsic" or material rewards. Unlike financial and other tangible rewards, "intrinsic" rewards are psychological rewards received by employees from doing meaningful work and performing it well

– the "emotional charges" during various stages of work which reinforce staff willingness to engage stronger.[84] In particular, there are four core types of intrinsic rewards which can make a difference:

- Increasing the sense of meaningfulness - helping employees to appreciate the purpose and value of their work.
- Increasing the sense of choice - helping employees to use their judgment and responsibility in choosing how they do their jobs.
- Increasing the sense of competence - helping staff to feel pride for meeting high standards.
- Increasing the sense of progress - helping employees to see that they are moving in the right direction, which raises their confidence in the choices made earlier.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Do health workers consider that rewards (financial or other) are given for fair, transparent reasons?	% Doctors & Nurses stating that reasons for positive stimulation (financial or with other means) are usually arbitrary and non-transparent, that it is difficult to say what are the reasons, or that rewards are not given at all	21.2%	Grade A
Does facility management encourage non-monetary positive reinforcement to their staff?	% Doctors & Nurses stating that their facility managers encourage line managers (Department Heads) to praise or give other similar non-monetary positive reinforcement to their staff	62.5%	Grade B
Does facility management encourage staff to honestly acknowledge mistakes?	% Doctors & Nurses stating that their facility managers encourage line managers (Department Heads) to reward staff who honestly acknowledge to have made a mistake and are willing to improve	57.1%	Grade B
Overall Grade			Grade B+

Most of the interviewed doctors and nurses believe that good performance is generally rewarded in a relatively fair and transparent way. Only 21.2% of interviewed doctors and nurses expressed highly negative attitudes towards the current system of positive incentives. 7.6% stated that achievements are not rewarded at all, 9.1% believed that criteria for rewards are arbitrary and opaque, without clear links to good performance, and 4.5% admitted that it was difficult for them to explain what criteria their management is using for the provision of rewards (as illustrated in Figure 26). In most cases (57.6%), doctors and nurses explained that rewards are given for regular good performance and in 7.6% - for extraordinary achievements.

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[84] http://www.iveybusinessjournal.com/topics/the-workplace/the-four-intrinsic-rewards-that-drive-employee-engagement#.UVguEhzTrLo
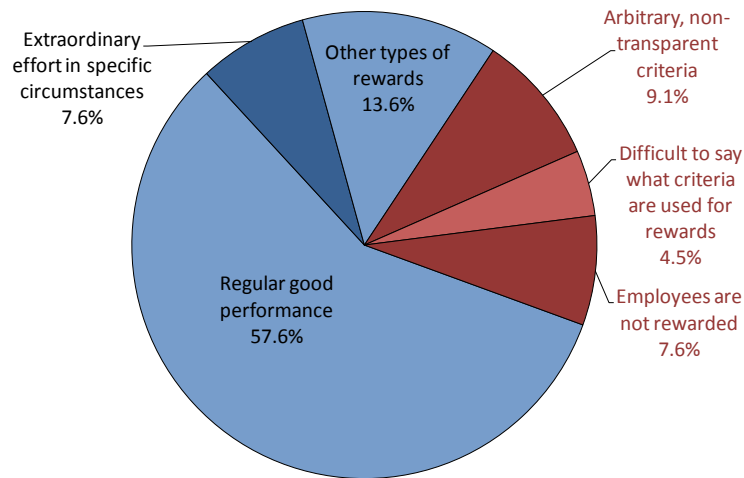
The majority of doctors and nurses trust that their management is trying to stimulate a positive environment, praising staff and using various non-monetary incentives. In 62.5% of cases, respondents agreed that heads of their facilities encourage line managers (such as Department Heads) to praise their teams and to incorporate various intrinsic rewards into positive stimulation systems. Interviews also confirmed that, unlike material incentives, such intrinsic rewards are rather popular. They include issuance of Letters of Recognition and Letters of Gratitude (usually either on the Day of the Medical Worker or on the anniversaries of respective employees), written and oral expression of gratitude by the management, written comments in the *labor book* or in the employee personal record file about exemplary level of performance, putting people's names on a "board of fame", and support to participation in existing professional competitions. Also, unlike current financial rewards, which are described as paltry or non-existent, non-financial rewards do bring some satisfaction to staff:

- *"Mostly we receive official letters of recognition and formal gratitude from the management. It is very pleasant and brings moral satisfaction."*

- *"Most of the positive stimulation we have is simply moral support and gratitude from management. But it matters and it is important, not least because your authority is growing and you are appreciated and recognized."*

- *"In the current circumstances, what often keeps motivation for medical professionals is a certain feeling of an 'esprit de corps'. It matters more than premiums and benefits. People who work here are dedicated professionals, they work on pure enthusiasm, and they realize that they are not appreciated by the state."*

- *"I worked here for 15 years and never received any reward, while others did, and I felt very upset. On the Day of Medical Workers I went to the management and really let it out; I said I deserve some recognition too and they must have being saving money on paper if they didn't even print me a Letter of Recognition, which is a little gesture, but it would have mattered to me! The Chief Doctor listened to me and raised my salary by 0.5 position."*

Just over half the respondents think that mistakes are accepted in their facilities if people admit them honestly. 57.1% of doctors and nurses think their managers are ready to accept mistakes. This was just sufficient to qualify for a Grade B, but was very close to the lower grade. The majority of the workers who were not afraid to admit mistakes were nurses, while doctors found it much more problematic.

- *"We try to learn from mistakes; mistakes are discussed at staff meetings, and it is good because it gives us an opportunity to learn for the future."*

Indicator HRM-10. Timely payment of salaries

Reliable and timely payment of salaries is the basic requirement to maintain high morale and good performance. Timely payment represents the core principle which substantiates employment contracts. It creates trust in the agreed terms of pay, as well as in the overall reliability of the organization and the system it represents, creating a climate of long-term security. This lets the employees focus on their jobs rather than on worrying whether they will have their pay and their job tomorrow, and what other elements of their organizations may turn out equally unreliable.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Do health workers always receive their salaries in time?	% Doctors & Nurses who state that their salaries during the previous year were always paid in time	100%	Grade A
If delays occur, how quickly and reliably they are recovered?	% Doctors & Nurses with experience of delayed salaries during the last year whose due salaries were already recovered	n/a	n/a
Overall Grade			Grade A

During the last decade, Ukraine has made dramatic progress away from the multi-year public sector arrears that characterized the end of 1990s, towards regular payment of salaries from the budget. With the economic and fiscal recovery which began in 2000, arrears were gradually repaid and essentially ceased to be an issue. During the economic crisis in 2008-2010, the Government reported that there were no arrears in the public sector, even though private sector wage arrears during that period tripled (Maynzyuk, 2011).

There are no publicly available statistics on the current level of public wage arrears, although healthcare trade unions reported growing delays during 2012. Throughout last year, professional unions of medical workers have expressed concern over the timeliness of salary payment in the health sector. Ukraine's Federation of Trade Unions stated on 15 Feb 2013 that wage arrears in public healthcare sector began to accumulate in several oblasts (Sumska, Odessa and ARC), and one more oblast (Luhanska) complained that its current public healthcare wage liabilities are not fully budgeted, creating imminent risks of delays[85].

Interviews for this study were conducted during the summer 2012 and revealed no episodes of salary delays. An overwhelming 100% of doctors and nurses stated that during the previous year they did not have a single episode when their salary payment was substantially delayed or not paid in full; with a maximum reported delay equaling 3 days. Only in one case, a nurse did not receive her holiday salary because she failed to submit a leave request in due time. Even in this situation, she was sure that she would eventually receive the payment.

At the same time, several interviewees revealed that disguised reductions in salary payments do exist. Even though all salaries are formally paid out at the moment, some respondents shared alarming stories about disguised arrears.

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[85] http://www.fpsu.org.ua/napryamki-diyalnosti/sotsialnij-zakhist/557-potribni-nevidkladni-zakhodi-dlya-usunennya-porushennya-trudovikh-prav-pratsivnikiv-zakladiv-okhoroni-zdorov-ya, http://kmppoz.org/ua/news/new131.html

- *"Salaries are paid regularly, but last year we were forced to take unpaid leave for three weeks. That is, we had to take a few unpaid leave days now and then during a month. In fact, during these days we continued working. But it was considered that we were on unpaid leave".*

Indicator HRM-11. Training

Rapid changes in modern healthcare require service providers to be constantly and actively learning to remain competent and relevant. Healthcare is one of the fastest changing sectors, with accelerating scientific and technological advances, growing levels of information on delivering care, tectonic demographic shifts and increasing importance of non-contagious and chronic illnesses. In order to provide effective medical services to the population in this new and changing context, clinicians and administrators need constantly updated skills and knowledge. Successful systems of continuous learning for health professionals combine regular formal training and retraining programs with an everyday environment which stimulates on-the-job learning, mutual exchange of information and experience among colleagues, and individual initiative to grow and learn.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Do health workers receive regular training and retraining?	% Doctors & Nurses who confirmed that in the last 5 years received not only mandatory recertification training, but also additional internal or external training (in their facility or elsewhere)	90.0%	Grade A
How effective are existing training programs for health professionals?	% Doctors & Nurses who assessed at least one of their continued learning activities as significantly useful	81.8%	Grade A
Do facility managers encourage individual learning and development initiatives?	% Doctors & Nurses who said that their managers were positive and supportive if staff initiated and funded additional training by themselves	79.1%	Grade A
Overall Grade			**Grade A**

The majority of doctors and nurses interviewed for this study have received more than one type of regular professional training. Continued learning programs available to Ukraine's health workers fall into three broad types: mandatory recertification training, internal facility-based and external events, as discussed below. For each of these types of training, participation rates were significant and, overall, 90.0% of all respondents confirmed that they have participated in at least two of the three types of training activities in the last five years. Moreover, as many as 58.6% of doctors and nurses said that they had participated in all three types of training.

Most of the respondents also confirmed that at least one of the training activities in which they participated had a strong effect on their work. 81.8% of doctors and nurses reported that at least one program was useful to a significant extent. Moreover, as illustrated in Figure 27, as many as 24.2% found two of the types of training useful to a significant extent, and 36.4% thought that all

training they received was very useful[86]. Most respondents explained that they see a lot of potential in training as such, but its quality and usefulness depends on the willingness of professionals to learn, as well as on particular trainers and training providers.

- *"It all depends on the level of the trainer and on yourself. If you are going into training with a real desire to learn, you will always find access to the information you need. I was lucky to attend useful training courses and I personally see a significant impact for myself."*

- *"Quality of the training fully depends on training providers. For example Kyiv, Donetsk and Kharkov have a very high quality, why Luhansk has zero quality. It depends on the team, on equipment, on management."*

Figure 27. How many current types of training programs were strongly effective? (% responses by doctors and nurses)
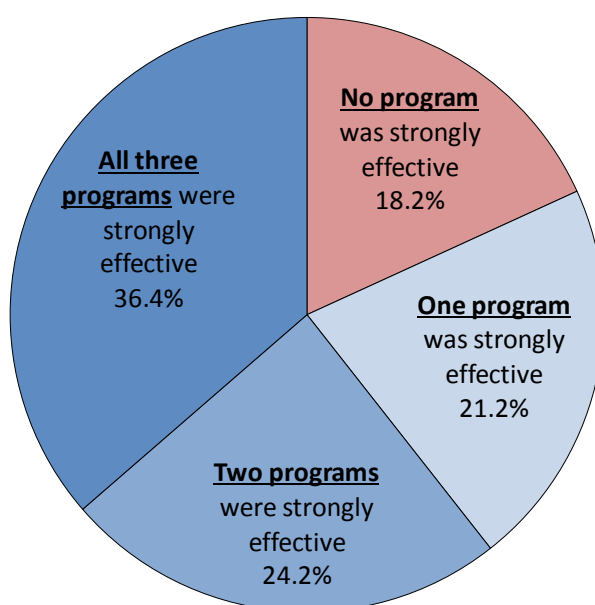
Generally, existing training programs seem to be less relevant for professionals with higher specialization. Among the respondents, doctors were generally more skeptical about the quality of existing training (22.0% of doctors finding no program significantly useful, compared to 15.4% for nurses). In some interviews, respondents also specifically explained that, in fact, many courses and conferences could be either too broad or too narrowly focused, making it difficult for some categories of doctors to find a matching and relevant curriculum.

- *"Many courses are narrowly specialized, but there is nothing which matches my area of professional interest. Internal trainings present the same problem: departments in our hospital are all specialized in their own areas and I find it difficult to extend knowledge in the fields I need. So, I have to go and attend trainings on totally irrelevant themes or on general medicine, which is useless."*

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[86] There could be a positive bias in this indicator: in a system where there are little or no incentives, receiving training will make people feel good; so they might be more likely to rate this as useful.

Training to confirm or raise professional qualification category

The biggest program covers mandatory professional training required as a core eligibility requirement for 5-year recertification process (see Box 6). Interviews confirmed that this mandatory training is attended by all professionals with qualification categories (91.4% of all doctors and nurses). Most health workers expressed positive feedback about this training and found it very useful. However, compared to facility-based and external events, mandatory state training received the highest number of critical comments. In particular, 60.0% of all doctors and nurses said that they think the content of this training needs to become more relevant to their work and fine-tuned to the needs of doctors in different specialties:

- *Positive feedback*	- *Critical feedback*
- *"I love going to these courses. They always have a significant effect."* - *"I attended courses for senior nurses and I was thrilled by them. They were provided under the auspices of the oblast hospital. They had a significant impact on me, because in this hospital they can teach all kinds of disciplines: labor protection, acute care, and even human resources department participated in teaching. They know all laws and regulations. I liked it very much; it was awesome."*	- *"These courses are totally formulaic, and they are practically useless."* - *"To be honest, these trainings are full of weaknesses. Many things they teach are redundant, outdated. These days there are so many modern, interesting lectures and materials. And they do have some lectures like this, but others just stagnate, showing us ancient posters, and reading notes which I studied as a student when I was in the medical school."*

Box 6. Professional training within Pre-Recertification Cycles

A core requirement for confirming or raising one's qualification category during 5-year mandatory recertification is prior completion of a professional training program. At least a year before applying for a new qualification category (or confirming an existing qualification category), every applicant[87] must first complete a *Pre-Recertification Cycle*:

▪ *Pre-Recertification Cycles* are completed in the Post-Graduation Education Facilities. They represent short-term training leading to an examination;

▪ To receive access to a *Pre-Recertification Cycle,* each potential applicant must obtain a *Route Permit*, issued by the respective Post-Graduation Education Facility. The Post-Graduation Education Facilities issue such permits based on the number and type of *Pre-Recertification Cycles*. These, in turn, are developed based on the assessed need of the country's healthcare facilities in re-training of their doctors;

▪ In case of successful completion of a *Pre-Recertification Cycle* and passing the exam, the applicant receives a Certificate with a recommendation for granting him/her a requested qualification category. If the applicant fails the exam, (s)he can go through the cycle once again.

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[87] Exceptions are made for academic staff of the post-graduation education facilities who can avoid going through the entire cycle and are allowed to sit the exams without the training (Clause 3.1).

Facility-based training

On top of mandatory recertification training, almost every facility runs a range of internal training and development activities. These activities include workshops, seminars, shadowing schemes, lectures and presentations. Participation in such activities was confirmed by 88.6% of doctors and nurses. In comparison to state courses, internal training courses were found to be much more relevant: only 48.3% doctors and nurses said that their content should be fine-tuned, and half (50.0%) said that the content was entirely adequate to their needs.

- *"Our doctors make fantastic presentations. They cover all kinds of areas: surgery, endocrinology, gastroenterology. All doctors participate, and they all prepare well. We also have specific extracurricular trainings on most problematic diseases: cholera, most risky infections, AIDS. And on these trainings we have tests and written examinations. Yes, we do have all these things!"*

- *"We have an exceptionally knowledgeable infectious diseases specialist in our hospital, and he can talk very competently about each disease. And if we have questions, we can ask him. Also, we have guest speakers from other facilities, for example from the oblast children hospital."*

- *"We have self-education: our nurses study professional literature, and we all search in Internet. And if someone has problems or gaps, we sit all together and try to understand and learn something new."*

- *"Every Tuesday and Thursday we have a guest speaker and some presentation, always. Which I think is enough. We also have staff meetings, where our specialists can present. Sometimes they receive specific topics for their presentations, which they need to prepare and share with others. There are so many of these presentations, to be honest, that I wish there were fewer. It happens at least twice a week, plus emergency meetings all the time to discuss some particular issue, or a new regulation that we need to comply with."*

- *"We have master-classes for the nurses. I lead them as a Chief Nurse, but senior nurses from various departments usually assist, if we need to look into the subject related to their department. It happens every week. At these meetings, we also discuss new laws, regulations and any organizational issues. And once a month, we have a master-class for the entire hospital and monthly specialized master-classes in every department by respective senior nurses. We can also make more of these if we see some particular problem. We even had a specific training on washing hands, and I personally checked how everyone learned the material."*

External training

A significant share of health workers (67.1%) also reported attending external training. These courses included various conferences, seminars and workshops, mostly held outside of the facilities. A significant proportion of these events appear to be organized and sponsored by pharmaceutical companies, but doctors and nurses also mentioned distinct courses and trainings, funded by other sponsors (for example through fellowships) or by the staff themselves (for example *"I attended thematic 2-months courses but I had to pay for them myself"*).

In many cases the difference between external and internal facility-based trainings was blurred. A considerable share of presentations organized within facilities seemed to have been funded by pharmaceutical companies and could therefore be classified as external (*"For example we had a conference in our hospital organized by a pharmaceutical company which produced a new catheter and they explained how to use it"; "Yes we do have external training – for example. We have this firm named X, and now our whole team will travel to Sevastopol to training they organized there"; "In order for us to be informed about new technologies, our hospital management invites pharmaceutical representatives to share their knowledge"*).

Opinions on the effectiveness of external training were mixed, reflecting the wide range of various external events which were attended. As illustrated by the quotes below, doctors and nurses had different opinions on the quality of external training they attended:

- *Positive feedback*	- *Critical feedback*
- *"They usually have quite an effect; we hear some new information, including something new about existing pharmaceutical products."* - *"Usually these external trainings are organized by pharmaceutical companies. They invite professors, academics, and they pay them for presentations."*	- *"External training courses are less useful and they have low impact. The thing is that it is hard to control quality. Those who graduated 20 years ago are happy to attend any conference. But more recent graduates and those who read any medical literature usually find that what they hear at these conferences they already know."* - *"They have almost no use and are usually at a very low professional level. But I am talking about our local events, while in Kharkov they are better. And they are usually fee-based".*

Several respondents mentioned opportunities of training abroad and the importance of international experience.

- *"Learning is for those who want to learn; and for those who want to learn it is useful to go abroad. And some people do it and attend trainings there."*

- *"If you truly want to learn, you should go abroad. There were some people who went, usually they received scholarships."*

- *"It is very important to attend training in other countries and to learn from their experience. Our healthcare is really in deficit in this regard. We are closed and isolated. Even when we are invited to go somewhere to study, it costs enormous amounts of money, not affordable to our doctors. Yes, domestic training here is important but it would be so much better to also go somewhere, at least once in a while. Even to Russia, if it has to be close. But better at least to the former socialist countries in Europe, to Czech Republic or elsewhere. This is where medical achievements really exist, and usually we simply don't know about them. We really lack international exposure."*

- *"We can learn from others who travelled abroad or attended international conferences, but it is not easy. For example our Head of Faculty sometimes organizes facility-based events with participation of Professor N. from Kyiv, who is an experienced cardiologist and regularly attends international conferences. On these events he shares with us the most up-to-date information on treatment and diagnostics. And this is our only window to the world. Professor N. also organizes a commercial winter-school in the Carpathians where training is combined with skiing. It is extremely expensive. I went a few times, it was really great, but I had to pay on my own and sometimes my husband partially paid. When it was up to UAH 3,000, it was somehow possible, but when it went up to UAH 5,000 I had to give it up. But international trainings really are a very big thing. Unfortunately, our doctors are completely unaware of what is going on in the international medical science, so to speak."*

Apart from training sponsored by pharmaceutical companies, for all other external professional development activities staff secure their own funding. In 22.9% of cases, respondents paid for additional training themselves, and in 34.3% cases they were able to attract other external funding sources such as scholarships. (*"Any such training has to be paid for either by me or by some sponsor.*

So, I search for kind lady or kind man to whom I can come and complain to about my poor situation, and how miserable and shabby I am, and how I need money. It all rests on personal contacts".) Such investment has been recently stimulated by the new requirements to obtain sufficient scores in order to gain eligibility to sit in the recertification exams; attending training and participating in conferences brings extra scores and is therefore needed by the doctors in order to retain their jobs or to obtain promotion.

The Facility management is generally supportive of their staff attending self-funded external training but there are many episodes when they refuse to co-operate by providing academic leave. In 79.1% of cases, doctors and nurses who participated in external professional development events at their own cost reported supportive and positive attitudes to these initiatives from their line managers. In 14.0% more cases, the attitude was neutral, and only 7% of the respondents chose to not even inform their management about having participated in some external training. The biggest problem in such cases was the need to take leave of absence to attend the courses. This was not always supported. Even when employees described management attitude as positive, it often implied that they were still not allowed to take leave. However, the attitudes of management differ in terms of whether they are willing to share some proportion of the costs, for example travel expenses.

- Supportive actions by management	- Lack of support from management
- "If doctors travel somewhere for training at their own cost, sometimes they may even receive some compensation for their travel costs, by classifying it as a business trip." - "Management is always positive and supportive when we want to go for external training." - "Very positive attitude. It is true that we only have short training courses, but they would always allow us to go." - "Positive: we were allowed to take personal leave for the time of the training." - "Our management is very supportive; in fact, if they know of some training that we should attend externally, they might even scold us for not going." - "Very positive attitude, but we should only do it on weekends." - "Management is always positive when people have aspiration to improve."	- "Every month our nurses travel to Luhansk to attend conferences. Their travel is not considered business travel. And for us it costs UAH 30 per person, while people from further rayons need to pay UAH 80 or UAH 90." - "We can only attend training outside of our working hours. If it was during the working hours, it would be a problem and it would not be supported." - "If you really want to go for training, you can always take personal leave at your own cost." - "It depends on your manager. If you are loyal, not complaining – if he calls you to his heel and you are immediately there at his heel – then you will be allowed to go. But if you start being difficult, mentioning the law and your rights, that will be the end. You can go, but only during your holidays. And I did just that, because I needed to go for this training." - "Even for formal trainings to receive the specialty category, it is not easy to get an approval to attend the training. Managers are obliged to let you go, but they can always justify their rejection by saying that they won't let you go during the winter because more people get sick during the winter, but during the summer there is no training – and you are trapped." - "When we have money and can afford it, we attend training courses and seminars."

Indicator HRM-12. Sanctions

Healthcare must be safe for the patients, but it must also be supportive and fair to the medical staff. Poor performance by doctors and nurses directly threatens patients and should not exist unrecognized under any circumstances. Timely detection of mistakes protects the patients in the short-run, but also in the longer-term by providing doctors with feedback on how they should improve their approaches. However, mistakes sometimes occur even if staff are dedicated, and sanctions in such cases must be proportionate and fair, helping professionals, where possible, to continue their career and to improve. With the paramount importance of patient safety in mind, performance accountability systems should remain transparent, consistent, and fair to all sides.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Are there formal rules on how poor performers are identified and treated?	% Doctors & Nurses who confirm existence of some formal rules	49.2%	Grade C
How often is poor performance actually sanctioned?	% Doctors & Nurses who state that poor performance is sanctioned always or almost always	60.6%	Grade B
Do health workers believe that the existing system of detection and punishment of poor performers is working well?	% Doctors & Nurses who think that the system is effective always or in most cases.	63.9%	Grade B
How well are doctors protected from mistreatment / unjustified punishments?	% Doctors & Nurses who believe that health workers are very well or at least partially protected.	23.1%	Grade D
Overall Grade			**Grade C+**

Approaches to detecting and punishing poor performance in the surveyed facilities are perceived by many health workers as generally effective:

- **60.6% of doctors and nurses% reported that in their hospitals and policlinics mistakes are detected always or in most cases.** As illustrated in Figure 28, 31.8% thought that problems were found and punished in absolutely all cases, and 28.8% said that it happened almost always. Most respondents were able to describe cases and episodes from their experience covering types of problems and sanctions which they entailed, such as written and oral reprimands, denial of bonuses and premiums, and social pressure. *"Problems are always detected; checks are made in cases when there are complaints or appeals to the Prosecutors office. Such cases are discussed, checked, there is a Commission established, and all is transparent." "Sooner or later, mistakes become visible, and therefore I consider that they are always detected and sanctioned."*

- **Moreover, 63.9% believed that the existing system of detecting and punishing poor performance was always or almost always effective.** Most interviewed doctors and nurses said that current sanctions usually achieve their purpose and help staff to correct mistakes and modify poor approaches. 29.5% also thought that the system is very effective in absolutely all cases (see Figure 29). *"In most cases it works; even the moral pressure itself is effective. Eventually it knocks down even the toughest. They either leave or adjust the way they work."*

Figure 28. How often is poor performance sanctioned? (% responses by doctors and nurses)
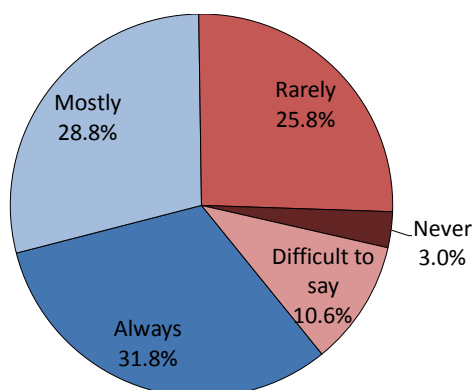
Figure 29. How effective is the current system of sanctions? (% responses by doctors and nurses)

Figure 28 pie chart: Mostly 28.8%, Rarely 25.8%, Never 3.0%, Difficult to say 10.6%, Always 31.8%

Figure 29 pie chart: Effective in most cases 34.4%, Sometimes yes, sometimes not 11.5%, Rarely effective 19.7%, Never effective 1.6%, Difficult to say 3.3%, Always very effective 29.5%
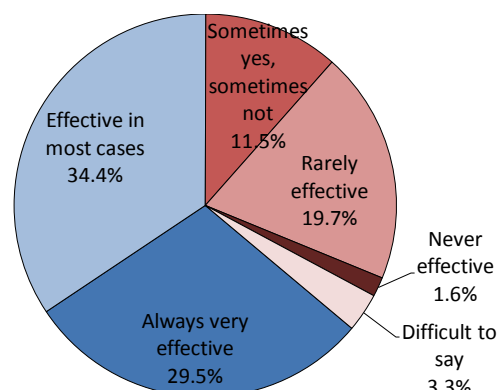
At the same time, the share of doctors and nurses who are skeptical about effectiveness of the current system of sanctions is significant. Many respondents were skeptical about the current system, saying that mistakes are identified either rarely (25.8%) or never (3.0%). A comparable share of them also expressed concerns about effectiveness of the system: 11.5% said it worked in some cases, 19.7% said it was rarely effective, and 1.6% completely dismissed it as not functional.

- *"It doesn't work at all here. Because our system is based on the concept of protection of the medical fraternity and loyalty to employees. We don't take our problems outside. Unless it gets so big that they will show it on TV."*

- *"It rarely works, because it is a formality and it cannot change the root cause of poor performance: poor resources, not funding, lack of proper equipment and medicines."*

- *"The system is not effective. As a Senior Nurse, I wish I could punish some staff at least by transferring their holiday time – to not let them take holiday during the summer and make them go on holiday during winter, so that the person would at least somehow realize that she is not doing her job properly. But there is no chance. Yes, they will receive reprimands, and maybe receive no premium this year. But if there will be no more reprimands, this one reprimand will be annulled at the end of the year. And I wish I could really make it clear: if you are responsible for the mistake, you will bear some cost."*

- *"Healthcare authorities are not interested in quality, they only care about numbers of staff and staff schedules. So this is the only issue which bothers the Chief Doctor, because this is what could impact him directly."*

While respondents could name examples of problems and respective sanctions, they found it more difficult to outline clear rules for identification and treatment of such cases. Only 49.2% of doctors and nurses were able to refer to a certain policy describing how to identify and deal with poor performance. Some said that *"It is all based on individual managers"*, and *"It all depends on the Chief Doctor"*, and that *"Choice of concrete form of punishment is arbitrary"*. Many respondents were certain that some document must exist (*"The management MUST have some regulatory document, surely nothing is done without an underlying document in our system"*) or even named departments or units who would have it (*"This document is available from the Unions Office / HR department / Legal department etc."*). However, in a few cases were interviewees able to actually explain a set of clear, universal and consistent rules, which would be applied in their organization.

Some examples of clear rules and processes did come up, including the following:

- *"Samples of patients' medical records are being frequently taken for inspection; they are given to specialists to control the quality of work of the family doctor. The Chief Doctor also has a routine of making unannounced inspections during patient visits. Moreover, our IT system helps to track the visits – who came with a visit to each doctor, with what purpose, how long did it last, what prescriptions were given etc. – This gives the Chief Doctor an opportunity to check and monitor performance right from his office. So, overall, the system is effective."*

- *"We have regular inspections of the quality of work of the nurses, how they comply with the various procedures."*

- *"We have staff meetings in which we discuss on-going issues and the results of our work – this is where problems could be discovered, but they are not punished, because it was not necessarily deliberately done and could be simply lack of skills and knowledge."*

Fairness and due protection for professionals received the lowest score, with less than a quarter of doctors and nurses (23.1%) feeling that medical staff are at all protected from mistreatment and unjustified punishment. As illustrated in Figure 30, 41.5% of respondents stated that they feel totally unprotected and vulnerable in the face of potential mistreatment, and 11.5% said that this danger is present at times. They named specific risks and situations which make doctors vulnerable and where it is usually very difficult to find protection or appeal to third parties in case of punishment:

- *"If there is a complaint from a patient against some doctor, it is like a red flag for the Chief Doctor. The doctor (against whom the complaint was filed) is guaranteed to have very, very bad time. At a very minimum, he or she would be totally humiliated by the Chief Doctor. And nobody will check whether this complaint has anything to do with reality, whether anything at all even happened. Any patient has more rights than any doctor here."*

- *"We are completely unprotected and vulnerable. And this is because in our system it is considered that it is not the patient who is responsible for his own health, but his/her doctor. If a patient writes a complaint, nobody will check whether it is true or not, the patient has more power than the doctor, and the doctor will surely have problems with the Chief Doctor."*

- *"There could be very unfair complaints from patients which are not properly inspected, and consequences for doctors could range from reprimands to dismissals; yes it happens rarely, but we did have such cases."*

- *"The only way to protect yourself is with your knowledge; only to make sure that you never make a mistake."*

- *"What doctors think is the right course of action could be interpreted very differently by the relatives of patients, and communicating with these relatives requires you to be a fine psychologist. And it is always assumed that the patient is right. So, we really need to work as if we were making jewels (very accurately), to avoid risks."*

- *"Patients can deliberately set you up."*

- *"The patient can think that you are using a wrong tone of voice, and write a complaint, and then it would be up to the hospital management to decide whether you used the right tone of voice. Or I had this episode: a patient came with a visit before working hours, I told him I had not yet started my working day, and he went to the Deputy Chief Doctor immediately and wrote a complaint. The Deputy investigated and there was no sanction against me, but I did get a complaint on file."*

- *"We are not protected at all because the patient is always right. Think about it: a person sits at home doing nothing for 2 years; his medical file is empty; I say to him: look, you should at least go and do an X-ray. And suddenly it turns out that this person has advanced cancer. Who is guilty? The doctor. But people don't go for check-ups, sometimes because they don't have the money."*

- *"We are not protected at all, and our problem number one is the patients and their relatives. For example we have many cases of life threatening injuries: we explain the situation to the family, we get their agreement for further action and treatment, but if it is unsuccessful the relatives say that the doctors are guilty. It is impossible to explain that in some cases doctors really cannot help. For such cases there has to be some insurance, some chance to engage external experts, who could look into the case and make their decision, and close this case. But in our situation, these complaints just stay there forever. Relatives continue searching for ways to punish doctors, they go to the Prosecutors office and further and further, demanding that he or she is fired. This area is totally unregulated. And it creates extreme psychological pressure, because you have to constantly deal with the courts, write some explanations etc."*

- *"We are completely unprotected. For example we had a patient who claimed that he was an assistant to a Member of Parliament. We have a system of advance booking of appointments, we have very long queues. And this one comes right into my door, and demands that I start working on his issue immediately. I told him it was not possible, so he went to the Chief Doctor, shouting that he is going to use his connections and we will all be dead. The Chief Doctor phones me and says: "Go and serve this guy immediately, because I don't want to have any complaints".*

Figure 30. How protected is medical staff against mistreatment and unjustified punishment? (% responses by doctors and nurses)
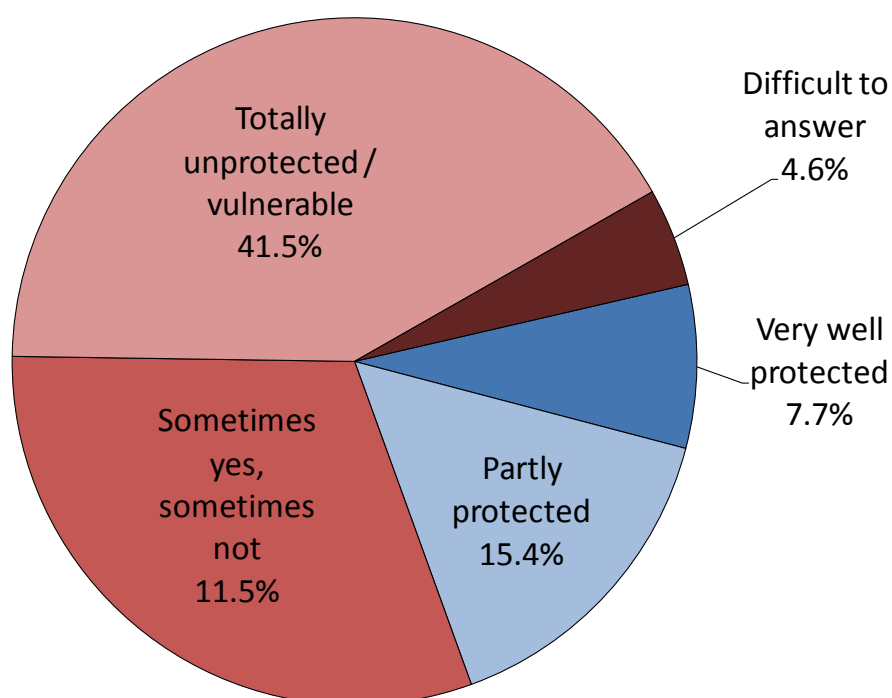
Box 7. Disciplinary measures: types, criteria, appeal procedures

What disciplinary measures could be applied?

▪ Facility management has a range of tools for punishing their staff[88]:

▪ Disciplinary measures (reprimands or dismissals). The choice between the two is up to the facility management. The *Sector Rules* recommend that, in choosing between the reprimand and dismissal, the authorized decision maker *"consider the severity of the violation and resulting harm, the circumstances leading to the violation, and previous record of this worker."* In other words, there are no clear legal distinctions between the grounds for using one or another type of disciplinary action, and managers essentially have to use their subjective judgment in choosing between reprimand and dismissal;

▪ Measures of civil influence are defined as measures which are taken by communities, organizations, labor collectives (staff) and their elected bodies towards their own members in order to ensure that such members comply with statute tasks, agreements, rules of social life, and discipline. Such measures can include "civil penalties" ("condemnation", reprimands, warning of exclusion from the community/team, and exclusion from the community/team). The measures are called "civil" since informal agreements over rules of community life do not have legal force;

▪ Suspension from work (temporary suspension of current duties).

What must be the grounds for the sanctions?

▪ Violation of labor discipline, that is, inappropriate performance of duties due to the fault of the worker (leading to either reprimand or dismissal). A generic list of labor duties for the healthcare workers is provided in Clauses 13-14 of the *Sector Rules*, but this list is not exhaustive and could be extended by additional resolutions, job descriptions, technical guidelines, qualification requirements etc. Thus, legislative definitions of the grounds for disciplinary responsibility are not precise. As discussed above, the *Sector Rules* are equally ambiguous about the choice of sanctions for any of these cases.

▪ Violation of labor safety, leading to suspension from work. Healthcare workers could be suspended from work in cases of: appearing at work in a state of alcohol or drug intoxication; refusal to undergo or avoiding compulsory health checks, trainings, and training in safety and labor safety[89]. Additional reasons include having infectious diseases, which are dangerous to others, contacts with patients who have such diseases, avoiding compulsory inoculations, etc.[90]

▪ Violation of employment regulations, leading to dissolution of contract. UCLL allows facility owners to dissolve contract with employees on the grounds which include:

a) Lack of compliance of the worker with the requirements for his/her post;
b) Systemic failure to perform agreed duties and responsibilities (but after first applying disciplinary actions);
c) Unauthorized absence from work;
d) Continuous absence from work during 4 months after temporary disability;
e) Appearance at work in the state of alcohol or drug intoxication;
f) Episodes of theft of facility property;
g) One-time severe violation of employment duties by the manager of the facility or his/her deputies;

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[88] MoH *Sector Rules for Internal Labor Regime* approved by the Order of the Ministry of Healthcare of Ukraine of 18.12.2000 "On Approving Sector Rules for Internal Labor Regime" http://lviv.medprof.org.ua/uploads/media/%D0%BF%D1%80%D0%B0%D0%B2%D0%B8%D0%BB%D0%B0_%D0%B2%D0%BD%D0%D1%83%D1%82%D1%80.pdf and compulsory for all facilities, organizations and enterprises in the healthcare sector of Ukraine

[89] Article 46 of UCLL

[90] Defined by *Law of Ukraine "On Sanitary and Epidemic Welfare of Population"*,

- Any individual labor disputes (including appeals) are considered by *Labor Dispute Commissions* (organized within each organizations) or Courts. The *Labor Commissions* are elected from staff at a general staff meeting, and must consist of at least 15 employees. The *Commission* itself elects its own head, deputy head, and a secretary.

- *Labor Dispute Commissions* must consider appeals or other dispute requests within 10 days from receiving the request. All requests are considered in the presence of the appealing persona and a representative of the organization's owner. *Commissions* may also call for witnesses and experts, and perform investigations.

- *Commissions* make decisions by majority vote.

- If the appealing person disagrees with the decision of the *Commission,* (s)he may further appeal to Court (within ten days after the decision is announced).

- Labor law suits are handled by rayon or city courts. Such legal suit must be filed within 3 months after the worker learned about the alleged violation of his/her rights. In cases which deal with dismissals, the suits must be filed within one month after announcement of dismissal.

Staff retention and turn over

Indicator HRM-13. Levels of pay in public versus private sector

Competitive pay is one of the main ways for public health facilities to attract and retain qualified staff and to minimize out-of-pocket payments. Rising costs of medical services make it difficult for governments in most countries to compete with commercial providers in financially motivating their staff. Low salaries may divert qualified professionals away from public facilities towards working in the private sector or push them into dual practice and moonlighting, ultimately diminishing the quality of the services they provide. In addition, inadequate remuneration prompts doctors and nurses to accept under-the-table payments for their work.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
How competitive do health workers find current remuneration for doctors?[91]	Average ratio between estimated current salary level and the level of salaries which respondents believe would allow to hire and retain well-qualified and motivated doctors	31.5%	Grade C

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[91] According to the "State Statistics Committee average salary by sector", March 2013) the average salary in the health sector is USD 280, and national average salary is USD 390.

How competitive do health workers find current remuneration for nurses?	Average ratio between estimated current salary level and the level of salaries which respondents believe would allow to hire and retain well-qualified and motivated nurses	35.8%	Grade C
How competitive do health workers find current remuneration for medical facility support staff?	Average ratio between estimated current salary level and the level of salaries which respondents believe would allow to hire and retain well-qualified and motivated support staff	42.6%	Grade C
Overall Grade			**Grade C**

Respondents estimate that, on average, current salaries of doctors represent only 31.5% of what is needed to retain and sufficiently motivate qualified professionals. This figure represents the ratio between the current level of doctor salaries and the estimated amounts which respondents believe would be sufficient to hire and retain well-motivated and highly qualified doctors. Moreover, as illustrated in Figure 31, the distribution of the individual estimates for doctor-level salaries was visibly skewed towards lower ratios: compared to nurses and support staff, the share of respondents who believed doctor salaries are less than 25% of the market was the highest. Estimates for doctors ranged from the minimum of 8% to a maximum of 67%.

Figure 31. Estimated ratios between current and desirable wages (% of responses by doctors and nurses)
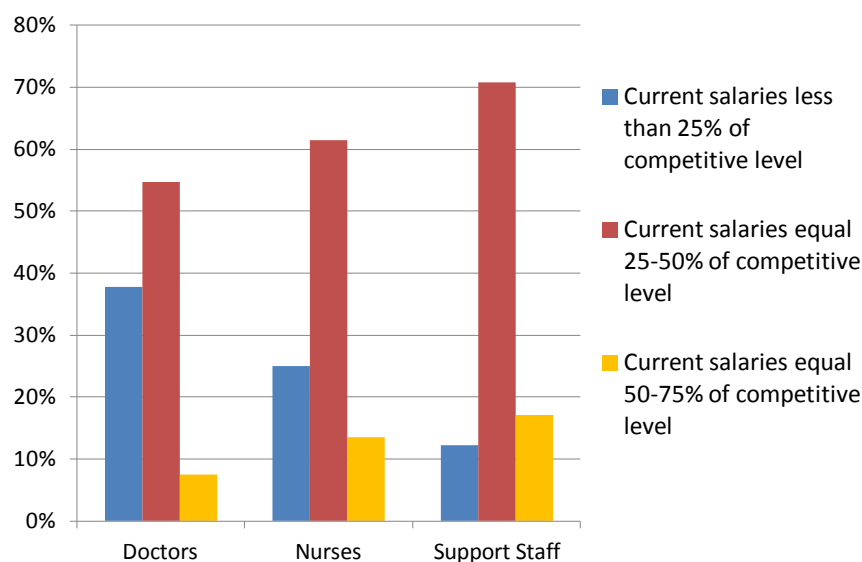
The estimated competitiveness of salaries for nurses and support staff is somewhat higher but still at less than 50% of the perceived market rate. Estimated ratios between current salaries and market level remuneration for nurses and support staff equaled, respectively, 35.8% and 42.6%. For these professions, responses were generally more optimistic, with bigger shares of health workers estimating current salary ratios as being in the range of 25%-50% and 50-75% of the market. However, even for these posts, maximum estimates were 73% and 75%, respectively.

Respondents strongly advocate making salaries more sensitive to differences in qualifications and more results-oriented. While many doctors and nurses wish their salaries were higher, the most popular appeal was not so much to increase salaries as such as to change the way they are defined. Most respondents believe that the current salary system is not effective because there is no link to performance and it does not reflect differences between posts, experience, education and other professional merits. Linking remuneration levels to some indicators of results would be an immediate and very important step to increase staff motivation. However, respondents often clarified that rules of such results-based calculation should be very transparent and clear to all, because risks of abuse would be very high.

- *"Salaries must be differentiated, so that there is some distinction between doctors, nurses, junior nurses. And their salaries must also depend on their real workload and their qualifications."*

- *"We should receive money for the work we do, not for the reports we produce. The paper we produce says nothing about the real results achieved by each of the staff."*

- *"Salaries must be calculated based on totally different indicators: the number of patients we see, the quality of the work."*

- *"The current system is totally ineffective. Patients must be able to choose their doctors, and doctors must compete, and their efforts must be reflected in the salaries. Not some abstract number of people assigned to each doctor, but the real number of visits and patients that he receives."*

- *"Salaries must depend on ratings calculated for each doctor; and it is important that rules should be clear; and rules should be consistent from the beginning to end, so that each employee knows his or her priorities."*

- *"Of course there are ways to improve the system of salaries; for example we can have anonymous population surveys and select the best doctors, and use these coefficients to calculate salaries so that such doctors are rewarded for their efforts."*

- *"Extra payments should exist, but they should not be influenced by our management, because otherwise they would just give them to whoever belongs to their circles. To introduce systems of extra payments you first need to have very honest people who could be put in charge of such systems."*

A very large number of health workers believe that low salaries as such do not affect the quality of existing service provision. Many doctors and nurses explained that, at present, there is a wide-spread attitude of resignation to the negligible salaries among medical staff and that, as a result, these very low levels have no impact on the way people do their jobs.

- **In some cases, this is explained by lack of alternative employment opportunities:**

- *"People agree to work on any paltry salary, because even such jobs are very difficult to find."*

- *"Salaries are miserable and it is nearly impossible to live on them, especially for the many single mothers who work in our hospital. But where would they go? Nothing else is functioning in our town, and we are all happy that at least we have a job."*

- **However, many doctors also believe that within their profession official salaries are increasingly ignored as a factor in decision-making:**

- *"Sure these salaries are not enough to make a living. But you see, we all belong to the old school, and it is in our cells to work for free. And even if we have to work for free, we still have to work well. You see, it is difficult to change our minds. Maybe young people will be different. But I believe that our salaries are completely irrelevant, they are nothing, and there is no way to live on them. But surely this is no reason to harm a patient, to work badly. This attitude is in our blood."*

- *"Yes, of course I agree that salaries should be increased; it has to be decent. But I have to explain, that regardless of what is the size of the salaries, you cannot work poorly and with low quality, you cannot do it."*

- *"We are working as well as we can anyway, simply we remain unhappy about our salaries, that's all."*

- *"People work here regardless of how much they would be paid. People work here for many years, and medicine is not an area where people would come to harm others. People would work regardless of how much money they receive. Salaries never had any impact on the quality of our work. Because nurses have received 70 rubles since Soviet times; and so what, they should now stop working?".*

- *"I don't even understand what you mean by 'effective remuneration system'."*

- **In other cases, the reasons for the resigned attitude to low salaries are simply left unexplained.**

- *"Our salaries are paltry; but don't you see that all posts are taken anyway?"*

Relative acceptance of low salaries is combined with evidence that using medical posts to obtain under-the-table income is a common practice. As was stated by one of the doctors, *"Stalin said, give doctors symbolic pay, and let them earn the rest. And this principle operates to this day."* When asked to assess the effectiveness of the current remuneration system, many doctors explained that salaries as such do not really matter, and that it is more important in their view to be able to use good equipment and quality medical supplies: *"Of course salaries should be increased; but we also need good equipment. We need, for example, high quality chemical agents for our labs. Because we have three laboratories and they each produce different results, so our patients get confused."* The fact that many doctors prioritize equipment as more important than salaries is reflected in the answers of Chief Doctors to the question of how their health workers understand "good working conditions". As shown in Figure 32, access to reliable modern equipment received highest priority (82% of responses), compared to only 55% respondents mentioning adequate salary. This comment by a Chief Doctor offers one view on this result:

- *"Good working conditions mean, for example, being able to stay in one's office beyond working hours, having good equipment, but also loyal, understanding management. Loyal management is that which doesn't control doctors too tightly. You know, there are many 'schemes', have you heard about the 'schemes'? Schemes are not about time, they are about various relationships, normally financial relationships. For example, I don't request anything from my doctors if they earn something. Yes, we do have charity contributions, but it is ok. We don't have additional things like 'I control you, so now you owe me something'. If I start using these kinds of 'controls', the hospital will turn into a madhouse."*

Indicator HRM-14. Turnover

While high turnover can create substantial costs and disrupt operations, low turnover may signal both the lack of flexible and rounded skills, but also "rent seeking" behavior by those holding the same position for a long time. Personnel turnover may be a serious problem for human resource management in healthcare for a range of reasons. High turnover creates direct and indirect costs for the facilities: management may need time and resources to replace leaving workers and to function through the transition, and reinvest into educate new employees. Indirect costs include low morale and dissatisfaction of the patients. On the other hand, low turnover may indicate that employees are not confident changing their jobs, potentially lacking comprehensive skills and knowledge. More dangerously, very low turnover can by a symptom of other hidden benefits enjoyed by remaining in same organizations: workers may have to "invest" into their positions and these "investments" maybe lost if they resign.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Are facility managers aware of the levels of turnover for major categories of staff?	% Chief Doctors who are able to quote turnover statistics for doctors, nurses and support staff for the previous year	21.4%	Grade D
How does the current average turnover rate in the interviewed facilities compare to the national average for doctors?	% by which revealed average turnover rate for doctors differs from the national average based on most recent NSSC data[92].	-85.9%	Grade D
How does the current average turnover rate in the interviewed facilities compare to the national average for nurses?	% by which revealed average turnover rate for nurses differs from the national average based on most recent NSSC data	-78.2%	Grade D

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[92] As of 2011, 28.6-30.9% (http://www.ukrstat.gov.ua/operativ/operativ2007/rp/ean/ean_u/osp_rik_07u.htm)

How does the current average turnover rate in the interviewed facilities compare to the national average for support staff?	% by which revealed average turnover rate for support staff differs from the national average based on most recent NSSC data	-72.0%	Grade C
Overall Grade			**Grade D**

Turnover of staff is extremely limited and turnover data is not utilized. Actual annual turnover rates quoted by the interviews were negligible. This is in line with extremely low internal mobility observed in the country as a whole (see **Box 8**), but contradicts the national statistics relative to turn-over rates (average of 29.75% percent across all sectors, according to official government statistics). As illustrated in the Figure 33 below, the lowest level is reported for the doctors (4.2%). A slightly higher level (6.5%) is reported for nurses and the highest level (around 8.3%) for the support staff. While this minimizes direct and indirect costs of potential replacements, such low level of professional mobility is also highly alarming, because it shows that medical professionals find it very uncomfortable to ever leave their posts, or look for new ones. Our initial discussion of the recruitment practices illustrated why they find it difficult. Moreover, the extent of potential benefits of staying is much higher for doctors compared to other health workers. As will be discussed further in this study, this finding resonates with the statements by many doctors about the need to make diverse and regular contributions to the operation of their facilities and to invest in establishing good relations with the facility management.

Figure 33.Average reported annual turnover rates for major types of health workers for 2012 (responses by Chief Doctors)
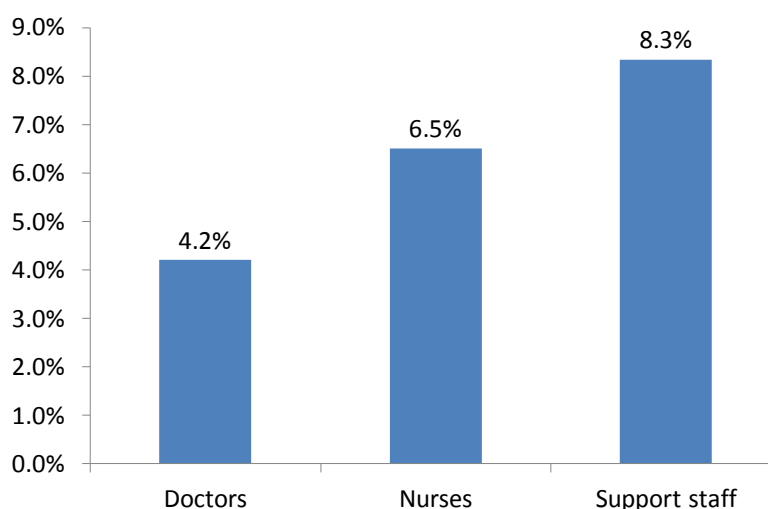
Of all the Chief Doctors interviewed for this study, only 21.4% were able to provide estimates of turnover rates in their facility for doctors, nurses and the support staff. Most of them believed it was not a major problem because they perceived turnover to be very low and, therefore, satisfactory: *"Turnover is extremely small, and therefore I cannot tell you precise numbers – but the HR department would certainly have detailed statistics.* Interviewed representatives of local Health Departments described turnover monitoring as one of the key areas of their work, with monthly data being regularly collected and analyzed by each facility. However, they generally also described turnover as a very insignificant issue: *"Our oblast does not suffer from turnover, therefore I am not concerned with this issue at all."*

No matter how internal migration rates are measured, in Ukraine it seems low when compared to other countries. The Life-in-Transition Survey (LiTS), a joint data collection effort by the European Bank for Reconstruction and Development (EBRD) and the World Bank, is a large micro-data set that contains information from all countries of Eastern Europe and Central Asia (ECA) and some western European countries. The questionnaire asks individuals about recent migration experiences, either within the last year, or within the last five years. According to this data, in Ukraine, 0.5 percent of the population moved either internally or internationally within the last year, and 4.5 percent within the last five years. These migration rates are clearly at the lower and of the distribution when comparing across countries (see Figure). Only 11 countries displayed lower migration rates, while 21 countries displayed higher migration rates than Ukraine.

Figure: Labor migration in Ukraine is low compared to other countries (Internal migration rates by country and by when migration happened, 2010)
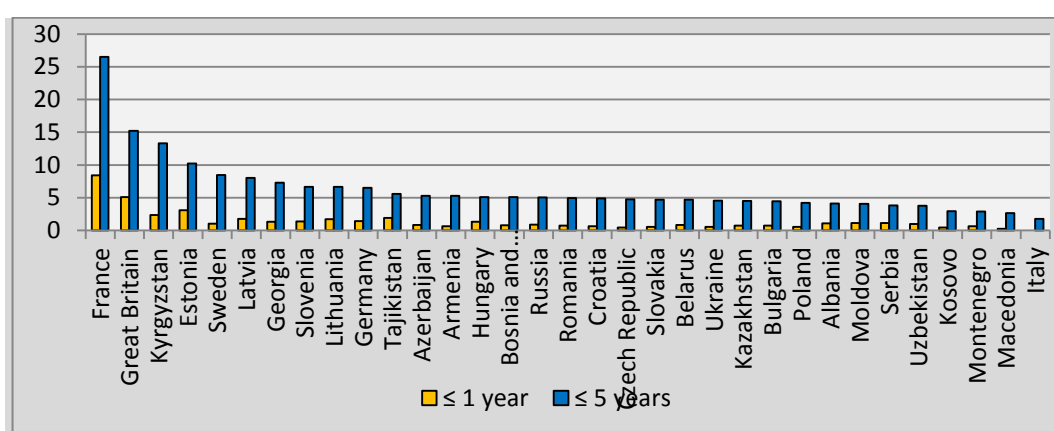
Note: Recent migrants include both internal and international migrants.

Source: European Bank for Reconstruction and Development (EBRD) and World Bank. 2010. Life in Transition Survey 2010. Online database, available at http://www.ebrd.com/pages/research/ economics/data/lits.shtml. Last accessed May 6, 2012.

Migration data provided by the State Statistics Service of Ukraine shows relative low mobility among the Ukrainian population. These data refer mainly to residential mobility. Using this data, between 2002 and 2009, an average of 1.5 percent of the total population in Ukraine moved across *rayons* (districts), from rural to urban settlements, or between urban settlements. This corresponds to about 600,000 people officially changing their place of residence to another settlement during the year. As expected, mobility across regions is lower—the internal migration rate was 0.5 percent in 2009. During the economic crisis, in 2009, internal migration rates actually fell compared to the average in previous years (from 1.5 percent when measured across settlements to 1.3 percent and from 0.6 percent to 0.5 percent when measured across regions). When compared to other countries, these rates of internal migration are also low. In particular, by international standards controlling for the size of the unit of measurement (like rayon or oblast), internal migration rates in Ukraine should be twice as high as those observed today.[93]

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[93] See World Bank (2012). In Search of Opportunities. How a More Mobile Workforce Can Propel Ukraine's Prosperity (Volume II: Technical Report). Available at https://openknowledge.worldbank.org/handle/10986/12287.

The risks of low turnover are not recognized by the healthcare managers, who generally consider it to be a positive sign of stability. Such very low levels of turnover are fully reflected in the narratives of all types of interviewees: Chief Doctors, facility staff, and local healthcare authorities. In an overwhelming number of cases, they described turnover as negligible and, very often, considered it to be a very positive result indicating stability and consistency of their teams:

- *"We don't have any movement. We have had complete stability for at least 3 years now. All positions are covered. All is stable and nothing moves anywhere. Only if there are new people, we might take them. But no one left for a long time."*

- *"There is no significant turnover. Really, one or two people might ever move. Today all our nurses posts are covered. We do have some gaps in the family doctor posts, this is true. But our biggest problem is the high percentage of doctors of pension and pre-pension age, especially in the rural areas. So, we are facing a looming gap there."*

- *"A turnover problem does not exist. The only type of turnover we ever have is when people get married, go on extended maternity leave or when they retire."*

- *"I have worked in my post for my whole life. We don't have any movement."*

- *"A doctor can work in one position for his entire life and be very happy."*

- *"Our Chief Doctor has remained in her post for 17 years now, and her deputy – for 20 years. They are both pension-age now, but they continue to work."*

Chapter 4: Planning, Budgeting, Financial and Performance Management

Introduction

Allocation of public expenditure on healthcare in Ukraine is mostly delegated to sub-national budgets. As illustrated in Figure 34 below, local government administrations, rather than the line ministries, are the key players in the country's public healthcare system, spending over 80% of the public budget. While central ministries (which are themselves key spending units) do provide some services directly (via some central programs), these expenditures are much less significant.

Figure 34. Consistently important role of sub-national budgets in Healthcare spending (2004-2012)
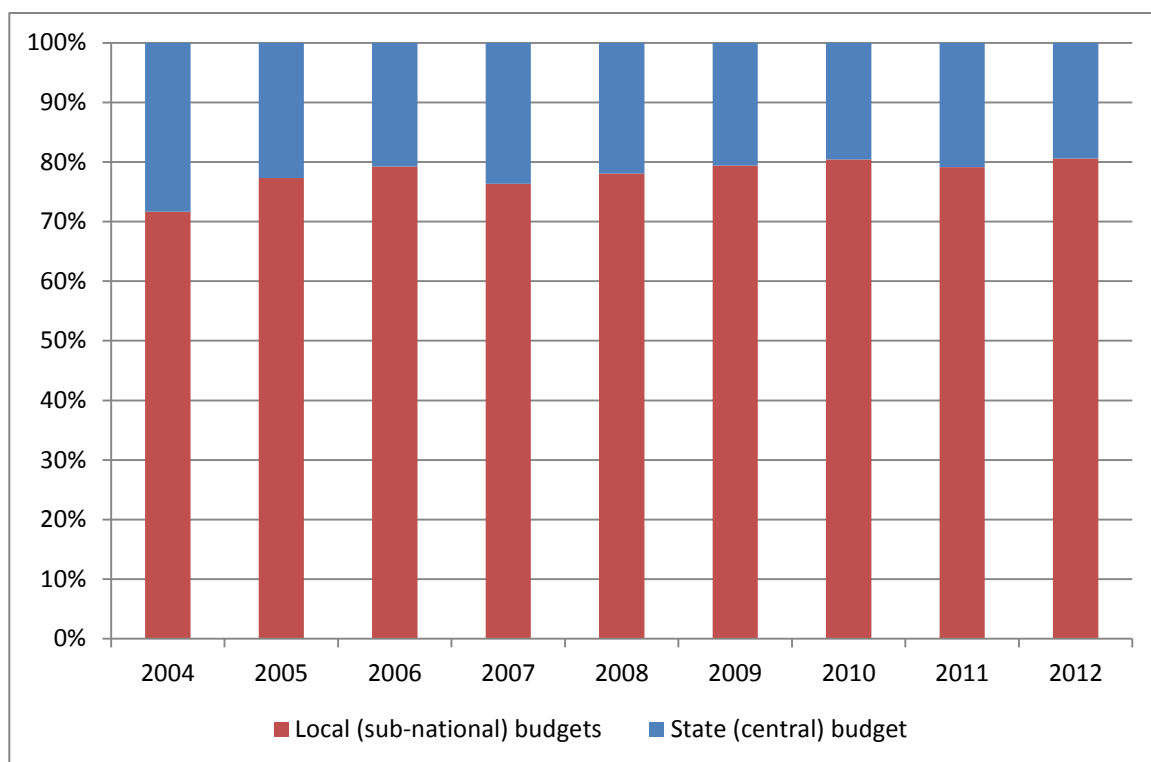
Source: State Treasury of Ukraine

At the same time, there is a sharp mismatch between financial, administrative, and functional responsibilities/autonomy at the local and regional level. Healthcare is one of the sectors which underwent a progressive intergovernmental financing reform in 2001. This started the allocation of equalization transfers to sub-national governments for funding delegated expenditures based on demographic variables rather than on existing infrastructure (such as number of hospital beds). The intent of this reform was that allocation of finances across local budgets would be based on objective indicators of relative demand for services (measured by proxies such as share of population living in that city, rayon or oblast). And it was intended that this, in turn, would lead to more economically optimal decisions about the management and provision of healthcare at the sub-national level.

Local administrations, however, were given very limited discretion in the allocation of funds and in program administration. Administrative decision-making (including facility-level budgeting) is subject to a rigid vertical structure of input norms, dictated by central line ministries. This mismatch and the resulting unfunded mandates is illustrated in Figure 35, which draws on the World Bank 2008 Ukraine Public Expenditure Review.

Figure 35. World Bank PER-2008: the mismatch between financial and administrative responsibilities at the local level
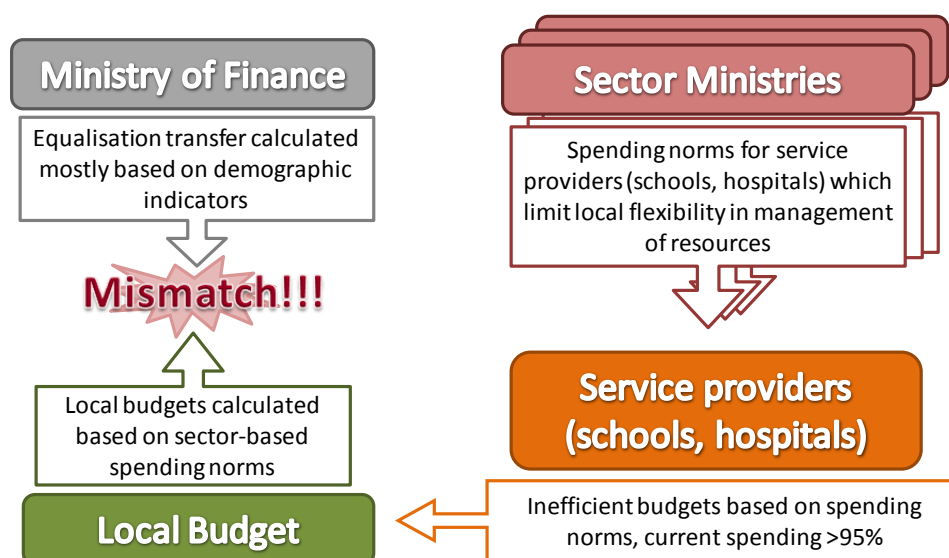
Healthcare facilities find themselves at the frontline of the mismatch, absorbing the resulting unfunded costs and, where possible, shifting them on to the patients.

Rules for the preparation of facility budgets in Ukraine are elaborate, strict and highly input-based. As one of the Chief Doctors stated: *"The key thing you need for budget planning – is time and lots of tedious, diligent work."* Budget requests must comply with a range of regulations, governing the number and type of staff which can be employed, precise salary levels, and all other possible types of expenditures, with detailed instructions (norms/formulae) for how these should be defined based on the facility input statistics (for example, the numbers of beds). In making these calculations, facility executives must also follow detailed templates and steps involving considerable administration costs. The sequence of applying the various rules in preparing a budget request is set out in

Figure 36. In preparing their budgets, facility executives must follow several sets of requirements:

1. **Precise templates and sequence.** The structure of the expenditures must correspond to key classifications and templates defined by the Ministry of Finance (MoF) (Order No 57 of 28.01.2002).

2. **Rules for defining the number of staff and their salary levels (Staff Schedule).** Draft budgets are developed, submitted, approved and amended in conjunction (and in parallel) with the development of facility Staff Schedules. The MoF Order No 57 mentioned above introduces the two templates simultaneously (for Budgets and for the Staff Schedules), and the two are closely related (the Staff Schedule should be fully in line with Budget Proposal in terms of the resulting payroll fund). The staff numbers in the Staff Schedule are defined based on the MoH Order No

33[94], which are then combined with Terms of Pay for Medical workers[95] and generic rules for defining salaries of budget-funded employees[96], to establish payroll cost implications for the facility.

3. **Expenditure norms and rules for calculating all other types of recurrent and capital expenditures**. Spending proposals by each code of economic expenditure classification must be supported by calculations against specific MoH Guidelines[97]. For each item of the economic classification, these Guidelines provide detailed instructions on how to calculate respective costs by multiplying these statistics by the so called "expenditure norms". For example, requested expenditure on food in hospitals must be calculated based on expenditure norms per one bed-day. Notably, Guidelines cover recurrent as well as capital expenditure items.

4. **Prioritization of "protected expenditure items".** Ukraine's legislation grants special "protection" to certain expenditure items by making sure that allocations to these categories are highly prioritized. These expenditures include[98]:

- Wages and payroll expenditures of budget-funded entities;
- Purchases of medications and sanitary goods;
- Food supplies;
- Utility and energy payments;
- Rehabilitation tools, medications and other individual supplies for disabled;
- Academic and applied research;
- Healthcare expenditures of those local budgets which were selected as pilot regions for Healthcare Reform (Vinnytska, Dnipropetrovska, Donetska, and the city of Kyiv) (this last expenditure item is introduced by Provision 12 of the Budget Code *Transitional Provisions*).

There are several mechanisms which ensure prioritization of some of the protected expenditures:

- "Protection" primarily implies that these expenditures cannot be reduced if approved budgets are cut;

- The Budget Code also requires that expenditures on protected articles (and any respective arrears) are reported and monitored separately to ensure strict prioritization;

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[94] Ministry of Health Order No 33 of 23.02.2000 "On Staff Normative and Typical Staff of Healthcare Facilities"

[95] Ministry of Labour and Social Policy, Minisry of Healthcare Order No 308/519 of 05.10.2005 "On establishing ordered arrangements for defining terms of pay for the workers of health facilities and Social Care institutions" (current edition – 25.06.2012)

[96] Unified Schedule of Bands and Coefficients for salaries of workers in publicly funded facilities, approved by CoM Resolution No 1298 of 30.08.2002

[97] These guidelines are established by the *Methodological recommendations on planning and utilizing budget funds for provision of medical help by health facilities (or "Methodological recommendations on expenditure planning)*. While not mandatory in theory, these Recommendations are strongly endorsed by the MoH. The Recommendations do not have a legal mandate and exist as a research paper developed by the MoH jointly with the MoH Institute of Strategic Research. However, this document was developed by the MoH in response to a clear regulatory request from the Cabinet of Ministers (stated within the CoM Resolution No 208 of 17.02.2010 *"On Selected issues for improvement of the Health system"*). None of these documents explains whether the Recommendations are mandatory, but the overall tone of the Recommendations is highly imperative.

[98] A particular list of Protected Expenditures is established within the Budget Code (Article 55). Theoretically, this list directly applies only to the State Budget expenditure; however, the Budget Code also recommends local councils to use the same list as a basis for developing Protected Expenditure lists for local budgets (Article 76).

- When Key Spending Units assess submitted draft budgets of their respective facilities (Spending Units of lower tier), they have to ensure that "Wages, payroll, and all expenditures related to maintenance of the facilities" are "strictly prioritized".

5. **Strict austerity principle.** Finally, in defining expenditure requests, Spending Units must be guided by the principle of strict austerity. Draft budgets must include only those expenditures which are dictated by the nature of activities led by the facility. Expenditures on equipment and capital renovations which are not urgent may be proposed only if other more urgent expenditures are covered and if there are no arrears payable[99].

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[99] Clause 20, 22 of the *Procedures for development, consideration, approval and key requirements to implementation of the budgets of budget-funded entities*;

Figure 36.Regulations guiding facility budget preparation process

CMU Resolution No 228
Procedures for Developing the Budgets of Budget Entitities
(Постанова КМ №228, „Порядок складання кошторисів")

What are key terms, roles, and steps in the budgeting process?

MoF Order No 57
Budget Execution Templates
(Наказ Мінфіну №57, „Затвердження документів, що використовуються при виконані бюджету")

What templates must be used?

Budget Template

Staff Schedule Template

Paper by MoH and Strategic Research Institute
Methodological recommendations on expenditure planning
(Публікація МоЗ та НІСД МоЗ, „Методичні рекомендації щодо планування видатків")

How many staff to hire and at what posts?

MoH Order No 33
Staff Norms
(Наказ МоЗ №33, „Про штатні нормативи та типові штати")

What are "recommended" rules for calculating every expenditure item within the budget template?

What should their salary terms be?

MoH/MoLSP Order No 308/519
Terms of Pay for Healthcare Workers
(Наказ МоЗ/Мінпраці №308/519 „Про впорядкування умов оплати праці працівників охорони здоров'я")

What should their salaries/ payroll be?

CM Resolution No 1298
Unified Schedule of Bands and Coefficients for Staff Salaries
(Постанова КМУ №1298, „Єдина тарифна сітка розрядів і коефіцієнтів з оплати праці")

Draft Budget and Draft Staff Schedule
(Проект Бюджету і Проект штатного розпису)

All managers of health facilities need to reconcile imposed norms with their budgetary realities. The way they do so is explained in detail in Box 9.

Box 9. Living with the "mismatch": how can providers reconcile input-based norms with actual funding ceilings?

Facility accountants tend to resolve the disconnect between available funds and expenditures dictated by respecting norms by referring to "imposed" norms in the budget requests, but supporting them with calculations which transform them into "actual, realistic" norms.

Since there is no formal guidance on how to accommodate unfunded expenditure norms in the budget requests, actual solutions at the facility level seem to differ. In many cases, these accounting techniques follow unofficial recommendations in the ample professional literature for facility accountants, which developed in response to the obvious unfunded mandates which permeate the healthcare system.

The dominant approach is to use ambiguities in the regulatory definition of "expenditure norms". The *Methodological Recommendations*[100] acknowledge that "norms" could mean different things:

- "mandatory expenditure norms"[101] (established by law and mandatory for all medical facilities),

- "monetary expenditure norms"[102] (actual unit costs of service provision) and

- "calculated expenditure norms"[103] (average unit costs of service provision based on the budget ceilings allocated to each particular facility – as the *Methodological Recommendations* put it, *"These are the norms which reflect that part of the facility budget which could be realistically covered from the public budget and would be reflected in the facility budget and/or which would be used in submission of the budget request"*).

Budget requests show "imposed" higher norms but also the modified "realistic" estimates, or "calculated expenditure norms". While the *Methodological Recommendations* invite providers to respect all three types of norms, the core personal responsibility of a facility manager is to design and implement the budget based on sufficiently justified "facility estimates". As a result, facility accountants are trying to compile their budget requests so that:

- the resulting document contains all the mandatory and monetary norms which the facility needs to abide by (so that they are reflected and become a part of the budget documentation);

- at the same time, it also shows what would be the actual or "calculated" norms and what amounts would be included into the budget;

- most importantly, the budget request is supplied with some explanation ("justification") of why the actual allocations have been reduced in comparison to the mandatory norms.

A hypothetical example from an article for facility accountants is provided in Table 7. It shows a hypothetical hospital with three departments including a separate ward for war veterans. The Table shows how the budget request combines the following steps:

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[100] These guidelines are established by the *Methodological recommendations on planning and utilizing budget funds for provision of medical help by health facilities (or "Methodological recommendations on expenditure planning)*. While not mandatory in theory, these Recommendations are strongly endorsed by the MoH. The Recommendations do not have a legal mandate and exist as a research paper developed by the MoH jointly with the MoH Institute of Strategic Research. However, this document was developed by the MoH in response to a clear regulatory request from the Cabinet of Ministers (stated within the CoM Resolution No 208 of 17.02.2010 *"On Selected issues for improvement of the Health system"*). None of these documents explains whether the Recommendations are mandatory, but the overall tone of the Recommendations is highly imperative.

[101] «Обов'язкові норми витрат»

[102] «Грошові норми витрат»

[103] «Розрахункові норми витрат»

- Initial expenditure estimates (black font) which use existing "monetary expenditure norms" and multiply them by the facility "production" statistics (beds and bed-days). In this example, these are called "Estimates of the facility" (Columns 13 and 14).

- Reduction of initial estimates to match budget ceilings (blue font). These numbers reflect the fiscal reality of the facility and they are "included in the budget" ("calculated expenditure norms" in columns 15 and 16).

Resulting "justifications" for all the reductions are an important part of any budget request. In line with recommendations in the professional literature, such separate calculations/justifications are attached for every individual expenditure item (a separate Annex is attached for each Code of Economic Classification, separately for general and special fund).

Notably, there is still some important difference in how this exercise is understood, since facility management is often unwilling to accept personal responsibility for "justifying" unrealistic figures.

- The professional literature recommends assuming that "calculated expenditure norms" are the result of ultimate expenditure reduction, and that these "calculated norms" would actually be included in the budget requests. It therefore strongly encourages facility managers to focus their "justifications" on these ultimately reduced amounts.

- For example, the actual price based on "monetary expenditure norms" for one emergency aid call for a case of hypertensive crisis is estimated to be UAH 4.62 (based on the prices of a package of medicine and materials consisting of Bendazol, Papaverine, Magnesium, Analgin, Lasix, syringes and spirit). However, the actual amount allocated to this purpose in the budget is UAH 1.62, or 35% of the full "monetary norm". Recommendation for the accountants is to make sure that calculated expenditure norms attached to the budget need to break down the UAH 1.62 (allocated amount), and not the UAH 4.62. In other words, the justification needs to show how the UAH 1.62 will actually be spent (perhaps choosing only some of the required medicine rather than the full package).

- However, the actual samples of "justifications" collected from the interviewed facilities show that at least some of them do not precisely follow the above instructions. Instead, they focus the "justifications" on the initial, bigger "monetary estimates". This policy seems to reflect the fact that facility managers are not comfortable assuming individual responsibility for "justifications" of the sometimes unrealistically low "calculated norms". A real life example of calculations for expenditures on food in a hospital budget request for 2012 is reproduced in

- Table 8. It shows the actual fiscally affordable expenditures for 2011 and 2012 (blue font), but also "facility estimates" in red font, which are considerably higher. While most expenditure norms could be reduced as described above, there is also a separate set of "mandatory" norms which cannot be reduced regardless of justification. For example, one "mandatory" norm relevant to the majority of facilities is the amount of spending on services for war veterans (UAH 40 per hospital bed, according to a specific CoM Resolution[104]). The professional literature insists that these estimates should be left untouched during the "justified reductions", and, in the examples by professional journals, these expenditures are funded at the cost of reduction throughout other expenditure items (see Table 7).

The real life budget-request reproduced in

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[104] Cabinet of Ministers Resolution No 680 of 26.04.1007 "On increasing expenditure norms for food and medications in medical facilities for war veterans"

Table 8t shows another example, for food expenses. As the table shows, estimates of food costs for the veterans in the budget are about 9 times higher than for regular patients; second, it shows that all food expenditures are still somewhat reduced in comparison to the initial "mandated" levels. Third, this example shows how such difference is "justified" in practice. The budget requests contain two separate "justifications" for "calculated expenditures" on food per one ordinary patient, as well as for one war veteran, outlining what difference in diet these norms are supposed to imply (in our example, expenditures for war veterans additionally contain mayonnaise and pickled peas). The impact of mandatory norms on the hospitals is confirmed by quotes from the interviews in hospitals, which complain about the need to protect these articles at the cost of reducing spending elsewhere in the facility:

– *"We have norms for most expenditure calculations, but they are not always adequate. For example, there is a norm that for war veterans daily spending on food should equal 35 UAH, and daily spending on medicine should be 45 UAH. This is too much. Maybe medicine I can understand, but with the food it is illogical: an old person is not capable of eating so much, it will be bad for his/her health. But we have to spend it anyway, and we have to report that this is how much we have actually spent per day."*

Table 7. Template for calculating expenditures on purchases of medications (CoEC 1132) provided in a professional journal article based on MoH Methodological Recommendations

Name of Department	Production indicators												Code of Economic Classification 1132 (Purchases of Medications and Bandage Materials)			
	Number of beds in 2009							Number of days per year when beds are functioning			Number of bed-days		Estimate by the facility		Included in the budget	
	Beds accounted by the facility				Beds included into the budget			2009			2009					
	Actual beds in 2008	Start of year	End of year	Year average	Start of year	End of year	Year average	Based on 2008	Estimate by the facility	Included in the budget	Estimate by the facility	Included in the budget	Expenditure norm per one bed-day	Total spending for the year	Expenditure norm per one bed-day	Total spending for the year
												(=7*9)	(=7*10)	(=13*11)		(=15*12)
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Therapeutic departments	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**320**	**330**	**330**	**19,800**	**19,800**	**8.68**	**171,864**	**6.75**	**133,650**
Therapeutic dpt for war veterans	6	6	6	6	6	6	6	320	330	330	1,980	1,980	40.00	79,200	40.00	79,200
General therapeutic dpt	54	54	54	54	54	54	54	320	330	330	17,820	17,820	5.20	92,664	3.05	54,351
Pediatric department	**30**	**30**	**30**	**30**	**30**	**30**	**30**	**327**	**330**	**330**	**9,900**	**9,900**	**5.70**	**56,430**	**4.05**	**40,095**
Surgery department	**45**	**45**	**45**	**45**	**45**	**45**	**45**	**345**	**345**	**345**	**15,525**	**15,525**	**9.66**	**149,972**	**4.70**	**72,968**
Surgery dpt for war veterans	4	4	4	4	4	4	4	345	345	345	1,380	1,380	40.00	55,200	40.00	55,200
General surgery department	41	41	41	41	41	41	41	345	345	345	14,145	14,145	6.70	94,772	4.70	66,482
Total	-	-	-	-	-	-	-	-	-	-				**378,266**		**246,713**

Table 8. Budget request calculations for expenditures on food (example from an interviewed hospital)

	Actual expenditures in 2011			Estimate by the facility for 2012			Expenditures included in the 2012 budget		
	Bed days	Cost per bed day (UAH)	Total cost (Thou UAH)	Bed days	Cost per bed day (UAH)	Total cost (Thou UAH)	Bed days	Cost per bed day (UAH)	Total cost (Thou UAH)
War veterans	9,948	12.90	128,329	10,500	35.00	367,500	10,500	17.50	183,750
Other patients	130,320	3.20	417,024	123,600	28.29	3,496,644	123,600	2.02	249,672
Total	**140,268**	**3.73**	**523,200**	**134,100**	**28.82**	**3,864,762**	**134,100**	**3.23**	**433,143**
Including vegetables:			**133,630**			**517,680**			**250,000**

Table 9. Justification to budgeted expenditures for food (totals)

Name of vegetable	Bed-days	Expenditure norms per 1 bed-day (kg)	Total	Price per 1 kg (UAH)	Amount per year (thou UAH)	Included in the budget Need (kg)	Amount (thou UAH)
Potato	144.3	0.400	57.72	4.0	230.88		99.90
Beetroot	144.3	0.055	7.94	4.5	35.71		22.78
Carrot	144.3	0.060	8.66	4.5	38.96		30.00
Onion	144.3	0.020	2.89	6.0	17.32		17.32
Cabbage	144.3	0.200	28.86	5.0	144.30		70.00
Tomato	144.3	0.010	1.44	7.0	10.10		5.00
Cucumber	144.3	0.010	1.44	7.0	10.10		5.00
Dill	144.3	0.015	2.16	14.0	30.30		
Total					**517.68**		**250.00**

Having explained what the expenditure norms are and how the budget is formulated in practice, the study can now turn to the analysis of the governance/public sector management indicators for planning, budgeting, and financial management.

Program-based budgeting

Effective use of resources is impossible without clear understanding of strategic objectives and priorities. To ensure that the healthcare system is generally capable of delivering relevant results, spending decisions throughout the sector must be guided by clearly formulated strategies, with explicit and realistic priorities. Critically for multi-tier service delivery systems, with significantly decentralized expenditure responsibilities, strategic objectives need to be coordinated between national, regional and local levels of government. At every level, spending units need to be aware of their long-term goals which have implications for their budgets, and have their own strategic plans which would reflect these priorities.

Indicator PB-15. Strategic guidance

Strategic priorities for the country's health care sector are clearly listed in the Government's Economic Reform Agenda 2010-2014 and reflected in secondary and sub-national regulations. As described in Box 10, since 2010 Ukraine's healthcare operates on the basis of an ambitious reform agenda with a range of clearly specified objectives. The objectives are grouped into three main reform goals: to increase quality of the medical services, to extend access to these services, and to strengthen mechanisms for service financing. This national agenda is implemented through a 4-region pilot, but also reflected in sub-regional strategic health plans of individual non-pilot oblasts, rayons and cities.

Scoring table (Method 1)			
Dimension	Source	Benchmark	Grade
Is there a multi-year healthcare strategic planning document at national and regional level which clearly outlines priorities? **[Weakest link]**	Desk study of national legislation	Clear priorities and reform agenda since 2010	Grade B

Do facilities have multi-annual strategic service delivery plans which explain their priorities?	% Chief Doctors who confirm existence of such plans	84.2%	Grade A
Do healthcare professionals believe that sector priorities are specified in a written document?	% Chief Doctors who confirm that there is a written strategic document which guides service delivery priorities	86.7%	Grade A
Are health professionals aware of these priorities?	% Chief Doctors who are able to name at least one of the priorities which coincide with actual policies outlined in current national/regional strategies	85.7%	Grade A
Overall Grade			**Grade A**

The majority of health professionals are aware of the national and regional strategies and able to explain current core priorities. Amongst the interviewed Chief Doctors, 86.7% were aware of the core strategic documents governing service provision in their area and 85.7% were able to correctly quote key priorities. Moreover, not only for the facility executives, but also amongst doctors and nurses, 57.1% of the respondents provided correct quotes of current strategic priorities.

> Box 10. Strategic guidance at national and regional level
>
> Health sector reforms are identified as a priority objective in the Presidential Economic Reform Program for 2010-14, "Prosperous Society, Competitive Economy, Effective State". Until 2010, Ukraine's healthcare sector was driven by a patchwork of national regulations which defined broad reform measures and response plans to individual diseases, but lacked a comprehensive reform agenda, clear priorities and practical implementation mechanisms. In 2010-2011, the new Government appointed after the Presidential elections formulated an ambitious sector-wide reform plan, which included a range of health-specific priorities but also proposed over the medium term significant changes in health financing approaches such case -based facility funding, introduction of social health insurance, introduction of new quality control systems and fundamental increase in the levels of pay for health professionals. The new reform plan was operationalized within the 2010 President's Decree *"On Additional measures on reformation of the system of protection of population's health"* [105] and further within the *Major Conceptual Guidelines for Healthcare Reform* introduced by the CoM Resolution No 208 of 17.02.2010 [106].
>
> After-2010 any new strategic national initiatives have been introduced in the framework of the 4-region pilot, covering Vinnytska, Dnipropetrovska, Donetska oblasts and the city of Kyiv. The overwhelming majority of reform-oriented regulations issued by the Government, and in particular by the Ministry of Health, since 2011, have been linked to the four-pilot initiatives, and conducted within the framework of the related Law. These additional changes to individual MoH regulations have been undertaken in an incremental fashion in the areas of financing, staff remuneration, budgeting, facility organization, health service quality indicators etc. [107]. The process, if and when completed, will include interventions along the following policy areas:

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[105] Order of the President of Ukraine No 70/2010 of 27.01.2010 *"On Additional Measures on reformation of the Healthcare system";*

[106] CoM Resolution No 208 of 17.02.2010 *"On Selected issues for improvement of the Healthcare system";*

[107] Detailed list of these regulations is available at the MoH Website (http://www.moz.gov.ua/ua/portal/hsr_reformlaw/);

1. Increasing quality of services, including: introduction of contract-based funding of facilities, improved equipment, introduction of evidence-based standards and clinical protocols, service quality indicators, and performance-based pay for healthcare professionals.

2. Extending access to services, including: clear delineation of primary, secondary and tertiary care levels, introduction of centers for primary medical care, hospital regions, and highly specialized facilities, development of family medicine, outsourcing public health services to private providers.

3. Strengthening healthcare financing mechanisms, including: pooling funds at the local level for provision of primary care, and at the oblast level – for provision of secondary and tertiary care, development of service unit costs to be used for contract-based funding of the facilities, transition from line-budgeting to autonomous management of funds at the facility level, development of preventive medicine, greater cross-sector cooperation to promote healthy lifestyles, including through raising alcohol and tobacco excises and earmarking the proceeds for public health initiatives, and gradual introduction of mandatory health insurance for the population.

Most sub-national authorities usually reproduce national sector priorities within respective local strategies. Apart from the pilot regions, other oblasts usually develop their local strategies by adopting relevant national Programs and adjusting them to local contexts. This is normally done by approving local health sector Programs and/or by including respective sector-related chapters into broader local Programs of economic and social development which often tend to be named identically to respective national Programs[108]. At the level of facilities, strategic priorities are defined by the facility statutes, as well as by the internal documents approved on the basis of such statutes.

However, not all of these local or facility-level plans strictly qualify as strategies, lacking clear goals and priorities, and some Chief Doctors themselves explain that these documents are often "activity schedules" rather than "strategic plans". In other cases, existing plans had priorities which were short-term and chosen without clear principles: *"We are mostly planning for one year, because every manager knows what is urgent, and what can wait – so based on these circumstances we approve an annual plan for the hospital."* In one case, a Chief Doctor of a municipal hospital in a large city explained that her hospital operates under a single strategy developed by the city Healthcare Department which includes plans for each separate facility.

Indicator PB-16. Links between strategic plans and facility budgets

To provide effective services, facilities need a framework for decision-making which realistically matches priorities to budget allocations. The importance of linking budgets to strategic plans is broadly recognized, but for most organizations in the public sector it faces many challenges. One typical problem is the fact that strategic planning at the national level usually has a long-term multi-annual focus, while most financing decisions are often done within annual budgets, with weaker focus on multi-year financial planning. The quality of prioritization at the facility level may also be compromised by unfunded mandates by the healthcare authorities, if their service delivery requirements do not match available funds. Moreover, even if the funds are available, decision-makers at the facility level may find it difficult to allocate their budgets strategically because of data gaps or limited capacity to analyze the costs of alternative projects and activities.

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[108] See, e.g., *Mykolaiv Municipal targeted Program "Diabetes" for 2010-2013; Complex sector-level development Program for Healthcare development for 2007-2011 for the city of Mykolaiv* at http://www.gorsovet.mk.ua/health/programs.ua; *Program for economic and social development of the healthcare sector in the city of Kirovograd for 2012, Program for medical and social provision for privileged and vulnerable population groups in the city of Kirovograd for 2012,* at http://kr-rada.gov.ua/galuzevi-programi.html; *Program for social, economic, cultural, and spiritual development of the Brovary rayon for 2012 at* http://www.brovary-rda.gov.ua/informacijni-resursi/rajonni-programi/programa-socialno-ekonomicnogo-rozvitku-2012.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Do facilities have multi-annual financial estimates?	% Chief Doctors who confirm existence of such estimates	58.3%	Grade B
When facility management discusses their priorities for the upcoming year, do they use any tentative indication of the budget/available funds, so that they could analyze trade-offs between possible different uses of the available funds in a realistic context?	% Chief Doctors who confirmed that they discussed priorities under a clear indication of available funds	46.7%	Grade C
Is planning at facility-level significantly inhibited by poor costing of services and by unrealistic mandates from healthcare authorities?	% Chief Doctors who assessed at least one of these problems (poor costing; unrealistic mandates) as very severe	53.3%	Grade C
Overall Grade			**Grade C+**

Most facilities have some version of development and service delivery plans, but these documents do not relate to budgets. 84.2% of interviewed facility managers confirmed that they operate on the basis of a multi-annual strategic plan for healthcare service delivery in their hospitals and policlinics. The rest of the Chief Doctors (15.8%) explained that the document which guides their decision-making is the facility budget. However, only about a third of hospitals and policlinics' Chief Doctors is aware of multi-year budget estimates, to back up their medium term facility development plans (see Figure 37).

Majority of Chief Doctors who produce multi-year financial estimates, consider this type of forecasting to be a useless and time-consuming formality (only one administrator called it a positive new idea). Often, such combined strategies for "social and economic development of the facilities" for forthcoming years have to be submitted to and approved by the local healthcare authorities, and so Chief Doctors take this task seriously, even when they do not agree that it matters. When long-term financial estimates are produced, they are calculated by simple extrapolation of historical data, using for example an approximate inflation rate.

- *"Yes, we are doing these multi-year estimates. For example last year we produced them or the period up to 2014. But these estimates are... how shall I say.... not very serious. We consider them initial estimates, and then we never use them."*

- *"We don't have multi-annual planning, we make plans only for one year. First, multi-year plans are almost never needed. And secondly, they are impossible to make. These things are impossible to predict."*

- *"Yes, our accountant does these estimates for 5 years. It is a very simple task: we simply add 5% to the current totals."*

- *"No, we don't have any multi-year forecasts, because our country is not ready for this. We are not ready for clear planning, our population is not ready. We cannot even plan our visits to doctors, we cannot absorb the concept of appointments: we simply show up one day and say, I need to have it now!".*

- *"When we produce budget request, we have to attach 2-year forward estimates. So that's what we do, we add an approximate inflation rate."*

- *"Yes, we are told to do this work, and we do this with calculations for the next five years. But what's the point of it, if our budget was actually shrinking two years in a raw? These calculations are simply additional burdensome tasks that we have to execute."*

- *"Yes, we have this multi-year plans for various areas, such as development of family medicine or oncology. But generally, I see no need for such plans at all."*

- *"We have a plan for 5 years which is called 'Medical facility modernization plan'. We submitted it for approval first with estimates to 2010, then to 2013, and now to 2015. I would have taken it seriously, if I lived in another country. But these plans are phantoms. I haven't ever seen any long-term plan actually be implemented. Because to be implemented, it has to be justified, and it has to be realistic in all respects. But we have no power over our financial decisions anyway, so why waste the time? For example, I do have certain ideas and plans for modernization, but who would approve them? They require a totally different kind of budget."*

Figure 37. For how many years in advance do you normally produce financial estimates? (% responses by Chief Doctors)
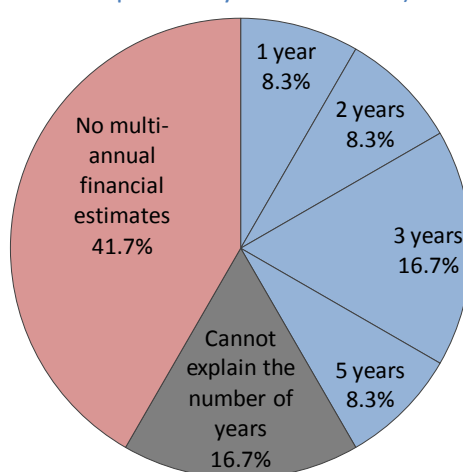
Discussions of spending options are almost never about priorities because of the overwhelming number of unfunded expenditure mandates which take away any flexibility in budget planning. When facility managers discuss their spending priorities, it always happens in the context of budget preparation. However, the budget preparation agenda is almost never focused on the priorities in the first place: agenda is driven not so much by the question of how to allocate funds to different priorities, but rather by the question of how to pay for all mandated expenditures given the limited actual allocation. In the overwhelming proportion of cases, Chief Doctors explained that their budget envelopes ("ceiling") are usually smaller than the total amount of all "protected expenditures" which are supposed to be funded as a matter of priority. In this context, the concept of priority spending risks of becoming meaningless.

- *"All expenditures are strictly tied and money is not enough. For example this year I even had a deficit planned in the budget, so now when we are approaching the end of the year, I don't have enough funds to pay the salaries. In this situation, it is difficult to discuss ideas for reconstruction or other such priority things."*

- *"All our expenditures are strictly defined. All we can do is discuss spending results every quarter in order to report on how we actually spent our allocated budget, and how much of the own revenues we have added to the operations."*

- *"We receive funds only within amounts needed to pay for protected articles – in other words, it is subsistence living. In simple terms some funds are given to us which are just enough "not to die"."*

46.7% of Chief Doctors mentioned the discrepancy between imposed spending demands and the available budget ceilings as an extremely severe barrier to effective budget planning. Only in few cases they also complained about poor understanding of activity costs (see Figure 38). However, in general, the costing exercise as such was perceived to be rather alien, given that most of the expenditures in the protected categories must be calculated according to precise legislative instructions.

- *"The key problem in planning is that we first have to submit a budget request, and then we receive one third of the funds than we ask for. So, we don't see a point in planning: the funding we receive is totally inconsistent with whatever priorities we may have."*

- *"Costing doesn't matter at all. Because all cost calculations are clearly prescribed in budget formulation instructions: the costs of energy carriers, of utilities, of the food, of the medications – of everything."*

- *"Unfunded mandates are an extremely big problem. And not only are they unfunded, they also contradict each other if we compare the requirements of different agencies. And we have to comply with all these requirements, even though they have nothing to do with our plans and they are outside our budgets. For example, a sanitary inspection may require us to refurbish our premises. If we have no money for this, we will need to pay a fine, or a hospital department would be closed. This means that employees are interested in helping to keep the department operational, and they collect personal money for the reconstruction so that they don't lose their jobs."*

- *"Even though we don't have the resources, we are still continuing to provide services. For example, we receive negligible amounts for medication. And for the food, we receive one hryvnya per day; but bear in mind, we need to feed people twice a day. What can we give them? Some kind of soup, a cup of tea, and a piece of bread."*

Figure 38.Chief Doctors who consider lack of costing data and/or unrealistic mandates to be a very significant problem in the budgeting process (%)
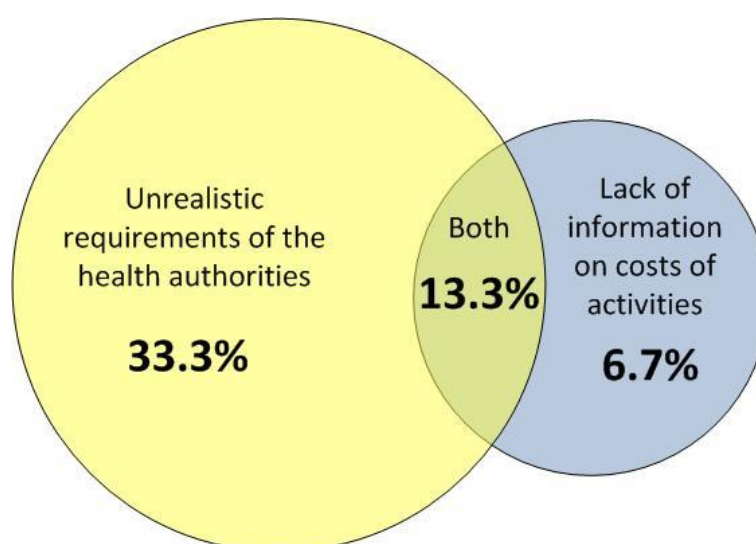
Indicator PB-17. Staff engagement with the strategic planning process

Engaging health care professionals in discussion of priorities increases their ownership of strategic decisions and motivates them to support implementation. Securing feedback from medical workers on the design of the facility plans and associated major spending decisions provides staff with an opportunity to express their ideas and concerns, but also helps them to better understand organizational problems and priorities. Team-driven strategies have proven to be much more effective in motivating professionals to deliver, but also to make them aware of potential implementation barriers and challenges.

Scoring table (Method 1)			
Dimension	Source	Benchmark	Grade
Is there any established practice in the facilities that allows medical staff (doctors, nurses etc.) to discuss priorities for facility development, share their needs and visions on the matter?	% Doctors & Nurses who confirm that such practice exist in their facility	71.6%	Grade B
How viable are such consultation mechanisms: are health workers able to provide actual examples of participating in strategic discussions?	% Doctors & Nurses able to provide such example of personal participation in strategic consultations over the previous year	50.7%	Grade B
How effective are such consultation mechanisms: are health workers able to explain what was the final outcome of the discussions in which they participated? **[Weakest link]**	% Doctors & Nurses able to explain what was discussed and what was the final decision	33.8%	Grade C
Overall Grade			**Grade C+**

A considerable proportion of staff report participating in discussions with the management, but these meetings seem to rarely seek their active feedback. 71.6% of doctors and nurses confirm that their management regularly consults their staff on strategic planning issues. Consultations are organized as staff meetings or facility-level councils or conferences. Moreover, 50.7% of all respondents could recall practical examples of participating in such consultations during the past year, even though only 33.8% were able to specify what strategic issues were discussed and what concrete decisions were made. In many cases, the meetings were described as advisory and awareness-raising, rather than interactive and consultative: staff was informed of certain new laws or procedures and they did not feel welcome or useful to provide feedback (*"Do we have discussions and meetings with the management? Yes and no, because I don't see any point in voicing my thoughts and speaking up there, and neither do most of the other doctors."*)

Overall, the study found that doctors and nurses are consulted frequently by management, although majority of times they are consulted on day to day management issues; **strategic choices and financial allocations are rarely discussed, and, when they are, the purpose can be to collect financial contributions from the staff themselves.**

Doctors and nurses stated that the most popular reason for consultations (33.8%) related to the selection of new equipment for purchase (for example "Purchasing a better ECG machine for the cardiologists", "Buying new, safer, and more modern quartz lamps"). The second most popular reason for consultations was the introduction of new initiatives at the levels of the facility, such as: participating in a pilot project for new approaches in rheumatology; introduction of new scrub-up rules; development of endovascular surgery; design and introduction of new ideas to stimulate

population to participate in check-ups. The third most common reason for consultation was the need to discuss various types of facility restructuring:

- *"Our hospital was restructured last year: the number of regular in-patient beds was reduced, but instead we received a new responsibility to provide trauma care. We needed to decide how to organize the new trauma unit, including some ways to increase capacities of the surgery block and acute care unit."*

- *"For our hospital, there was a decision to unite children's in-patient care with the delivery unit, and also for us to begin providing children's infectious diseases services to the general municipal hospital. In connection with this, we needed to decide how to restructure allocation of units across buildings, and related issues."*

- *"We collectively discussed whether we should open an acute care unit. In the end, we decided to open an entirely new acute care centre with new equipment, and this is what was done."*

- *"Our doctors participated in municipal discussions about the need to reform and create centers for primary medical care, and we did decide to create such a centre in our city."*

Importantly, in many cases, joint strategic meetings with staff were called to organize collection of personal contributions to co-fund facility operations.

- *"The Chief Doctor gathers us in his office and asks us to work harder. He explains that our hospital is under the risk of cuts, and that, in order to save our jobs, we need to show that we are a good hospital. During the last meeting the decision was made to collect money to pay for the refurbishment of one of the departments."*

- *"During the consultations we discussed the need to buy a new device to monitor blood oxygenation and how to collect money for this purchase. In the end, we decided that our previous contribution to the hospital piggy bank would be enough to pay for it."*

Figure 39. Issues and decisions discussed at strategic consultations with facility staff (% responses by Doctors and Nurses)
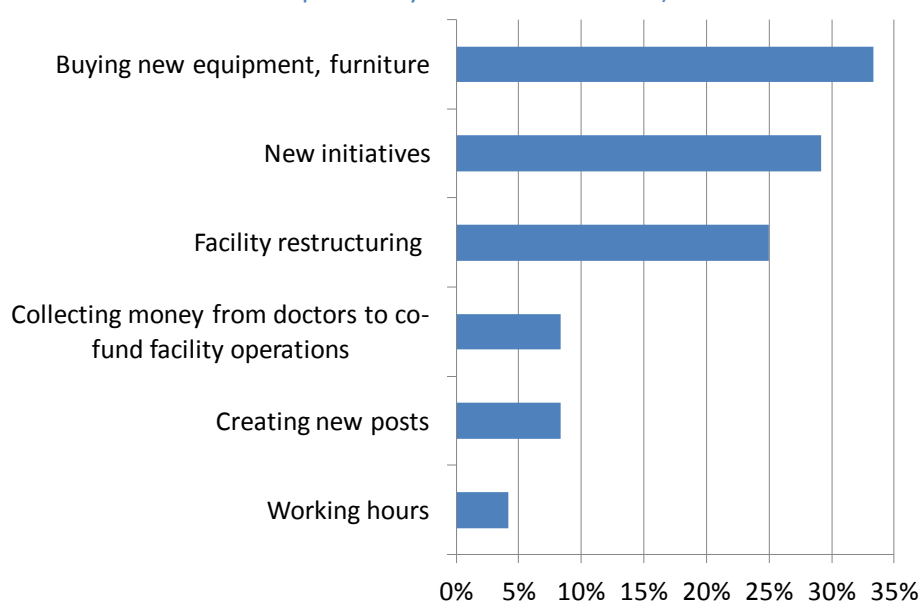
Indicator PB-18. Capacity for strategic planning and budgeting

Effective planning and budgeting requires specialized training, experienced and motivated professionals who can dedicate time to manage this process. Apart from training and experience in specific clinical areas, healthcare executives need to be familiar with the principles of financial management, strategic planning, public health and administration. Depending on the size and nature of the facility, executive teams must be of sufficient size with the appropriate number of assistant administrators to handle planning-related tasks. Moreover, in order to apply the existing skills effectively, budget managers and planners need to have sufficient time and motivation to invest in organizing and leading a high-quality planning process.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Is budgeting and planning led by appropriately trained professionals?	% administrators who state that they have received professional training in Budget Management	71.4%	Grade B
Are professionals able to dedicate sufficient time to the planning and budgeting tasks?	% administrators who state that they can dedicate sufficient time to the planning and budgeting tasks	33.3%	Grade C
Are professionals sufficiently motivated to effectively engage in the planning and budgeting process?	% administrators who state that are sufficiently motivated to effectively engage in the planning and budgeting process	42.9%	Grade C
Overall Grade			**Grade C+**

Regular training and re-training in planning, budgeting and financial management is one of the eligibility requirements for executive posts and most personnel involved in the planning and budgeting have taken this training. Of all interviewed Chief Doctors, 78.6% stated that they have received specialized professional education in budget planning and management. Another 14.3% said that they find it difficult to provide a clear answer, implying that they might have had some similar training, and only 7.1% appeared to have no relevant qualification. Notably, formal qualification criteria to health facility managers (Chief Doctors and Deputy Chief Doctors) contain an explicit requirement of a post-graduate training in "Health Care Organization and Management" and a professional qualification category with specialization in "Health Care Organization and Management".[109][110] As was explained by the respondents, this training usually contains modules on financial management. Moreover, many Chief Doctors explained that local Healthcare Departments in their cities/rayons/oblasts run additional regular workshops in budget management, which are usually timed to match the annual budget preparation cycle. These workshops are designed for Chief Doctors as well as their deputies, statistical specialists and facility accountants. The purpose of the workshops is to explain the latest changes in the budget legislation and any new requirements for the upcoming budgeting cycle.

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[109] *Reference book of professional qualifications (Volume 78, "Healthcare")*, approved within the *Order of the MoH No 117 of 29.03.2002*

[110] *Reference book of professional qualifications (Volume 78, "Healthcare")*, approved within the *Order of the MoH No 117 of 29.03.2002*

At the same time, some Chief Doctors admitted that the training they receive is still insufficient and they have to search for additional sources of information to be able to meaningfully engage into the planning process. Many Chief Doctors are trying to learn on the job, consulting with their accountants or representatives of the local financial and healthcare authorities.

- *"A Chief Doctor needs to check everything personally and really know what the numbers mean, because he needs to know what will come out under his personal signature."*

- *"The training we receive mostly deals with general management of the facility. For details on the budgeting process I have to rely on my accountant."*

- *"To be honest, financial issues are a difficult area for me. We really need some additional, focused training in this area. See, I was trained to become a doctor, and now my job requires me to be an economist. And yes we do have some trainings, but in terms of the financial management they are not very strong. So, we have to learn from the experience of others. And I am not ashamed to go to the local authorities, I always ask them any questions I have."*

- *"Yes, we attend specialized courses and lectures, but also we all engage into a lot of self-education."*

While lack of qualified staff is not considered a severe problem, more Chief Doctors and other administrators complain about lack of time and motivation to invest into strategic budgeting. Lack of time was cited as a significant problem by 26.7% administrators, and only 42.9% of all administrators interviewed said they had enough motivation for planning as such. Majority complained that planning has little sense: *"all the planning is based not so much on what we want to achieve but on whatever we get to spend, and therefore a hospital whose basic needs are funded 75-80% is considered prosperous"; "there are no resources to make major decisions such as buying new equipment or reconstructing facilities".*

Indicator PB-19. Results-oriented budgeting

Linking resources to results increases accountability and transparency of the budgeting process, and is the key way to measure and increase value for money spent. It has been recognized by governments around the world that traditional line-item budgets are not appropriate tools for organizations to make informed and responsible decisions about best way to allocate their resources to maximize performance. In order to increase value for money – or the benefits achieved from the available resources – managers need to be able to manage, by comparing results to the incurred costs and to reallocate funds to the most efficient uses corresponding to organizational priorities.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
What share of recurrent spending allocations is driven by program-based considerations?	% Chief Doctors who say that at least some share of their budgets is allocated based on the program-based principle rather than by a formula, or incremental increase to previous year, or negotiations	0%	Grade D
Is there any established practice in the facilities for assessment of spending efficiency, linking spending to indicators of results?	% Chief Doctors who say that there is such practice and confirm that they link assessment to some result indicators	7.1%	Grade D
Overall Grade			**Grade D**

In the last decade, the Ukrainian Government has implemented extensive reforms to transfer the country's entire general budget to a performance-based budgeting principle. As discussed in detail in **Box 11**, the rules for budget preparation in Ukraine have been consistently modified since 2001 to incorporate the principles of linking expenditures to indicators of results. Over these years, the Government has designed detailed regulations for preparing and implementing budgets based on "programs" – activities governed by a joint purpose with some performance measures. Applying this program-based budgeting principle was made mandatory for all recipients of central budget allocations in 2010 (although de-facto the application began much earlier). Recipients of local budget allocations (which comprise most healthcare spending units) began to implement PBB principle in 2007 and are supposed to entirely transfer to PBB based spending by 2014[111].

The study shows that applying PBB in parallel with line-based spending requirements makes it difficult to truly link inputs to results, even where program-based accounting is duly observed. As was explained at the beginning of the chapter, the PBB system in Ukraine coexists with a wide range of rigid regulatory requirements, such as detailed spending norms for individual expenditure items and spending priorities mandated by the central ministries. These requirements on how to determine the line-items according to the economic classification of expenditure dominate the process of budget preparation; at the end, resulting budget totals are grouped into programs and approved in the program-based classification breakdown. Among other things, for all budgets operating under PBB, submission of budget requests by programs with attached program passports (including respective result indicators) is mandatory. Some utilization of the concept in some of the facilities assessed by this study must be therefore inevitable. Moreover, at least two oblasts in the sample interviewed for this study (Lvivska and Luhanska) have started to implement PBB as they were among the pilot oblasts to take up the PBB initiative in 2009-2010.

Interestingly, almost no Chief Doctor interviewed by this study appeared to be aware of the idea behind results-oriented budgeting, even when their facility was already operating under the PBB. When asked what share of their budgets was designed by result-oriented programs as opposed to pre-defined formula, negotiations or some other method, not a single Chief Doctor said that program-based principle underlines any part of their spending decisions at all. An overwhelming number of managers said that they define their expenditures by a precise formula, as shown in Figure 40. The rest said that some sort of formula dominates their calculations but they have a smaller share of the budget allocated by some alternative principle: either through an incremental adjustment to historical trends for similar budget lines, or by keeping a small share of the budget flexible for any needed discretionary spending. These responses were given even by those Chief Doctors who use PBB accounting in their facilities during the budget process and submit budget passports (see below) as part of the budget request documentation.

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[111] MoF Order No 805 of 02.08.2010 "On Approval of Key measures for introduction of Program-based method in planning and implementation of local budgets" clearly describes the sequence of PBB introduction and commits to full transfer of all local budgets to PBB by 2014. According to MoF, already hundreds of local budgets are "using elements of PBB", even if full roll out is planned during 2014. Some of peer reviewers pointed out that implementation of the PBB at local level is lagging behind, and the templates for implementation are being developed only in 2013.
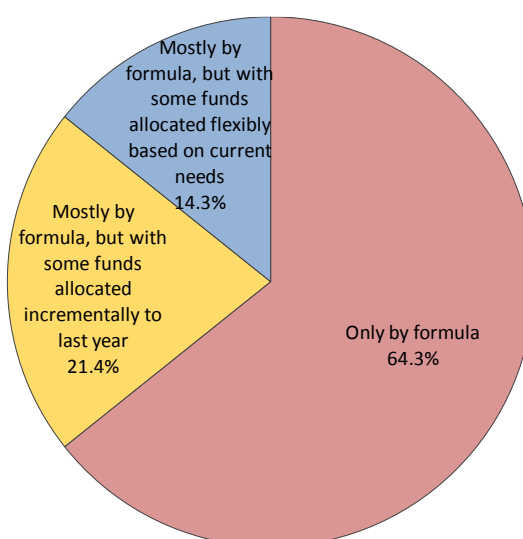
When asked whether their facilities were executing or participating in any budget programs, the only programs mentioned were national vertical programs such as TB or Diabetes control, Reproductive Health program, under which their facilities receive respective centrally procured medications or vaccines.

The overwhelming majority of facility managers were not aware of the spending efficiency concept or found it relevant. While many Chief Doctors stated that they regularly monitor "efficiency" of their spending, only in 7.1% of cases they understood it as an exercise which involves relating inputs to some indicators of performance *("We have a range of performance indicators such as length of hospital stay per patient, with benchmarks, for example 9 days. So, we have to regularly analyze whether our management and spending helps us to stay within these performance benchmarks").* In most other cases, spending efficiency was understood as making sure that expenditures are kept within required ceilings, and identification of required cuts and savings were not in any way linked to analyzing benefits and results of alternative expenditure allocations (Figure 41). Moreover, most often, Chief Doctors simply called their budgets highly efficient because of how tight their allocations were in the first place: not having to make any cuts and living on the minimum was understood as leaving no waste; analyzing the efficiency of what was spent made no sense to interviewed managers.

- *"There is no point in evaluating efficiency: our funds are so small, we spend them on the most important things anyway."*

- *"We have so little money that we buy the most critical things anyway, and we have no surpluses."*

- *"Asking our sector to gain efficiency is like trying to get water out of a stone."*

- *"We don't have sufficient money to make it necessary to analyze efficiency. We are spending on the most important things, and their efficiency is evident. Because without these things our facility would stop existing."*

- *"Sure we analyze efficiency: we are constantly trying to save by seeing where we can make more cuts."*

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Figure 41. Is there an established practice for assessment of spending efficiency? (% responses by Chief Doctors)

Evaluate intensity and appropriateness of using equipment and infrastructure
21.4%

No attempts to evaluate at all
7.1%

Do not link efficiency analysis with indicators of results
64.3%

Evaluate efficiency of current spending based on output indicators for in-patient care
7.1%
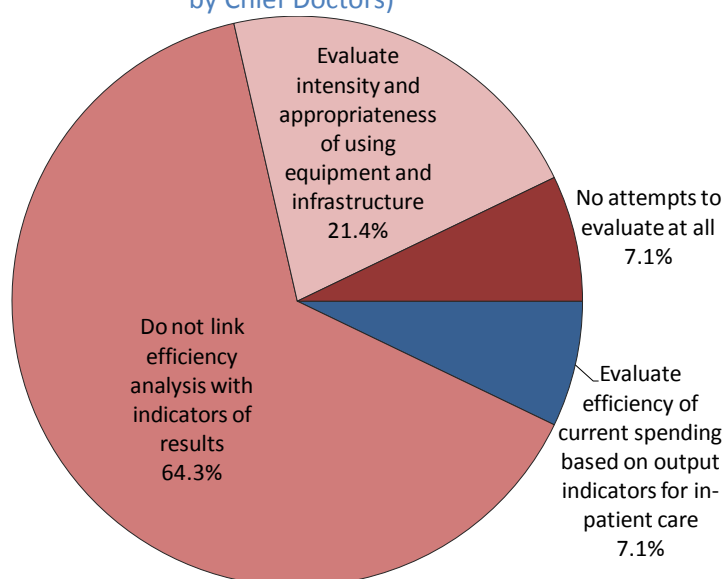
Box 11. Program-Based Budgeting in Ukraine's Public Finance112

Since 2001, the Ukrainian Government has been gradually transferring all budget entities to a "program-based budgeting" (PBB) principle. The legal framework for applying existed in Ukraine since 2001-2002 (since the first edition of the Budget Code and the Concept for Introducing Program-Based Budgeting[113] approved by the Cabinet of Ministers in 2002). Initially, application of the approach was entirely optional. In 2010, PBB became mandatory for Spending Units which receive State Budget proceedings, and optional for those financed from local budgets, if so decided by a respective local council[114]. However, all local budgets are supposed to ultimately introduce it by 2014 [115] in the following sequence[116]:

- 2009-2010: introduction at oblast level in four pilot regions (Zhytomyrska, Lvivska, Luhanska oblasts and ARC);

- 2011-2012: introduction by all oblast budgets; plus rayon and city budgets in the four pilot regions;

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[112] The PBB theme was one of the themes which raised the largest number of comments during the study peer review. This seems to be showing that the topic deserves as precise explanation of our understanding of the PBB concept as possible, and justifies this Box. It is also important to explain the background on PBB to readers not familiar with Ukrainian context, not least because the Indicator on Results-Oriented Budgeting yielded one of the most disappointing results in this study.

[113] Cabinet of Ministers of Ukraine *Mandate No 538-p of 14.09.2002 "On Approval of the Concept for introducing Program-Based Budgeting Method into the budget process"*

[114] According to Article 20 of the current edition of the *Budget Code*, approved in 2010[114], Planning and Implementation of the State Budget must be undertaken based on the PBB method.

[115] Cabinet of Ministers of Ukraine *Mandate No308-p of 23.05.2007 "On approval of the Concept for Local Budget Reform"* (current edition – 21.07.2010)

[116] the MoF Order No 805 of 02.08.2010. *"On Approval of Key measures for introduction of Program-based method in planning and implementation of local budgets"*

- 2013: introduction by the budgets of aggregations of territorial communities[117] once such entities are created[118];

- 2014: introduction by all local budgets of Ukraine.

As of 3 October 2012, based on the MoF Report, a total of 346 local budgets across Ukraine were transferred to a PBB approach[119].

The definition of Budget Programs: Ukraine's Budget Code defines *Budget Programs* as "a set of measures aimed at a single goal, tasks or expected result, which are defined and implemented by a budget *Spending Unit* according to its assumed functions"[120].

Program-based classification of expenditures: Under the PBB, the *breakdown of expenditures into programs* is the core classification by which annual budgets must be approved (rather than *agency classification,* as before). In 2002 the Budget Law presented expenditures as allocations by certain result-oriented activities (= programs), but each item was still traceable to a particular spending agency responsible for implementation of this program (through the structure of the item's code).

For example, the pre-PBB 2001 Budget (and earlier Budgets) contained an allocation to the Ministry of Health (code 230), within which there would be a separate allocation to *"Higher Education Facilities of III and IV Accreditation Levels"* (code 070602). From 2002, the State Budget had an allocation for *"Training and Professional Development of Medical, Pharmaceutical, Academic and Pedagogical staff by Higher Education Facilities of III and IV Accreditation Levels"*. This allocation had a code 2301070, which showed that this expenditure would be managed by the Ministry of Health (3 first digits of the code), but it was now to be formulated as a result-oriented task[121].

Development of Budget Programs:

- Roles: *Budget Programs* are developed by *Key Spending Units* but need to be approved by a financial authority at the respective level (Ministry of Finance or local financial authority). The *Key Spending Units* also appoint an *Executive Manager* for each Budget Program (either delegating this role to a subordinate spending unit or retaining it for implementation by the Key Spending unit itself).

- Process: The *Key Spending Units* propose their Programs within their annual budget requests (along with a spending forecast for two more years). The Programs which would be eventually approved represent a Program Classification of expenditures – the breakdown of spending as it is approved in the annual Budget.

At the central level, *Key Spending Units* are encouraged to use an existing "typical" Program classification approved by the Ministry of Finance[122]. However, if they need to propose an entirely new Program which requires a new regulation to explain the rules for funding such activity, they must

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[117] "Об'єднання територіальних громад"

[118] Draft legislation to create Aggregations of territorial units is being currently considered by the Parliament (Draft Law of Ukraine *"On Aggregations of Territorial Communities"*, submitted by the Cabinet of Ministers of Ukraine, registered on 14.12.2011 No 9590)

[119] http://www.minfin.gov.ua/control/publish/article/main?art_id=355996&cat_id=355989

[120] Article 2 of the Ukraine's *Budget Code*, approved on 08.07.2010, No 2456-VI (current edition – 07.11.2012)

[121] Notably, each code of the *Program classification* is also linked to an individual code in the *Functional classification* of expenditures, so that each spending item could be also analyzed in terms of its role within one of the ten spending functions (in the case, *"Training in Education Facilities of III and IV Accreditation Levels"* corresponds to Code 0942 in the *Functional classification* (Function 0900 – *Education*; sub-function 0940 – *Higher Education*; and within this category – 0942 – *Higher Education facilities of III and IV Accreditation Levels*).

[122] Article 10 of the Ukraine's *Budget Code*, approved on 08.07.2010, No 2456-VI (current edition – 07.11.2012)

also propose a respective draft Procedure for Utilization of State Budget Funds (to be approved by the CoM or by the Spending Unit itself after agreeing it with the MoF)[123]. For example, in 2012, the Ministry of Social Policy proposed a new Program of spending on *"Rehabilitation of children with infantile cerebral paralysis".* It required an approval by the Cabinet of Ministers or a Resolution No 572 of 20.06.2012 *"On Approval of Procedures for utilization of funds allocated in the State Budget on implementation of measures for rehabilitation of children with infantile cerebral paralysis"* (which described proposed rehabilitation measures, requirements to implementing rehabilitation facilities, rules for purchases of equipment, requirements for consultations with civil society organizations etc).

At the local level, during the period before 2014, when all local budgets will be transferred to PBB, all local budgets must use a "Temporary classification of expenditures and crediting of local budgets" as well as the emerging Program classification of local budget expenditures124. In other words, every spending item at the local can even now be linked to a certain Program through this classification.

Again, as at the state level, the idea of the Program classification of expenditures is that for every spending item, the Code of the Program would reflect the identity (number) of the Key Spending Unit which is responsible for this Program, the number of the Executive Manager of this Program, the number of the Program itself, and the type of spending which the Program assumes[125].

Budget Program Passports:

Definition: Budget Program Passport is a document which defines the Program's goal, tasks, expected spending items, executive managers, and result indicators126.

Development of Program Passports: Program Passports must be developed by the Key Spending Units which propose the Program. The Program must be approved by the joint decision of this Key Spending Unit and the financial authority of respective tier (Ministry of Finance or the Finance Department of the respective local administration), and a copy of this decision is submitted to the State Treasury Service. The Program must be submitted within 30 days and approved within 45 days *after* the respective Annual Budget becomes effective[127].[128] Absence of the approved Program Passport constitutes a ground for the Treasury to refuse payment against the respective budget allocation[129]. Precise rules and Templates for development of Program Passport, as well of rules for reporting against these Passports, are defined by a specific Ministry of Finance Order[130].

Result indicators within Program Passports: The legislation and the template require each passport to contain a section (Section 10) dedicated to "Result Indicators", including indicators of inputs, outputs, efficiency and quality, as well as respective measurement units and sources of verification.

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[123] Part 7 of Article 20 of the Ukraine's *Budget Code*, approved on 08.07.2010, No 2456-VI (current edition – 07.11.2012)

[124] *Ministry of Finance Order No 805* of 02.08.2010. *"On Approval of Key measures for introduction of Program-based method in planning and implementation of local budgets"*

[125] *Ministry of Finance Order No 97* of 14.02.2011 *"On Approval of the Code for the Program classification of expenditures and crediting of local budgets and Approval of the Codifier for numbering of the typical lists of budget Programs within local budgets".*

[126] Article 2 of Ukraine's *Budget Code*, approved on 08.07.2010, No 2456-VI (current edition – 07.11.2012)

[127] Part 3 of the Ministry of Finance Order No 1098 of 29.12.2002 "On Passports for Budget Programs" (current edition – 16.01.2012)

[128] Article 20 of Ukraine's *Budget Code*, approved on 08.07.2010, No 2456-VI (current edition – 07.11.2012)

[129] Part 2 of the *Ministry of Finance Order No 1098* of 29.12.2002 *"On Passports for Budget Programs"* (current edition – 16.01.2012)

[130] *Ministry of Finance Order No 1098* of 29.12.2002 *"On Passports for Budget Programs"* (current edition – 16.01.2012)

Given the need to comply with expenditure norms and protected spending requirements, CDs find it difficult to meaningfully apply results-oriented budgeting principles. However, where PBB is formally approved, they need to compile their requests accordingly, broken down into programs and supplied with respective program documentation such as program passports: *"In December[132], after we develop our first draft budget together with the initial passports[133], we submit this draft. We need to compile and submit these passports and get them approved every time. And mind it, every passport is about 150 pages long[134]. Because every passport needs to contain very detailed expenditure calculations. In reality, nobody needs them."*

Indicator PB-20. Clarity and consistency of budget preparation guidelines

Regulatory guidance on facility budget preparation must accommodate any existing expenditure mandates with the way ceilings are defined and negotiated. Finding a way to reconcile rising healthcare costs with the current and long-term budget constraints is a growing concern in countries of all income groups. Most healthcare systems are searching for ways to combine fee-for-service payment approaches with some caps on spending to motivate providers to constraint their funding requirements. However, no matter what mechanisms are chosen to impose the budget constraints at the facility level, and regardless of the current levels of hospital managerial autonomy, the basic good governance requirement is to ensure that any expenditure mandates imposed on providers by the Government are fully funded. The budget preparation stage is when existing unfunded mandates emerge. In addition, regulatory guidance on facility-level budgeting must be clear and consistent regarding any mandatory norms and procedures.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
How clear and consistent are the rules for facility budget preparation?	National legislation	Rules exist but there are significant gaps or contradictions (see Box 10)	Grade C

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[131] *Ministry of Finance Order No 1098* of 29.12.2002 *"On Passports for Budget Programs"* (current edition – 16.01.2012)

[132] Note that, according to the Budget Code, local councils approve local budgets in December. Therefore, drafts are no longer considered or submitted in December. So, the CD interviewed showed that his facility was delayed in the process.

[133] Note that in the Budget Law there is no such concept as "initial passports" and the passports are not sent anywhere three times a year for planning. However, as we understand, each program must be approved by the financial authority of respective tier (Ministry of Finance or the Finance Department of the respective local administration), therefore it would be natural to assume that there are some initial drafts which could be modified before approval (otherwise approval would be automatic).

[134] The amount of pages (150) is a citation and it is an important number because it is strikingly large. The standard forms approved by the MoF (if we understand correctly, the comment refers to the Ministry of Finance Orders No 1098 of 29.12.2002 "On Passports for Budget Programs" (current edition – 16.01.2012), No 1536 of 10.12.2010 *"On Result indicators of Budget Programs"* (including *General Requirements to defining Result indicators of Budget Programs*), and No 15 of 14.01.2011 *"On Approval of a Typical list of Results indicators for Budget Programs")* are indeed shorter, but they must get much longer when they are actually filled in.

Are all mandatory norm-driven expenditures covered by the budget ceilings?	% Chief Doctors whose description of budget preparation process shows that most of the budget expenditures are mandatory and norm-driven but not covered by the budget ceilings	61.5%	Grade C
Overall Grade			**Grade C**

Faced with the evident unfunded mandates, all facilities need to find some way to reconcile imposed norms with their fiscal reality. Facility managers are personally responsible for submission of legally accurate budget requests which comply with all existing requirements. While there is no formal guidance on how to achieve this, the dominant practical approach is to use creative templates which reflect all requirements but also calculations which "transform" imposed expenditure norms into actual ("calculated") norms within the budget ceilings (we described this practice in Box **9**.)

Interviews confirmed that the bulk of the facility budgets are strongly formulae-driven and with widespread unfunded mandates. Among the Chief Doctors who participated in this study, 61.5% said that they mostly allocate funds based on the norms and formulae for expenditure calculation and that their original calculations are not nearly close to the actually available funds (see Figure 42). At the same time, in 23.1% of cases, Chief Doctors believed that while most of their expenditures are mandatory and fully defined by the formulae, this mandatory spending has usually been fully funded in recent years, although this leaves only very small leeway for the facilities to pay for anything else, such as reconstruction or new equipment.

- *"We have normative indicators, norms. But we are funded only by about 40% of what this would require. How do we know how much is required? We calculate it. We take all the protected expenditure items, take all the statistics such as bed-days or patient days. And then we look at how many patients we have in different departments. And that's how we know how much we require."*

- *"We compose our budget request and we show it to the healthcare departments. They look at it, but they always give us about 50% of what is calculated. So, we are spending as much as they give us. For example, if we need 1000 liters of patrol, but they give us 500, we just use 500 liters."*

- *"We have almost the same budget every year. Protected expenditures take up about 99.4%; this includes wages, utilities, medication, food. Everything else should be funded within 0.6% of our available budget: any other materials and inventories we need to buy. And then there are articles which are non-funded: capital reconstruction, expensive equipment."*

Figure 42. What share of mandatory expenditures usually falls within available budget ceilings?
(% Responses by Chief Doctors)

Pie chart segments:
- Budgets are very tight but we have some allocation flexibility to survive 15.4%
- Most mandatory norm-driven expenditures are duly funded and the rest of the funds are budgeted based on needs 23.1%
- Most expenditures are mandatory, norm-driven and not covered by enough financing 61.5%
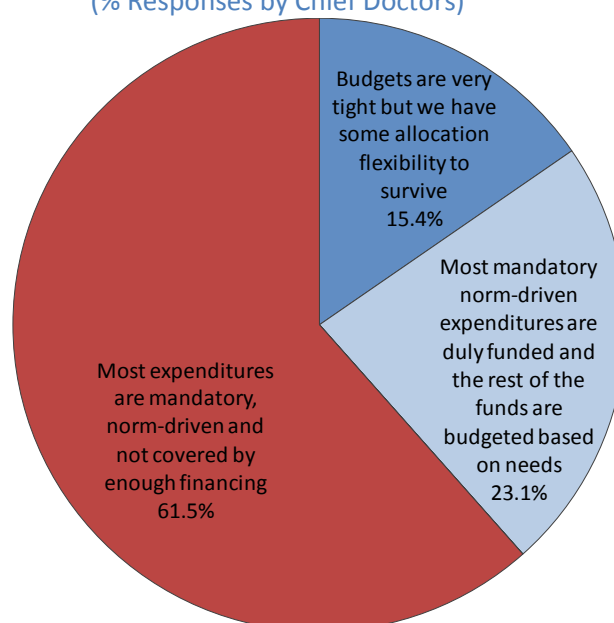
Administrators need to not only present their budgets whilst respecting unachievable norms, but also find a way to actually provide services within their budget envelopes. Pervasive fiscal deficits at facility level prompt administrators to search for alternative ways to resource their service provision. In some cases, as was mentioned earlier (under Indicator PB 17), the shortfall is collected through personal contributions from doctors and/or patients.

Capital budgeting

Indicator PB-21. Criteria for prioritizing investment projects

Decisions on priority capital investments must be based on transparent criteria and follow long-term organizational objectives. Before facilities begin to appraise individual investment projects, they need to make longer-term choices about the general strategic direction for capital investment. These choices should be consistent with the strategic development objectives set out in the facility and regional healthcare service delivery plans. To achieve the greatest value for money, these choices should also follow transparent criteria and be free from political patronage and subjective decisions of administrators, authorities or other stakeholders.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Are capital budget allocations linked to development strategies as specified in strategic service delivery plans?	% Chief Doctors confirming the link	50.0%	Grade C
Are there transparent criteria for project selection?	% Chief Doctors assessing transparency of criteria as very strong or good enough	58.8%	Grade B

How often do political patronage and other subjective criteria impact selection of the projects?	% Chief Doctors who believe that subjective and political criteria usually strongly influence project choices	6.3%	Grade A
Overall Grade			**Grade B**

Investment decisions are essentially made by local authorities rather than at the hospital level, and priorities are defined through negotiations. Resources for capital spending are allocated across medical facilities by the local healthcare department, after consultation with all facility executives. However, obtaining such capital allocations is quite unusual for most facilities. Normally their budgets are almost fully allocated to cover recurrent costs. If any capital needs arise, facilities normally cover them from their own revenues or by seeking personal contributions from their staff.

- *"We haven't had capital allocations for a long time, it is a very rare phenomenon. All we spend our regular budget on is protected articles: wages, utilities. The reconstruction we are doing is all funded from charity contributions."*

- *"It was so long ago that we last had any capital budget allocation that it is really hard for me to respond to your question. We came to work in this building 10 years ago, and every improvement has been entirely funded through the contributions of our staff. Everything you see, even the roofed parking lot – we paid for it all with our personal funds."*

- *"We have to beg for our capital allocation [from the local authorities], and once received, it is strictly earmarked for the agreed projects. But we really have to prove hard that these projects are needed."*

At the same time, most Chief Doctors believe these negotiations are transparent and that the resulting investment priorities are generally defined based on objective criteria. In 58.8% cases, respondents said that transparent criteria are followed in prioritizing investment initiatives, and 50.0% confirmed that these priorities are usually based on overall understanding of priorities for the sector as a whole in their city, rayon or oblast. The influence of political patronage and subjective judgment was assessed to be minimal (6.3%).

- *"This planning is collegiate: sector specialists submit requests, and on the basis of these requests the authorities scrutinize the key issues for our infrastructure development. We also need to make inspections and calculate the costs of any required projects, for example, for reconstruction or for the equipment. We send these requests to the rayon council, and if we are successful in receiving allocations, the funds are provided as earmarked transfers."*

- *"There is a certain procedure: there is a team of specialists – including an engineer, chief economist, etc, who produce a **'report on infrastructure deficiency'**, which outlines which parts of our premises and equipment are outdated and what list of works is needed to repair these gaps. For example in our latest request we explained why exactly we need UAH 300 thousand for reconstruction of our sewage system."*

Notably, these prioritization criteria were overwhelmingly linked to the level of deterioration of the current infrastructure. In most cases (62.5%), the Chief Doctors rely on a system which estimates the level of deterioration of current the facilities (buildings and core equipment), so that infrastructure which is in the worst shape is financed as a matter of priority. This approach helps to maintain the level of services at some minimum level.

- *"We have a special system for assessment of the state of infrastructure. We use recommendations from inspections by various agencies (sanitary service, service for exploitation of the buildings, fire*

safety service). These recommendations outline necessary repair and reconstruction work. Based on these recommendations we calculated the expected project costs and make requests."

- *"Our assessment system is based on the basic analysis of what is needed for the facilities to survive. We ask for the most critical needs. But these requests have been met in the last years. The assessment is done by commissions: they look at the premises and decide where repair or reconstruction is badly needed, and then a team of economists/accountants calculates the costs."*

- *"Allocations are made in cases when we really cannot function any more with the current infrastructure. These priorities are identified by the commissions and inspections of the infrastructure."*

- *"We have a system to assess the state of our infrastructure – because it is evident what is already completely and utterly out of shape and simply cannot be used anymore. Once we identify these clear gaps, we try to find some funds to address the problems – often by raising these critical needs with the rayon or oblast authorities. Sometimes we have emergency situations when things stop working, which is an additional argument we can use. Luckily, in our local council, there are some doctors from our rayon, which helps our lobbying efforts."*

- *"If a roof is leaking, it is obviously a priority. If somewhere a heating system is broken, it is also an obvious priority. If some key equipment fails, this is another type of urgent request. All these requests are submitted to the Healthcare Department, along with the cost calculation.*

Indicator PB-22. Projects appraisal and selection

To maximize value for money, capital investment alternatives must be appraised through sound technical procedures, with elements of cost-benefit analysis and the incorporation of long-term costs. Within the areas which need development and investment, managers need to make difficult choices about which project options would represent best value for money in the long-run. These choices require technical expertise and competent comparison of costs and benefits of alternative options, by in-house specialists as well as independent sources. Moreover, any capital investment decisions produce long-term financial consequences, such as additional recurrent costs for the new equipment or premises, which need to be duly incorporated into project appraisal and selection. Another long-term consideration is the need to ensure that on-going projects receive priority over new investments, in order to finish up investments already started before starting new ones.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
How good is the technical guidance for project appraisal?	% Chief Doctors assessing technical guidance as very strong or good enough	56.3%	Grade B
Are recurrent cost implications of capital spending fully incorporated in the investment projects?	% Chief Doctors who state that recurrent costs are fully incorporated in 75-100% cases	35.3%	Grade C
Is there normally an independent assessment of quality / cost efficiency of projects?	% Chief Doctors who confirm independent assessment of costs and benefits in 75-100% cases	31.3%	Grade C

Do on-going projects receive priority for financing to be completed before new ones are started?	% Chief Doctors who state that on-going projects receive priority in 75-100% cases	50.0%	Grade C
Overall Grade			**Grade C+**

Chief Doctors admitted that their work on the actual analysis of project alternatives suffers from a range of weaknesses:

- Even though technical guidance on this process was assessed positively by the majority of respondents (56.3%), the calculations are still usually based on strict norms contained in national regulations rather than more advanced and realistic approaches.

- Only 35.3% of respondents confirmed that their calculations incorporate recurrent cost implications of the new projects as well as the capital costs.

- **Independent cost-benefit analysis is a very rarely practiced (confirmed in 31.3% of interviews)**. First, most of the analysis is conducted by in-house specialists, and, second, it rarely involves comparison of expected costs and benefits. In only one case did the hospital explain that it based its request for new equipment on the calculations of expected cost-benefits, outlining how the new equipment would help them shorten the duration of in-patient stay for every person.

  - *"We do involve technical specialists, but there is no way to call them independent. Sure, some of the key issues such as functioning of lifts or oxygen systems are inspected by outside specialists. But most of the analysis for our equipment requests is conducted by the in-house technician who is responsible for the maintenance of this equipment."*

- **Facilities find it difficult to undertake multi-year investment projects.** The capital budgeting process has a strict annual cycle and multi-year estimates are not reliable, even where they are being attempted. Moreover, only half of the respondents believe that their investment prioritizes already on-going projects vis-a-vis new ones.

  - *"In 2007 we started to build a new surgery department. We planned to finish it in two years. But we are currently lacking UAH 6 million to finish it. These funds were supposed to be allocated in this year's budget, but we only received UAH 1 million. In our own usual budget, 85% of all resources go into wages and food, and even so, after allocating the bulk of the budget for these protected articles, they are only funded at 40% of what is required by the norms."*

Budget execution and management of funds

Indicator PB-23. Predictability in availability of funds

At all levels of budget execution, spending agencies need to have reliable information on available funds to allow them to accurately make expenditure commitments. Predictability of financial flows is one of the core PEFA indicators for the national PFM systems (PI-16) and this indicator is directly relevant to budget management at the facility level. To be able to operate in line with their service delivery plans and with the agreed budget appropriations, healthcare facilities need to be sure that the level of funding made available for a specific period of time will not be reduced during that period. As outlined in the PEFA Guidelines, predictable financial flows require effective flow planning and monitoring, based on regular and reliable cash flow forecasts. In cases when the government (central or local) needs to adjust the agreed cash flow commitments, significant adjustments should be undertaken in a transparent way decided in advance, and significant changes should not be frequent.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Do facilities operate under regularly updated cash flow forecasts and with reliable indication of available resources, being able to commit at least a quarter in advance?	% Chief Doctors confirming that they prepare an annual cash flow forecast, update it at least once a quarter, and are able to commit in accordance to budget appropriations for at least 3 months in advance	66.7%	Grade B
Is the installment plan which drives monthly allocations a reliable tool which helps to realistically forecast financial flows at the facility level? How common it is for funding agencies to change this plan because of budget cuts or poor planning?	% Chief Doctors who state that if the monthly installment plan is changing during the year, it is usually done by the funding authority (e.g. as a result of budget cuts or other adjustments)	7.7%	Grade A
How often do facility managers face delays in the agreed installment schedule?	% Chief Doctors who report delays in receiving installments agreed within the monthly plan	23.1%	Grade A
How credible are budget allocations?	Frequency and scale of deviation of actual expenditure from budgeted amounts during the last 3 years (average for all facilities)	In no more than one out of the last three years has the actual expenditure deviated from budgeted expenditure by an amount equivalent to more than 5% of budgeted expenditure	Grade A
Overall Grade			**Grade A**

A Monthly Installment Plan, approved by local financial authorities and the State Treasury, is one of the core legal requirements and the basis for authorization and release of funds for all facilities. As outlined in **Box 12**, the principal tool for cash flow forecasting for every public health facility in Ukraine is the Monthly Installment Plan. Development and approval of this document is a painstaking process, given that the Plan ultimately becomes the core basis for the multiple cross-checks when facilities request the Treasury to allocate funds to their accounts and to release payments for their assumed liabilities. Amending this schedule of monthly payments ceilings is equally difficult, as it requires all engaged parties to repeat required rounds of consultations, agreements and approvals. Using this required tool for annual cash flow planning is one reason why responses scored highly on the dimension related to existence of some cash forecasting. However, not all respondents found that updating the forecasts is possible at least once a quarter or that the indication of actual resource availability reflected in their annual installment plans is sufficiently reliable, resulting in only 66.7% believing that their annual forecasts given them an opportunity to commit at least 3 months in advance.

Box 12. "Monthly installment plan": development, approval and commitment control

As budget spending units, public health facilities operate on the basis of a "Monthly Installment Plan" (*"Розпис бюджету"*), which breaks down the facility's annual budget into monthly spending ceilings. The Monthly Installment Plan is developed by the facility as part of their budget planning, as illustrated in Figure 43. Draft Monthly Installment Plans are designed in the second round of revision of their budget requests, after approval of respective local budgets by the local councils and learning their respective annual budget ceilings (*"Лімітні довідки про бюджетні асигнування"*). These draft Monthly Installment Plans are agreed with local Finance Departments and verified by the State Treasury (to check whether the totals fall within the approved budget appropriations). Only after the Monthly Installment Plans are approved, can facilities develop their final versions of the draft budgets and send them for final approval[135].

For every spending unit, the Monthly Installment Plan becomes one of the key documents in the process of authorization and release of funds[136] (see Figure 44). Before the spending units can assume any payment liabilities, the Treasury uses the Monthly Installment Plan to provisionally allocate available budget funds across the spending units for subsequent utilization (registering individual appropriations on the facility accounts). Once the funds are allocated provisionally, the spending units can take expenditure commitments, but before the funds are actually released, the Treasury runs at least two more rounds of cross-checks for every liability (to see whether it corresponds to the budget appropriations, monthly budget ceilings and whether there are enough funds available for the payment).

Given that development and approval of the Monthly Installment Plans is such a long and complex procedure, any amendments are equally time-consuming and must follow the same lines and rounds of consultations, verifications, agreement and approval.

The Monthly Installment Plan almost never changes as a result of top-down cuts or revisions. Whenever the Monthly Installment Plan is amended, this usually happens at the request of the spending facilities themselves rather than because of budget cuts or other top-down changes imposed by the authorities. Top-down changes were reported only by 7.7% of respondents. The requests for amendment made by the facilities themselves usually reflect unexpected spending hikes, for example as a result of unplanned activities, emergencies, growing prices. However, they may also be needed if the facilities manage to achieve saving on some spending lines and need to reallocate them on other activities:

- *"We need to change the Monthly Installment Plan when we don't have funds because we planned our initial forecast with incorrect assumptions about prices, for example, for energy payments. We then need to ask authorities for help to cover the deficit, and we need to reflect new amounts in the monthly ceilings."*

- *"Amendments are always as a result of new needs we could not forecast, usually rising prices, for example on energy or medicines."*

- *"The key reason is that we lack funds. For example when our boiler broke down, we needed to repair it regardless of the ceilings, so we needed to reflect the changes in the monthly plan."*

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[135] *Cabinet of Ministers Resolution No 228 of 28.02.2002 "On approval of Procedures for development, consideration, approval and basic requirements to implementation of the budgets of budget entities"*

[136] *Ukraine's Budget Code; Procedures for management of State Budget's expenditures and credit operations"* approved by the MoF Order No 1223 of 30.09.2011, *"Procedures for Treasury management of local budgets"* approved by the Order of the State Treasury of Ukraine No 205 of 04.11.2002, and *"Procedures for accounting of liabilities of Budget Spending Units in the State Treasury"* approved by the Order of the State Treasury of Ukraine No 136 of 09.08.2004.

- *"We need to modify monthly ceilings if we have to do something we have not planned earlier; for example, we need to send someone on a business trip."*

- *"We ask to change the Monthly Installment Plan when we achieve some savings, for example on electricity, and we need to use them on other utility payments." (This comment was made several times)."*

- *"Last year, I was successful in my lobbying for more funds during a local council session, and they agreed to give us more funds at the end of the year, so the ceilings were changed. And for these few months we lived like we were back in the USSR, the acute care department really lived with 100% of their costs covered, and some other departments too. But of course, next year, everyone had a hard time re-learning how to live our usual life again."*

The approved monthly ceilings are usually respected by the Treasury, although cases of delays are growing. Most facility managers confirmed that, in line with the legislative requirement, they are able to retrieve due funds according to the agreed budget appropriations within the monthly ceilings. Release of funds takes place several times a month, in line with needs that arise, sometimes on particular days (for example on the days when salaries are usually paid). However, in 23.1% of cases, respondents mentioned a recently emerged problem with delays (the survey took place in autumn 2012). In their experience, funds were released only for protected spending lines, while payments for any other activity were "blocked".

- *"Previously we used to receive due payments every month, but starting from August the accounts in the Treasury are blocked and our payment requests are not serviced, with the exception of protected budget lines. We think this is because they lack funds."*

- *"Payments against our requests are conducted every week, as we incur spending needs, but within the planned monthly ceilings. But sometimes the funds can be blocked on our accounts and they would not be released for anything except protected budget lines. Sometimes we cannot receive funds even from our Special Fund accounts.[137]"*

- *"We have problems with delays in payments for unprotected articles. Earlier we didn't have these problems, but this year these problems and delays are constant."*

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[137] Note: Any public budget in Ukraine (including the budgets of individual spending units such as hospitals) consists of two major parts: the *General Fund* and the *Special Fund*. Most revenues and expenditures are included into the *General Fund.* However, a strictly specified list of revenues and expenditures is accounted within a *Special Fund*. The *Special Fund* revenues must be clearly earmarked for a specific purpose, and expenditures must fully coincide with the respective revenue sources and their authorized purposes. Any actual expenditure from the *Special Fund* can be made only within actual receipts of respective earmarked revenues.

Figure 43. Flow chart: key stages of the budget planning process

Figure 43. Flow chart: key stages of the budget planning process

Figure 44. Flow chart: key stage of authorization and release of funds
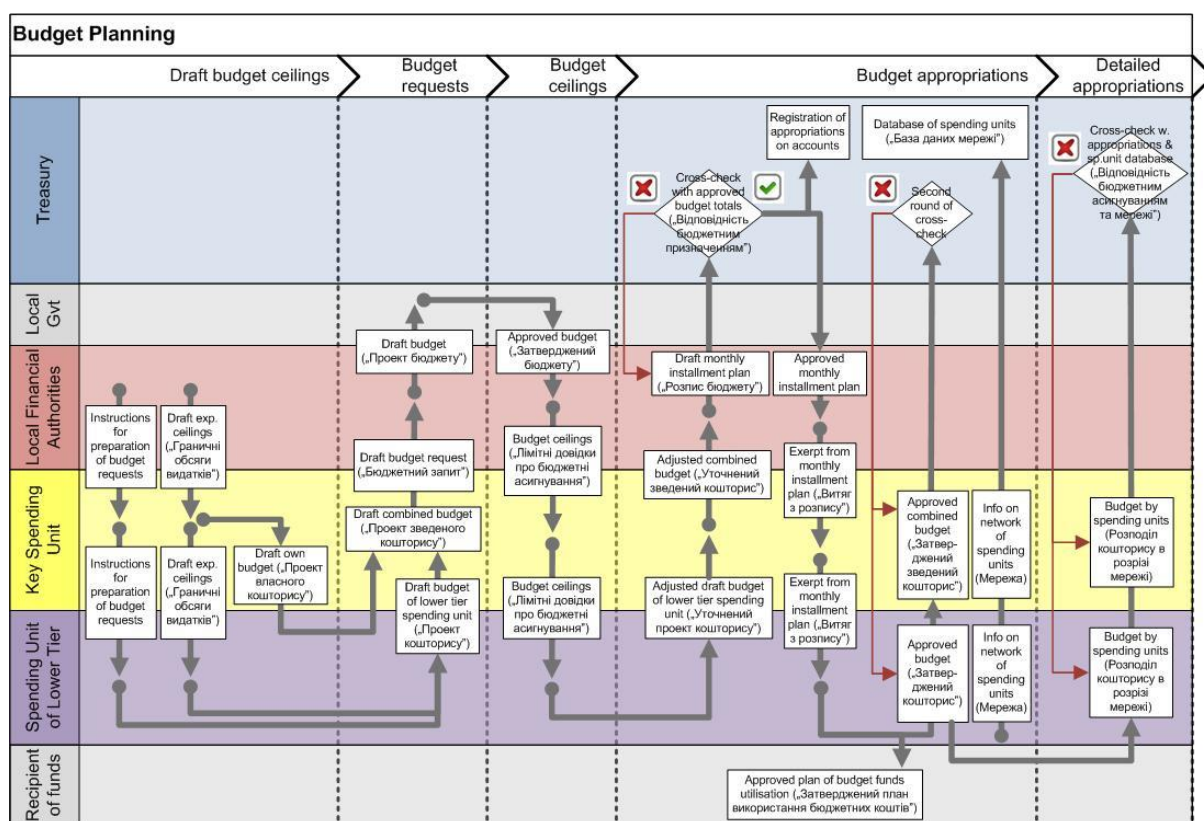
Figure 44. Flow chart: key stage of authorization and release of funds
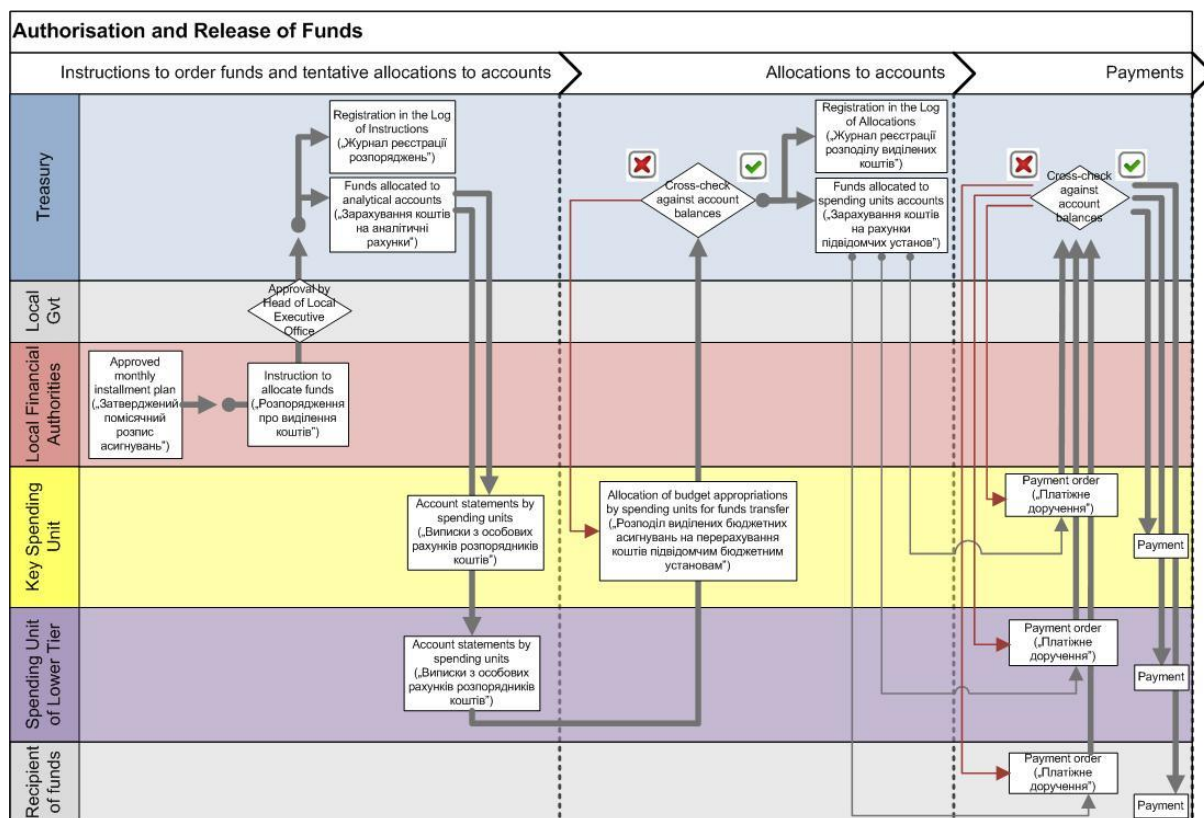
Notwithstanding these recent delays, actual allocations to the facilities in the previous years have been credible. Figure 45 shows the history of average deviations between budgeted and actual total expenditures for several interviewed facilities which agreed to share their financial data. It shows that in the period 2008-2012, actual allocations have never deviated from the planned totals by more than 5%; in fact, in 2011 and 2012 they have somewhat exceeded the budgeted figures. In this way, agreed budget ceilings so far remain a credible orientation for the public healthcare providers, currently qualifying for Grade A.

Figure 45. Average deviation of allocations from approved budgets and actual spending from received allocations
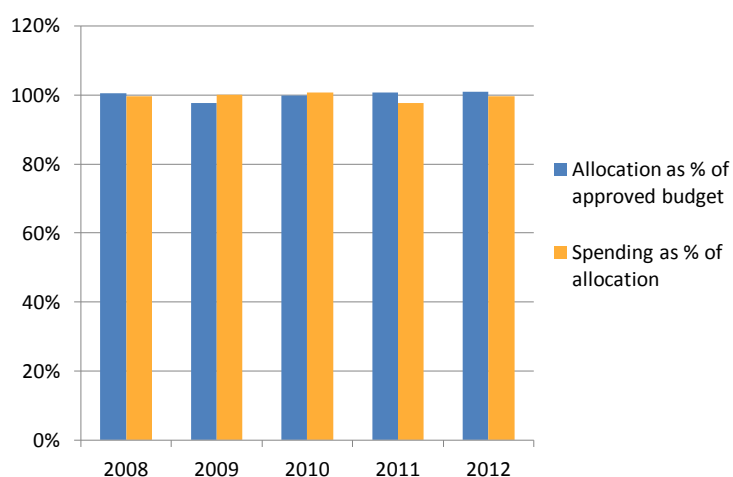
Indicator PB-24. Spending flexibility and transparency of adjustments

Facilities need to retain a reasonable degree of flexibility at the margin to reallocate within their budgets to allow effective and timely responses to unexpected situations. Unpredicted expenditures in service delivery may happen for a range for reasons, including emergencies and changing prices. Moreover, hospitals may achieve savings in service delivery, creating opportunities to use allocated budgets more efficiently for other activities. Accommodating these possibilities requires facility managers to enjoy some executive power to reallocate within their budgets (across budget lines and across monthly estimates) during the budget execution process. At the same time, these adjustments should not be too frequent, and if they are substantial, they should be undertaken through a transparent and accountable procedure.

Scoring table (Method 2)			
Dimension	**Source**	**Benchmark**	**Grade**
Do regulatory rules for budget execution provide enough flexibility for reallocation but also enough clarity on transparently handing significant in-year adjustments?	Budget planning and execution rules	Guidelines for cash flow management suffer from numerous weaknesses, making implementation difficult	Grade C
If there are cash shortages during the year, what are the procedures for adjusting the budget?	% Chief Doctors who report that if significant in-year adjustments to budget allocations take place, they	80.0%	Grade A

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	occur only once or twice a year and are done in a fairly transparent way		
Are facility/hospital directors authorized to manage the budget, or part thereof in any way? For example, does the facility/hospital budget have any flexibility to change allocations among the different items?	% Chief Doctors who report that they enjoy some flexibility in budget execution	46.2%	Grade C
Overall Grade			**Grade B**

Current rules for budget planning and execution are complex and rigid, making in-year adjustments a long and difficult process. The legislation which drives budget execution is comprehensive and elaborate, with very detailed guidance for cases when in-year adjustments need to be made, reallocating expenditure appropriations either between lines or between the months of the year. However, this complexity often runs against the need for flexible cash management, making it very difficult to introduce changes, as was discussed in **Box 12**. This was reflected in the interviews with Chief Doctors who complained that requesting any such changes is difficult or nearly impossible:

- *"Of course we need to make adjustments, and there are always some nuances which come up during the budget execution which we need to incorporate. But we have already learned the hard way that achieving these adjustments is unrealistic."*

- *"The concept of cash management is not really applicable to us, because we do not manage our funds. All our expenditures are strictly planned in advance."*

- *"In order to change our budget, we need to write a justification, make all necessary calculations with the planning and financing department, then send them to the finance department, then wait for the oblast council commission to consider our case, then wait for the oblast council session. In the best case scenario, it takes at least 2 months."*

A strong majority of Chief Doctors (80.0%) believe that if significant adjustments do occur, they are not frequent and are not done in transparent way. Procedures outlined by the respondents for actual in-year adjustments in their budgets fully correspond to the legislative guidelines and assume a sophisticated procedure, which takes a lot of time. The procedure involves detailed explanation and justification, to explain the request for the change, and, in case of provisional agreement with the healthcare authorities, a subsequent process of budget amendments (preparation of proposal, consultations with the local administration, voting at the local council, coordination with the Treasury). Local healthcare authorities try to avoid even initiating the process, and, where possible, they recommend facilities to find other ways to accommodate the changes (such as by using their own revenues), rather than go through the formal budget amendment process.

- *"Cash shortages during the year which need amendments? God forbid. And it almost never happens."*

- *"There is a clear process described in the budget legislation. We write explanatory letters, justifications, provide all the supporting documents. Then our requests are considered by the healthcare Department Head. If he is supportive, we go on with the amendment process. Sometimes they do give us more funds. But sometimes not, if there are no more funds."*

- *"Where possible, we try to cover our gaps with our own funds, we try to avoid adjustments and amendments."*

- *"Whenever we have a cash shortage, we submit letters to the healthcare department, but their usual response is – go and use your own revenues from the Special Fund."*

- *"Sure we can write letters and requests, but usually it does not happen. Only if the prices went up and there is nothing we can do, they might help – by frontloading our ceilings from some later months."*

- *"Of course it is not quick, on-the-spot reaction to problems; nobody is talking about this in our system. A on-the-spot reaction means that I can react tomorrow to the problems I have today, and I doubt that anybody at our level can use their funds like this."*

Emergency situations which require immediate additional spending are addressed by using the emergency reserve fund within the local budget. Cases of absolute emergencies are referred to the local council and handled by the local emergency commission. This commission may recommend expenditures from the Special Fund of the local budget earmarked for crisis situations, in which case they may be funded within several days. However, any such requests should be supported by a range of justifying documents.

- *"If something really urgent happens, we can use the Special Fund of the city budget. But everything else is according to plan, and this is what we are trying to do where possible – live by the plan."*

- *"In exceptional circumstances, funds can be allocated by the resolution of the Head of the Oblast Administration, but it has to be a really exceptional case."*

Even for small adjustments, flexibility for re-allocation of funds across budget lines is very limited. Only 46.2% of Chief Doctors stated that they enjoy some leeway in shifting funds to other budget lines without the complicated procedure of budget amendments, and even so the share of funds which could be reallocated is very small. Any reallocations should be within unprotected items only (which is a very small share in the first place) and should be previously agreed with the local healthcare department.

- *"I can manage funds only within identical budget lines, for example, within utilities, if I have funds left after I paid for the water supply, I can use them to pay for the heating or electricity. But if I still have funds left, I might convince the healthcare department to allow me to use them for medicine, but there is no way to use them for the salaries. Only if I start yelling and making scenes that we are on the verge of delaying salaries, they might agree. So, there is no way for me to use the benefits of saving."*

- *"If only they either gave us enough or, alternatively, let us spend reasonably! For example last year we needed UAH 115 million, and we received 28% of that amount, but on top of this we were told precisely how this amount needs to be spent. I would live with this 28% if I could only decide myself: which people to employ, what numbers of people to put on what tasks, how much to set aside for electricity, for the water supply! You see, it's not every time that we need as much water as was we are told to spend on the water supply! But they demand that we spend it on the water, because they know who now owns the water supply company. And it is just a waste of the country's money. I could live with these funds if only I could cut some of the positions, to send people work elsewhere. If we could buy an oxygen supply device for 1.5 million (UAH), it would have paid for itself in two years, because every year we are spending 800,000 (UAH) to buy the oxygen. And I've been saying this for 7 years now. I can't describe what effort I had to make to refuse to use the hot water supply, because it was such low quality and impossible to use, and to buy boilers to be installed in our departments instead. We are wasting insane amounts of money on heating, instead of buying a heater and putting it on our own roof. How could I talk about developing our facility? I spent three years working to reject this hot water supply, and I only managed to do it because I myself am an elected member of the local council. If I didn't have this status, I would have never achieved it. And after we pay for all these inefficient things, we are left with miserable amounts for the medicine. We cannot go outside the numbers defined for our salaries, water and electricity, and I cannot make additional payments to good doctors or take on a new person to fill a vacant post during a financial year. And my proposals are not heard. The scariest thing is our Healthcare Department's policy that I cannot make extra payments to the doctors and that I cannot take people to the vacant posts during the year."*

Indicator PB-25. Authorization of funds and commitment control

To ensure that payment liabilities remain within available cash limits, commitment control systems must be relevant and cost-effective. An effective internal control system is highlighted as a separate dimension in the PEFA framework (PI-20) given the importance of avoiding taking unaffordable and unsolicited liabilities or of creating expenditure arrears. As outlined in the PEFA Guidelines, to work effectively, this system should be based on a proper assessment of risks that need to be managed. It should also be cost-effective, in that control procedures need to be widely applied without creating unreasonable administrative pressures or delays.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Does the system of Treasury control ensures that funds are always used strictly according to allocations and released without delays?	% of Chief Doctors who believe that Treasury controls make it almost impossible to use budget funds for unauthorized purposes	100%	Grade A
How reasonable are the extra administrative costs imposed on facility managers by having to comply with the Treasury control procedures to ensure timely release of funds?	% of Chief Doctors who report that the percentage of their work time spent on delivering tasks or solving problems related to Treasury control of budget execution is less than 5%	15.4%	Grade D
Overall Grade			**Grade C+**

Without a single exception, all interviewed Chief Doctors believe that Ukraine's system of Treasury control makes it impossible to make commitments outside the budget appropriations, reflecting a robust financial management system. As discussed in detail in Box **13**, at all stages of budget planning and execution, expenditures are monitored and controlled by the State Treasury Service, a central executive authority. As discussed earlier, the State Treasury also monitors budget ceilings in the monthly breakdown, thereby coordinating cash flow forecasting and management at the level of each individual facility. Once the budgets are approved, the State Treasury undertakes several rounds of cross-checks for each of the payment requests against budget appropriations, approved expenditure lines, and monthly ceilings, before the funds are released.

- *"They check and control every kopijka; it is absolutely impossible to use budget funds on unauthorized purposes. When you go to the bank, you may encounter some mistakes, some slippages. But not in the Treasury. Here it never happens."*

- *"There are more control authorities than there are funds. Believe me, they check enough."*

Box 13. Treasury monitoring and control of budget execution

The State Treasury Service of Ukraine (or State Treasury) is a central executive power body, whose activities are coordinated and directed by the Cabinet of Ministers through the Minister of Finance[138]. The State Treasury functions through a network of its local offices ("territorial bodies") in oblasts, rayons and cities. While the State Treasury and its local offices are part of the country's system of executive power, in the process of budget planning and execution it has a set of responsibilities which are distinct from the roles and functions of the Finance Departments of local executive offices (administrations) and the Ministry of Finance.

The State Treasury monitors and maintains control over budget expenditures at all stages of budget planning and implementation (starting with the formation of the spending unit network and finishing with the release of funds from the accounts of Spending Units and Recipients of Budget Funds). In particular, the State Treasury Service or its local offices implements the following types of expenditure monitoring and control:

- Ensures the accuracy of reported network of Spending Units of various tiers (maintains the Unified Register of the Spending Units and Recipients of Budget Funds, verifies information entered in this Register and monitors compliance of spending by individual spending units);

- Cross-checks proposed expenditure allocations, monthly installment plans, and their various breakdowns for compliance with the registered network of Spending Units, with approved and open appropriations, and for accuracy of applying existing expenditure classifications;

- Monitors facility budget indicators and any changes to them, and cross-checks approved facility budgets with the accounting data;

- Registers and monitors budget liabilities, and conducts preliminary control over whether the use of budget funds is appropriate;

- Opens budget appropriations and makes decisions on allocation of funds to itemized accounts[139];

- Conducts automatic checks of the allocations of open appropriations which are submitted by Key Spending Units (in terms of whether the allocations comply with appropriations, with available balances on accounts, with the registered network of Spending Units), and maintains registers of these allocations;

- Controls payments from accounts based on Payment Orders from Spending Units and from the Recipients of Budget Funds. This is done by checking whether the Payment Order corresponds with an existing open financial liability; contains all required information and is correctly filled in; contains a seal and signatures which correspond to earlier approved samples; corresponds to an existing Budget Program Passport; is not subject to any legislative limitations to the requested types of expenditures; is not subject to judicial complain as a result of alleged violation of public procurement legislation; remains within available unused open appropriations which are sufficient for the payment; corresponds to the approved Budget; contains all necessary supportive documentation (contract; report on procurement procedure; proof of receipt of goods or services, etc.) in cases of advance payment; etc.

- Checks whether financial and budget reports of the Spending Units correspond to the same data contained in the accounting books maintained by the State Treasury Offices; signs the financial reports of the Spending Units and Recipients of Budget Funds, as well as consolidated financial and accounting reports[140].

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[138] *President of Ukraine Order No 460/2011 of 13.04.2011 "On Approval of Standing Orders of Ukraine's State Treasury Service"*

[139] Literal translation of this term from Ukrainian would be "analytical account", however, in this paper we use the international equivalent term of "itemized account", which define detailed account in any bank (or Treasury) – as opposed to "control account" which is a summary account, not detailed by individual items. The "control accounts" in Ukrainian terminology are known as "synthetic accounts.

[140] Clauses 2.1, 2.2, 2.4, 2.7, 3.2-3.5, 4.4-4.6, 6.3, 6.4, 6.6, 12.1-12.3, 12.8, 12.11 of the *Procedures for management of State budget expenditures and crediting* and Clause 1.14 of the *Procedures for development, considerations, approval and key requirements to implementation of the budgets of budget-funded entities;*

However, while Treasury controls are effectively imposed to avoid unauthorized spending, the system is bulky and imposes extreme administrative burden on facility managers. Only 15.4% of all Chief Doctors said that they spend less than 5% on tasks and problems related to dealing with the State Treasury to have their payment requests verified and granted. As shown in Figure 46, a majority of the administrators spend about 15-30% of their time of these issues, while some may actually allocate 30-50% or even more of their time only on these tasks. Notably, Treasury controls cover all types of revenues and expenditures of the facilities, including their own revenues, which are accounted within the budget's Special Fund. This sometimes makes it difficult for the facilities to use even these theoretically more flexible amounts.

- *"Dealing with the Treasury takes a lot of time, at least a third of all my work time. It takes a lot of time to plan, to comply with all the regulations. We have to provide them with a lot of documents, and we have a lot of problems."*

- *"We have some tensions and conflicts with the Treasury every single day. First, sometimes they say they do not have funds. Secondly, they are bookworms and pedants, they pounce on every detail and their nagging is not justified. They require lots of documents, even those documents which we are not supposed to provide. They do not have flexible thinking."*

- *"When the Treasury was established, we were told that they would replace the Control and Revision Department, because the Treasury would take over all the checks and controls, it would be more than a bank. But now we have both, the Treasury and the Control and Revision Department, and this is totally excessive."*

- *"We just had this really annoying episode, we even had to complain to the Treasury Head. We made a payment request for a regular technical inspection of our ambulance, and this payment was not granted for two weeks. We have only one ambulance, which works for two acute care departments. Ok, now it was paid, but when we had to wait for these two weeks, it was really annoying. Moreover, we were supposed to pay for this inspection out of the charity contribution we received (into the Special Fund), so it was especially annoying, because this was money we earned ourselves, we wished that at least these funds would not be delayed."*

Figure 46. Percentage of work time spent by facility administrators on dealing with the State Treasury (% responses by Chief Doctors)

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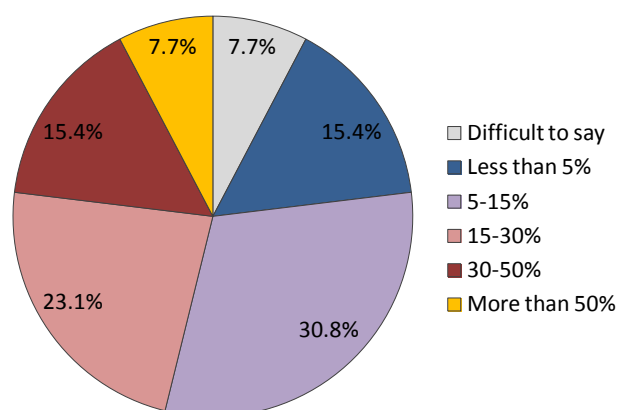
Audit

Indicator PB-26. Scope and nature of audits

Effective audit provides facility managers with feedback on their performance, helping to improve service delivery and improve transparency in the use of public funds. Comprehensive audit systems must include an internal audit mechanism of the executive agencies (the audited agencies and the Ministry of Finance) as well as external audit conducted by an independent financial oversight institution. The two core dimensions of effective audit are related to its frequency / regularity and coverage. In particular, inspections should cover a sufficient range of systemic issues related to the use of public funds and service delivery, going beyond compliance and financial audit and including analysis of performance and value for money.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Are facilities audited at least once a year?	% Chief Doctors who confirmed that their facility was audited within the 12 previous months	73.3%	Grade B
Do facilities undergo internal, as well as external audit?	% Chief Doctors who stated that their facility is inspected by internal as well as external auditors	16.7%	Grade D
Are facilities subject to unannounced inspections by the local healthcare authorities?	% Chief Doctors who confirm that they are subject to such inspections	50%	Grade B
Do audits cover a comprehensive range of issues?	% Chief Doctors who state that audits covered at least two of the following: - Absenteeism; - Use of equipment; - Status of infrastructure; - Other issues.	42.9%	Grade C
Overall Grade			**Grade C+**

Most of the interviewed facilities (73.3%) confirmed that they went through an audit during the last 12 months. As described in **Box 14**, national legislation imposes a range of mandatory and optional audits on the public healthcare facilities. This includes comprehensive internal financial audit by facilities' own designated units as well as by the **State Financial Inspection** (SFI), which is responsible for regular revisions to monitor financial accuracy, legislative compliance and, to some extent, performance and value for money achieved by the spending units. While mandatory external financial oversight is exercised only for facilities which receive direct funding from the central budget, sub-national authorities may introduce their own external audits. On top of this, healthcare authorities at all levels conduct a range of sector-level audits focused on the service delivery process and outcomes. As was stated by one of the respondents,

- *"What kind of audit do we have to go through? We have a journal at the reception desk where we register all inspections we go through; you can take it and look at the list. You will see for yourself that we have a lot of inspections. It is hard to tell who does not inspect us."*

Overall, interviewed Chief Doctors mentioned the following range of various inspections they undergone during the previous year (altogether, 30 inspecting agencies):

- State Financial Inspection;
- Accounting Chamber;
- State Treasury;
- State Tax Inspection;
- Tax Police;
- Police;
- Prosecutor Office;
- State Security Service;
- State Antimonopoly Committee;
- State Price Control Inspectorate;
- State Inspectorate for Energy Oversight;
- State Committee for Industrial Safety;
- State Service for Medical Products;
- Department for Control over the Quality of Medical Products of the Ministry of Healthcare;
- Tender Inspection Committee of the Local Council;
- Property Inspection of the Local Council;
- Finance Department of the Local Administration;
- Healthcare Department of the Local Administration;
- Financial Unit of the Healthcare Department of the Local Administration;
- Local Chief Pediatrician office;
- Human Resource Department of the Local Administration;
- Sanitary and Epidemiological Oversight Service;
- Ecological Oversight Service;
- Fire Inspection;
- Pension Fund;
- Social Insurance Fund;
- State Fund for Insurance against work-related injuries;
- Unemployment Insurance Fund;
- Professional Unions;
- Boiler and Pressure Vessel Oversight Service.

External oversight of healthcare facilities was reported only in 16.7% of the cases. As discussed in Box **14**, external financial audits for most healthcare facilities are optional, since they are typically funded from the local budgets rather than the central budget, which falls under the mandate of the Accounting Chamber. Notably, in several cases, Chief Doctors of such local hospitals still reported inspections by the Accounting Chamber (which may be related to their participation in some of the centrally funded programs). In some other cases, facilities did undergo inspections by locally organized commissions under the local councils. However, these audits were usually focused on the procurement process and property utilization practices, rather than service delivery and recurrent spending.

Most facilities are subject to diverse inspections by healthcare authorities, which are often unannounced. Sector-level authorities conduct various types of inspections addressing a range of aspects in service delivery, and in half of the cases facilities experienced such inspections without prior notice. However, while these sector-level inspections normally address particular standards and procedures under the remit of respective auditing authorities, only in 42.9% of cases did interviewees confirm that the audit addressed systemic issues related to human resource management (absenteeism), use of equipment and the status of the infrastructure.

Most Chief Doctors were very supportive of the idea of internal audit, but often complained that they find it difficult to allocate people to undertake these tasks. Not all of the facilities have separately designated units for internal audit functions as recommended by law, but many use their planning departments to undertake these tasks. Where in-house audit is undertaken, it is assessed as very helpful and much needed: *"Our economists are tracking it all the time, where do the funds go, and whether it is all reasonable and efficient, whether we can save anywhere; it is all under constant review."* At the same time, where hospitals complain that they lack resources for internal audit, they admitted that it is a big failure. In particular, they believed that internal audit could be very useful for the facilities for collecting evidence to protect themselves against critical findings by other inspecting agencies:

- *"Unfortunately we do not do much on internal audit, simply because it needs more people. We only have two accountants, and they have too much work already."*

- *"Unfortunately, we do not conduct internal audit yet, but we do plan to start. Because, if I can be honest with you, audit requires a lot of money, and in the budget-funded entities all our expenditures are strictly planned and controlled. But we need it so much. Because if I disagree with the SFI findings, my game is lost, and mainly because I didn't have the funds to conduct my own internal audit. So, all I can do is hold my breath and try to allocate funds for it next, so that next time I am better equipped."*

Box 14. Nature, type and scope of audit in the healthcare sector

Ukraine's legislation requires all health care facilities at all levels, as well as all health authorities, to regularly undergo a range of financial and sector-specific audits, as described below:

Internal audit within the Healthcare Sector: Healthcare facilities and authorities at all levels are expected to undertake regular internal audits using their own designated units[141], in line with rules and procedures established by the Ministry of Finance[142]. For central healthcare authorities, this practice is mandatory, while local authorities and facilities it is optional, but strongly recommended. This audit is supposed to cover financial, compliance and performance audit.

Audit by the State Financial Inspection: All healthcare facilities and authorities, regardless of their level, are subject to mandatory financial audit by the State Financial Inspection (SFI)[143]. This audit is focused on

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[141] *"Procedures for establishing structural units for internal audit and for undertaking such audit in the ministries, other central executive bodies, their territorial offices and budget-funded entities which are supervised by the ministries and other central executive bodies"*, approved by the CoM Resolution No 1001 of 28.09.2011

[142] MoF Order No 1247 of 04.10.2011 *"On Approval of Standards for Internal Audit".*

[143] The rules for Internal Financial Audit by the Government of Ukraine are defined in the Law of Ukraine "On State Financial Control in Ukraine"143 (approved in 1993, but repeatedly amended during 2002-2012) and by a range of secondary regulations which define specific audit procedures, inspections, and rules for control over public procurement. These secondary regulations include, among others: "Procedures for inspection of public procurement by State Control and Revision Service", approved by the Order of Main Department for Control and Revision of Ukraine No 136 of 26.06.2007; "Procedures for state financial audit of operations of budget-funded entities by State Control and Revision Service", approved by the CoM Resolution No 1777 of 31.12.2004; "Procedures for inspections conducted by the State Financial Inspectorate and its territorial offices", approved by the CoM Resolution No 550 of 20.04.2006.

compliance audit and financial audit, but – to some extent – also supposed to include performance audit. Apart from the audit of financial and economic operations, SFI is also responsible for inspection of legislative compliance of the budget-funded organizations.

- ▪ *Revisions* can be both planned and unplanned, and the planned ones must be conducted in line with a *Program of Revisions* approved by SFI authority. As a rule, unplanned *Revisions* should not last longer than 15 days, planned *Revisions* should not last longer than 30 days;

- ▪ *Revisions* are conducted through *Documentary Inspection* (which includes analysis of documents) and *Actual Inspection* (which include analysis of available funds, inventory of assets, inspection and control measurement of provided goods and services etc). Conclusions of the *Revisions* must be documented and reflected in Revision *Statements;*

- ▪ Based on the results of *Revisions*, SFI officers can make oral recommendations to the management of the inspected organization to remove identified problems and avoid their reoccurrence. In case such recommendations are not taken into account, SFI offices may, within 10 days after issuance of the *Revision Statement*, send a written request to remove violations identified by the *Revision*;

- ▪ Based on the results of the *Revisions,* the SFI can also take measures to hold to legal account those officers of the inspected organization who were guilty of allowing the identified violations. The SFI can also facilitate lawsuits on behalf of the state aimed at removal of identified violations and recovery of illegally received funds to the State Budget.

External financial oversight at the central level by the Accounting Chamber: All authorities and facilities which are directly funded from the central budget are subject to independent financial oversight by Ukraine's Accounting Chamber[144]. The Law on Accounting Chamber does not clearly specify the types of audit which it is entitled to perform, but in practice the Chamber conducts all three types of audit (compliance, financial and performance) of utilization of the State budget funds. The audits cover State Budget Spending Units and Recipients of State budget funds of all levels and forms of ownership. Inspections could be planned (based on annual work plans of the Accounting Chamber) and unplanned (based on decisions of the Accounting Chamber Collegium). If the Accounting Chamber reveals violations of law and infliction of harm to the State, the Accounting Chamber informs the Parliament of these facts. In cases of identified violations findings of administrative violations, or criminal responsibility, the Accounting Chamber Collegium may transfer the relevant evidence to law-enforcement authorities for due response.

External financial oversight at the local level: Although auditing mandate of the Accounting Chamber is limited to centrally funded entities, sub-national authorities can introduce additional types of audit for health facilities in their ownership. There are known cases when Local Governments chose to exercise these possibilities in practice. For example, municipal council of Kamyanets-Podilskyi introduced an additional medical and economic audit for municipal health facilities, and outsourced it to an independent company[145].

Sector-level audit by healthcare authorities: National and sub-national Health authorities have a broad mandate to control compliance of health facilities with sector-level regulations[146]:

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144 The rules for external financial audit of Health authorities and facilities in Ukraine are defined by the Law of Ukraine "On Accounting Chamber" (approved 11.07.1996, latest edition 30.07.2010) and by the Accounting Chamber Standards on "Procedures for preparation and conduct of inspections and for documenting their results", developed on the basis of this Law (approved by the Resolution of the Collegium of the Accounting Chamber No 28-6 of 27.12.2004).

[145] See: Пливанюк Ю., Зарицький О. Проблеми реформування охорони здоров'я на рівні міста; http://www.viche.info/journal/1211/

[146] These audit powers and functions are established by the regulations which define the institutional profile of respective authorities (the respective *Standing Orders*)

- ▪ **The Ministry of Health** has a range of control functions[147] including: Control and supervision of compliance with legislation in the health sector; ensuring that health facilities respect the right of the citizens for protection of their health; establishing criteria and standards for state accreditation of health facilities; establishing standards and clinical protocols for provision of medical aid; control over the quality of medical aid; establishing procedures for inspecting economic agents and control over the quality of pharmaceuticals; monitoring of safety and effectiveness of pharmaceuticals used in in-patient Health facilities; etc. At the same time, existing legislation does not clarify rules and procedures for implementation of such functions by the Ministry of Health.

- ▪ **Sub-national Health authorities** have a similar range of control functions over health facilities operating under their supervision.[148],[149] These functions include: control over the quality and level of medical and sanitary aid provided by health facilities, based on the sector-level medical standards and control over compliance with legislation in the health sector and sanitary rules by health facilities. As in the case of the Ministry of Health, existing legislation does not clarify rules and procedures for implementation of control functions at sub-national level.

Indicator PB-27. Administrative burden associated with audits

Audits must be cost-effective, focusing on high risk areas and avoid imposing excessive administrative burden on service providers. One of the core international standards expected of the audit function is its ability to use risk assessment techniques, focusing on selected systemic issues rather than blanket-coverage of low-risk issues leading to unnecessary losses of time and efforts by all parties involved. The administrative costs related to inspections (in terms of preparation and submission of required documentation, working with the auditors and other related activities) should be reasonable and should not be disruptive to the actual provision of services at the facility level.

Scoring table (Method 1)			
Dimension	Source	Benchmark	Grade
Are audits a burden to the facility operations, taking excessive time and other resources of the facility management? **[weakest link]**	% Chief Doctors who consider audits a significant burden	68.8%	Grade C
Can audits cause significant disruptions, potentially endangering service delivery or seriously compromising their quality?	% Chief Doctors who mention significant problems related to undergoing audits, such as having to spend their entire time on audit for extensive periods	47.1%	Grade B
Overall Grade			**Grade C+**

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[147] *Standing Orders on the Ministry of Health of Ukraine*, approved by the Order of the President of Ukraine No 467/2011 of 13.04.2011

[148] Clauses 4.5, 4.28 of *"Typical Standing Orders on Healthcare Departments of oblast, Sevastopol city state administration and Main Healthcare Department of Kyiv City State Administration"*, approved by the COM Resolution No 1845 of 20.12.2000;

[149] Clauses 3, 4.6 of *"Typical Standing Orders on Healthcare Departments of Rayon State Administrations"*, approved by the CoM Resolution No 1364 of 28.11.2007;

Most of the facility managers (68.8%) consider audits to be a significant burden, and 47.1% believe that audits may be disruptive and ultimately damaging to service quality. While many Chief Doctors admit that "any audit is a stress and a burden", the majority still think that the current pressure they experience because of various inspections is significant and, often, excessive. The SFI revisions in particular are lengthy (taking 1-1.5 months), during which time some of the Chief Doctors said that they had to spend all their time (and work overtime) simply dealing with inspection-related tasks.

- *"They stayed in the hospital for a month, and everybody's attention was only on them. Everybody was only thinking how to serve them, how to provide the necessary documents. It was a very tense period."*

- *"The last inspection took a month, and I worked on it full time."*

- *"State Financial Inspection worked in our hospital for a month, and we stayed with them full time and overtime."*

- *"We had an inspection which started on 21 August and ended on 12 October. It lasted for 10-12 hours every day. The inspection covered the last 3 years, and this meant a lot of documentation had to be found and provided. We have 710 employees in 5 different salary bands, which means a large number of documents and calculations. Of course, there are also medical questions, but they are not limited to medical issues. For example we have to explain in detail how we calculate the salaries of all workers, and the calculations are different for different positions, such as for drivers and doctors."*

- *"We have some sort of inspection every month. The inspections are conducted by all kinds of agencies. Overall, it adds up to about 15 inspections per year, plus one annual revision. It is too much, too often. If we could at least do this annual inspection once in two years rather than every year. It really makes it difficult for us to work, to fulfill our duties. We have to spend 8 hours alone on photo-copying the documents and sending them as needed."*

- *"The State Financial Inspection audits us every year and their analysis is very difficult for us. We have to show them a lot of formulae, a lot of documents."*

- *"The SFI inspection lasted for 45 days and we worked with them full time. Our work was paralyzed, because every number, every digit needs to be justified. We have to answer questions which require recalling old events, and we need to be constantly with them. If the Inspector notices that I don't pay enough attention and don't follow every note that he is making, I am going to be in big trouble."*

Indicator PB-28. Extent of follow up

The critical element of a sound audit is effective follow up. The importance of follow up to audit findings is reinforced by the PEFA framework, which remarks that lack of response to audit recommendations completely undermines the rationale for the internal audit function and considerably weakens the role of external inspections. Generally, follow up must include some corrective action to address identified mistakes and weaknesses. Importantly, while such corrective action may include punitive measures, the ultimate goal of the response must be on eliminating the problems rather than locating the guilt. Follow up measures may include but should not be limited to purely punitive measures such as fines, sanctions and reprimands.

Scoring table (Method 1)			
Dimension	**Source**	**Benchmark**	**Grade**
Is there any follow up to the audit findings? **[weakest link]**	% Chief Doctors who provide examples of the follow up to the audits in their facilities	92.3%	Grade A
Does the follow up include effective corrective actions (elimination of mistakes, lessons learning, retraining) or is it limited to punitive measures?	% Chief Doctors who mention corrective measures	38.5%	Grade C
Overall Grade			**Grade B**

The overwhelming majority of respondents listed a range of follow up actions to the inspections they undergo. 92.3% of interviewed Chief Doctors stated that some follow-up took place. They explained that the range of measures usually follows precise lines specified for relevant cases in the legislation. The inspecting authorities outline their findings and recommendations in a signed report, and the nature of follow up actions is usually also specified by the legislation: it may involve reprimands, fines, penalties, or even law suits and firing of the staff which had made mistakes (for example in one of the interviewed facilities, an accountant was fired in 2011 as a result of the SFI inspection).

Most of the response measures quoted by the respondents were punitive in nature, although there were positive exceptions. This is shown in Figure 47. When recommendations were mentioned (in 52.8% of all responses), they were often described without any explanation of whether they were actually implemented in practice, and how this was verified. At the same time, in some of the facilities, inspections have led to positive action and lesson learning, stimulating change and capacity building:

- *"After inspections, we have staff meetings to discuss the results. If the inspection finds administrative mistakes, we may reprimand the employees who were responsible and invite them for separate personal talks. If the mistakes relate to medical issues, we hold clinical investigations, exchange opinions and experience, and produce our conclusions on the episode. The person who was responsible for any medical mistake usually has a hard time, sweating a lot, but given that this is not an administrative mistake we would not fine him or her, but we would put a note on the record. If this person makes a mistake again, we might consider further action, for example recommending the removal of his or her medical category."*

- *"Inspections do result in better services, and we might even get help from inspectors in how to improve. They may impose fines, which helps, or they may help to send people for retraining".*

- *"The goal of inspection is to teach us how to work better. If we are not abusing our positions and resources, then we can learn a lot from every inspection. I personally support inspections as an instrument, I only think they really should not be as frequent as they currently are."*

Figure 47. % Responses on types of follow-up after the audits (Chief Doctors)
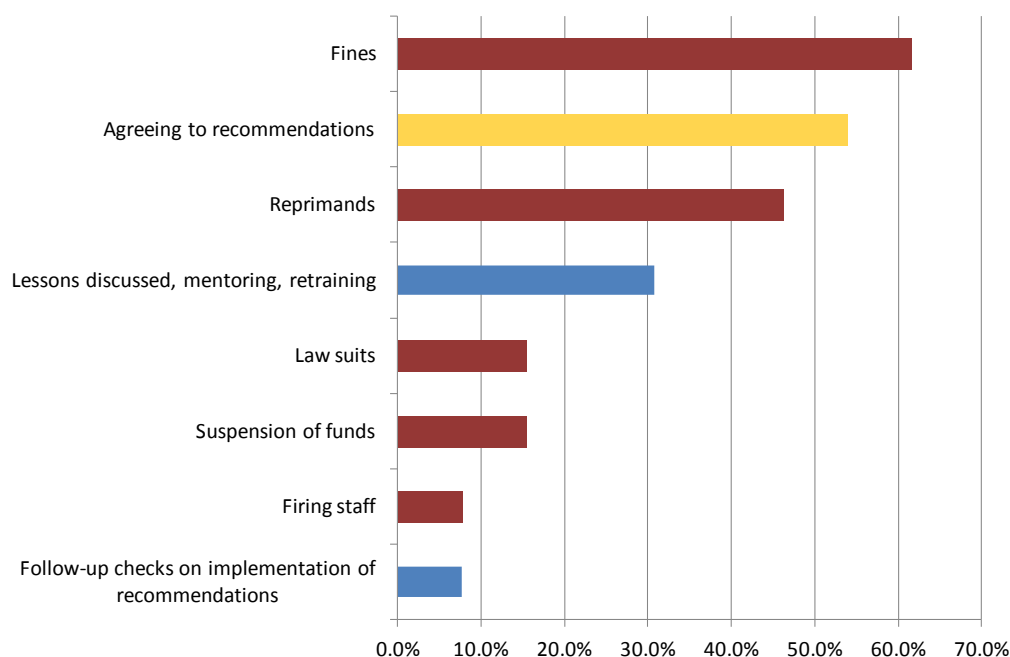
In some cases, facilities reported that follow up on inspection results led to negative and costly consequences. Some of the recommendations made by the inspections are questionable, and they do not always respect fund availability for the implementation of recommendations. In several cases, these recommendations actually led to visibly negative results:

- *"Our hospital bought new modern chrome-plated surgical tables which really improved our work. It all worked well until we had an inspection from the sanitary and epidemiological service, which said that by the existing norms all surgical tables should be cleaned with a mixture comprising large quantities of synthetic detergent, chloride of ammonium and perhydrol. Soon after we started washing the tables in this way, they became spoiled, the hydraulics are no longer working and all their useful features became dysfunctional. Unfortunately, the norms used by our inspections are very old and they do not keep up with progress in medical technologies."*

- *"We have good washing machines bought by international donors. The sanitary inspection told us that these machines do not satisfy current norms, even though these are modern machines, and their norms are very old. The inspection instructed us to use a larger quantity of traditional disinfectants for washing. It was difficult for us to find the money to buy these additional disinfectants, so we collected our own private money and started using them. But then all our patients, and also medical staff, developed an allergy to these disinfectants, and we had to treat them all as a result."*

Indicator PB-29. Redress policies

A fair audit system must include a robust grievance procedure for managers to be able to challenge audit results and findings. If facility administrators are dissatisfied with the audit results and find its reprimands unfounded, they should be able to use clearly available and operational mechanisms to voice their concerns and to contest audit findings. The mechanism should be based on clear regulatory guidelines and fully understood by all stakeholders. It should also be applicable in practice, without any significant legal, institutional or other barriers discouraging managers to challenge their auditors and to achieve fair resolution of their claims.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Are there clear and operational redress policies in case facility management feels audit results are unfounded? **[weakest link]**	% Chief Doctors stating that there are such policies in place	73.3%	Grade B
Are existing redress policies effectively applied in practice?	% Chief Doctors providing examples of successfully applying redress policies	17.6%	Grade D
Overall Grade			**Grade C**

A majority of facility managers are aware of redress procedures and consider them clear and operational. Precise knowledge of redress mechanisms was reported in 73.3% of cases, and the Chief Doctors also explained that the inspecting authorities themselves usually reminded them of the options for challenging the findings and of the existing grievance procedures.

At the same time, redress procedures are not widely used, and often described as "hopeless", even though cases of successful redress do exist. Actual challenging of the audit results was mentioned by 17.6% of the Chief Doctors, and some others said that even though they know about the procedures, they do not believe that it is possible to succeed in these contests. Notably, as mentioned earlier, some believed that one type of leverage which could be helpful in such situations is the evidence produced by the facility's own internal audit, if it exists.

- *"What is written by the SFI specialists is considered final. We do have the right to contest it, but at the end of the day it would be us who would suffer as a result. Overall this is typical logic for Ukraine as a whole. You either need someone big and influential behind you, who can say to anyone who hurts you 'Hey, you, leave this guy in peace!', or you lose. But for cases when we are really pressured by the auditors, I do have my contacts. And many people do, but they try to save them for really bad cases. However, here locally, for resolving issues with the city, I do feel ready to voice my opinion and to challenge the accusations, and I will be heard, and they might even correct the verdict. But already starting at the oblast level, the decision of the inspecting authority is final."*

At the same time, several Chief Doctors shared stories of successful contestation of audit results as described below:

- *"It does happen that we disagree with the audit results and recommendations. For example we had an SFI inspection last January which recommended we organize a paid (fee-based) parking lot in our courtyard. But we believe that this would represent a violation of the current legislation, because we are a hospital for children and we are not supposed to provide fee-based services. So, we disagreed. However, the SFI still noted our position as a violation, and wrote down their recommendation for this parking lot. They also recommended we introduce a range of other fee-based services, such as prescription of lenses by eye doctors etc. I disagree, and I think these services should be free. So, we complained to the City Healthcare Department, and, thank God, they supported us. They too decided that it is wrong. And so, these SFI accusations did not influence us in any way (did not cause any negative consequences to the facility)".*

Revenue collection and financial risk pooling

Indicator PB-30. Significance of formal own-source revenues and expenditures

One of the core goals of a healthcare system is to ensure that it is funded by revenues which have been mobilized with sufficient pooling to share the financial risks. Effective and fair funding of healthcare services requires resources which are sufficient and sustainable, and which also spreads the risk from individuals to larger pools of contributors and eliminates situations when people have to pay for the services at the moment of their utilization. This is especially important for ensuring access to healthcare for poorer citizens, for whom direct out-of-pocket payments for medical services may be especially catastrophic or simply unaffordable.

To achieve this goal, the share of out-of-pocket expenditure in the overall health financing mix should be minimal. Health funding is usually mobilized through a combination of public funds (taxes and social insurance), private funds (private insurance and out-of-pocket payments), and external funds (loans or donor assistance). Of these sources, out-of-pocket funding provides the lowest degree of risk-pooling and is least conducive to equity in the sector. High shares of out-of-pocket contributions are typical for low-income countries with less developed systems of private insurance and inefficient tax-funded health services. Notably, direct out-of-pocket financing creates these dangers regardless of whether the payments are formally accounted for and visible in the financial reports or conducted under the table (although in the latter case the risks are exacerbated by lack of transparency and accountability).

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Is the share of own-source revenues raised out-of-pocket relatively small?	% Chief Doctors who mention fee-based services or charity contributions among three biggest sources of own revenue	53.3%	Grade C
Are there clear and transparent pricing mechanisms for the fee-based Key and Additional Services provided by the facility?	% Chief Doctors who confirm existence of the pricing rules (average for the two types of services)	72.3%	Grade B
Overall Grade			**Grade C+**

Ukraine's healthcare system is mostly tax-funded, but with a considerable share of out-of-pocket payments, both formal and informal. Ukraine's healthcare is funded from the general budget, although proposals for mandatory social insurance have been debated for several years and outlined as a strategic goal in the current healthcare reform strategy. The size of Ukraine's organized private healthcare market is marginal, both in terms of provision and in terms of private insurance funding (voluntary private insurance covers less than 2% of the population, and many of the insured services are still provided by the public health facilities given the extremely small size of the private provision). At the same time, out-of-pocket payments are substantial and represent, by some estimates, around 3% of the country's GDP (World Bank, February 2008) and more thank 40 percent of total health expenditures (State Statistic Services, 2010).

The legality of out-of-pocket payments is subject to an ongoing constitutional debate, but they are formally raised by the facilities and must be reflected on their Treasury accounts. As discussed in **Box 15**, the possibility of formally charging patients directly at the time when they receive services in the public medical facilities has been debated since 1996. Fee-based services are allowed by a range of current regulations (including the Budget Code), but they contradict Article 49 of the Constitution, which states that all healthcare should be free of charge. At the background of this debate, facilities routinely collect private payments which they can formally reflect in their fiscal reports. As described in Box 16, all such payments are accumulated in the facilities' Treasury accounts (within the budget's Special Fund) and are earmarked for a strictly defined range of expenditure.

Box 15. Private payments for medical services

Are private payments allowed?

Constitutional debate over the legality of private payments has been ongoing since 1996. The possibility of private health payments was first mentioned in a CoM Resolution No 1138 on 17.09.1996[150] and was later followed by another CoM Resolution No 659, 17.05.2002[151] which contained a more detailed list of various possible off-budget revenue sources, including private payments, and instructions on how they should be used. However, this created a legal collision with Article 49 of the Constitution which states that "in state and communal health facilities medical aid shall be provided free of charge".

The 2002 Constitutional Court Ruling failed to resolve the issue, which remains open. The Ruling of the Constitutional Court on this case[152] was that "Free provision of medical aid does not exclude the possibility of private payments for certain medical services"; but, at the same time, that such services should be of "secondary importance" and that their list and rules for provision should be defined by Laws of Ukraine. The CoM Resolution No 1138 of 17.09.1996 remains effective to this day. Moreover, the new Budget Code approved in 2010 included most of the previous guidelines on accounting and utilization of fee-based services, which were earlier included in the CoM Resolution No 659, 17.05.2002. However, given that financing of medical services with direct private payments by patients is currently regulated by a Cabinet of Ministers Resolution, not a Law of Ukraine, the question of whether such payments are constitutional, remains open. Subsequent attempts to reconsider the issue during the 2008-2009 economic crisis have been unsuccessful.

How are such payments accounted for? Payments for services provided by the budget-funded entities must be fully reflected in the *Special Fund* of the respective budget (as revenues as well as expenditures which these revenues can cover).

Reflection on Treasury Accounts: There are two possible ways for the health facilities to receive private payments: (1) as Payment for Services and (2) as Charity Contributions, Grants, Gifts and Investment. This decides how the funds are accounted for, as described below. In each case, the funds are transferred to the specific designated sub-account (called Special Account) in the Treasury. And in both cases, these sub-accounts are not used exclusively for such payments but also include other types of transfers.

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[150] Resolution of the Cabinet of Ministers of Ukraine No 1138 of 17.09.1996 *"On Approval of the list of paid services provided by the State Healthcare Facilities and Higher Medical Education Facilities"*

[151] Resolution of the Cabinet of Ministers of Ukraine "On approval of the list of own revenues of budget entitites, conditions for attracting such revenues, and ways to spend them", of 17.05.2002, No 659 (lost effect)

[152] Ruling of Ukraine's Constitutional Court on the case of constitutional appeal from 53 Members of Parliament of Ukraine for official interpretation of the provision of Part Three of Article 49 of Ukraine's Constitution stating that 'in state and communal healthcare facilities medical aid is provided free of charge' (the case on free medical aid), approved on 29.05.2002 (Case No 1-13/2002)

- **Payment for Services.** The State Treasury Service which manages respective local budgets keeps a specific sub-account for each health facility - *Sub-account No 323 "Special registration account for funds received as payment for services"* - which is designated for:

Funds received by the Facility as payment for services in line with its functional responsibilities;

Funds received by the Facility as a result of its economic activity;

Payment for rented Facility assets;

Funds received from sales of assets[153].

- **Charity Contributions, Grants, Gifts and Investment.** Another designated sub-account in the Treasury – *Sub-account No 324 "Special registration account for funds received from other own revenue sources"* is designated for:

Funds received for implementation of specific instructions;

Grants, gifts, charity contributions, and investments[154].

More than a half of Chief Doctors (53.3%) stated that private payments represent one of the three biggest items of their own-source revenues. Fee-based services do not always dominate, but they outpace all other types of own revenues, including rental payments and charity contributions: "additional services" have been chosen as the biggest own revenue by the highest percentage of Chief Doctors (see Figure 48). Charity contributions did not feature highly in most facilities, but some did use them extensively: for example facilities which provide services for children are not allowed to provide any services for fees, and charity contributions are used as an alternative way to accept and accommodate private payments.

- *"Most of our paid services are the fees we take for preventive check-ups which we are conducting in various enterprises."*

- *"Payments for services represent about 98% of our own revenues, although there are also charity contributions, rent payments and payment from interns for their study".*

- *"As a children's hospital, we did have some support from the parents last year, but it was about 20% of own revenues total. We ask parents to contribute if they have an opportunity. This is not compulsory and this is not some kind of violence, we are only asking, and some people give the money, some don't, and the amounts depend on how much they can afford. For example, when we complete an ultrasound, we already ask them to help a little. It is not much, less than UAH 40. And it is all going into the bank, not into anyone's own pocket. And altogether, it can give us about UAH 2,000 a month. You see, we are constantly inspected and we have to be totally transparent. We make similar requests to those who rent our premises; we say: please help in any form you can. And all these funds go into our bank account and we use them in the same way as our regular budget. We ask permission to spend these funds from the Healthcare Department. In turn, they ask the Finance Department, and only if they agree then we can spend them, and only through the Treasury. Usually we spend it on medicine or to provide expensive services to those parents who cannot afford it."*

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[153] *"Instruction for accounting of funds, transfers, and other assets of the budget-funded entities"*, approved by the Order of the State Treasury of Ukraine No 242 of 26.12.2003 (http://zakon2.rada.gov.ua/laws/show/z0106-04);

[154] *"Instruction for accounting of funds, transfers, and other assets of the budget-funded entities"*, approved by the Order of the State Treasury of Ukraine No 242 of 26.12.2003 (http://zakon2.rada.gov.ua/laws/show/z0106-04)

- *"I will not hide it: we have a charity fund, and we ask everybody who is accepted into our in-patient care to make charity contributions. The person goes to the cashier, writes a donation letter, and pays the money, which all goes into the bank. You see, we do not have paid services, because they are forbidden for pediatric facilities. Only voluntary charity. Besides, we have some big sponsors whose children were treated in our hospitals and who are grateful, and they provide regular support, for example with reconstruction or other things."*

- *"People help us. Someone might help replace an old window, another may buy a refrigerator. We ask patients to help with the windows, with painting. But the official mechanism is that we have a cashier and we have to explain to the person that they have to go to the trouble of going to the bank, standing in the line. And many people don't have enough energy to use this mechanism."*

Figure 48. What are the three largest sources of own revenue in your budget? (% Responses by Chief Doctors)
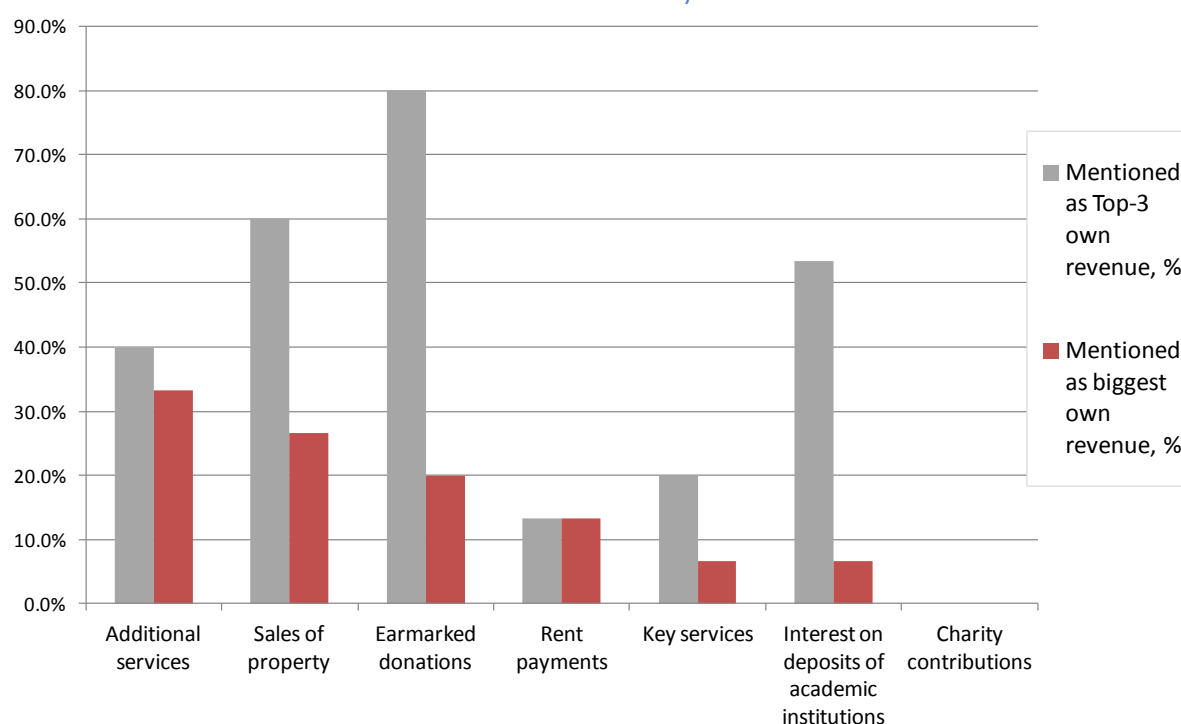
In most cases, Chief Doctors were able to explain clear pricing mechanisms for the fee-based services which they provide. For key medical services, a clear pricing approach was outlined by 90.0% of respondents, and for additional types of services, by 54.5% (see Figure 49). The pricing mechanism for medical services is usually approved by the oblast state administration and is universal across the oblast (but it varies across oblasts). It is clearly outlined in a resolution and publicly available. The pricing levels are developed by the pricing department of the administration (not the healthcare department) and are justified with cost calculations, although facilities believe that these costs are not realistic and that they are underestimated to make services more affordable to the population.

Figure 49. Are there clear pricing mechanisms for each of the own revenue types allowed by the Budget Code? (% Responses by Chief Doctors)
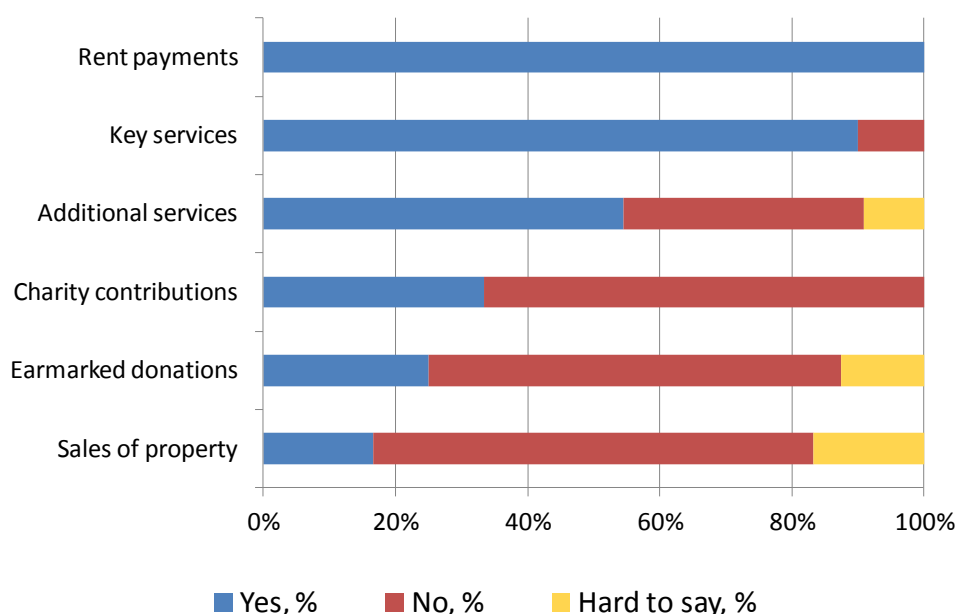
Indicator PB-31. Extent of unreported revenues and expenditures

Own revenue and expenditure of the facilities should be transparently accounted for within the budget to ensure a complete picture of public healthcare financing. Comprehensive reflection of all public revenue and expenditure in fiscal reports is pivotal for PFM transparency and accountability. At the national level, this requirement is covered by a separate PEFA indicator (PI-7), which assesses the general scope of unreported extra-budgetary expenditure, including donor funds. For healthcare facilities in particular, potential unaccounted extra budgetary funds relate to cash and in-kind donations, as well as private contributions to service delivery. Notably, such unaccounted contributions might be raised directly from the patients, or indirectly, from the doctors, who then shift the burden of these costs onto the patients through under-the-table out of pocket payments.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
How many facilities have extra-budgetary expenditure (other than "own revenue/expenditure") which is not included in the fiscal reports?	% Chief Doctors admitting such expenditures	11.8%	Grade A
How many facilities raise unreported in-kind private contributions?	% Chief Doctors admitting that they receive such in-kind contributions	90.9%	Grade D
How often do doctors and nurses have to contribute own funds to support service delivery in their facility?	% Doctors & Nurses who confirm that they had to contribute personal funds to support the operations of their facility	58.8%	Grade C
Overall Grade			**Grade C+**

Ukraine's legislation does not allow budget-funded facilities to receive any off-budget revenues and to spend any funds outside of their budgets. The way budget-funded health facilities are defined by Ukrainian legislation implies that all their revenues and expenditures must remain explicitly on-budget (that is, they must be accounted as Revenues and Expenditures of either General or Special Budget Fund and managed by the State Treasury as discussed in earlier sections). In particular, Ukraine's *Budget Code* directly states that central government and local self-government authorities, as well as budget-funded entities, are not allowed to create any off-budget funds. Moreover, it prohibits such agencies to open any off-budget accounts for managing their budget funds (including *Own Revenues*)[155].

Facilities are allowed to raise own revenues, but they must be fully accounted in their reports, used through Treasury accounts and clearly earmarked. Facilities can receive and spend additional *"Own Revenues"* but these must be fully accounted within the Facility's Special Fund[156]. Moreover, the *Budget Code* clearly classifies possible sources of *Own Revenues* and exact types of *Own Expenditures* which could be covered from respective own sources, as described in Table 10.

Table 10. Specification of own revenues and own expenditures by Ukraine's Budget Code

Groups and sub-groups of own revenues	Own Revenues	Own Expenditures which can be covered with revenues of respective group
Group 1	**Payments for services provided by the Facility (as specified by legislation)**	
Sub-Group 1	Payments for core services (those provided in line with the core activity)	Covering costs related to organization and provision of such services
Sub-Group 2	Revenues from additional economic activities	Covering costs of organization of respective economic activities; Economic needs of the facility, including payments for utilities and energy carriers
Sub-Group 3	Revenues from renting assets	Covering costs of maintenance and renovation of utility assets, purchases of equipment and property
Sub-Group 4	Revenues from sales of assets (except immovable property)	Covering costs of repairs, modernization or purchasing of new assets; covering costs of collection and transportation of waste and remaining metal parts to collection points; Economic needs of the facility, including payments for utilities and energy carriers
Group 2	**Own revenues from other sources**	
Sub-Group 1	Charity contributions, Grants, Gifts	Organization of core activities of the facility
Sub-Group 2	Funds received from enterprises, organizations, physical persons & other budget-funded entities for implementation of specified activities	Implementation of specified activities
Sub-Group 3	Interest from deposits of temporarily free budget funds received by high education facilities if they have the right to place such deposits.	Organization of core activities of the facility

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[155] There are three exceptions from this rule: (1) the possibility for the MoF to deposit funds for purchases of securities in coordination with the National Bank, described in Part 8 of Article 16 of the *Budget Code*; (2) the possibility for foreign diplomatic bodies to open foreign currency accounts, and (3) the possibility given to selected high education facilities to place on deposit temporarily free balances of funds received from provision of paid services;

[156] The *Special Fund* of the facility budget includes a list of revenues and expenditures, which are clearly defined by the legislation. The revenues must be clearly earmarked for a specific purpose, and expenditures must fully coincide with the respective revenue sources and their authorized purposes. Any actual expenditures from the *Special Fund* can be made only within actual receipts of respective earmarked revenues.

Many facilities are disappointed with the way their own revenues are accounted for and they sometimes find it difficult to recover raised revenue when it is surrendered to the Treasury:

- *"All our own funds go into the bank and into the city budget. This year I hoped to use them, but I wasn't successful in recovering them from the budget. It was possible last year, but not anymore. I was told it somehow violates the Tax Code, but I am not sure."*

- *"Let's take the example of rental payments for some of the premises which we can sublet. What can I say? In principle, the hospital could get a lot of extra money from renting some of the premises. You can see for yourself all the attractive spots around. And there were times when we did rent them, and I was interested in doing more of this, searching for potential tenants. We hoped to open a hairdressing shop, a pharmacy, some other simple personal services for the patients. I was glad and open to this type of co-operation with the businesses, because we could retain 90% of these revenues in the facility. But now we are only able to retain 50%, and even those amounts might not be actually transferred for our spending. And I have no idea where this 50% is going. At the moment, our rent payments bring about UAH 80-100,000 a year, 50% of which we can keep. But if was as before, and we could keep 90%, believe me, I would do everything it takes to raise more and we would have minimum UAH 500,000."*

Although budget-funded facilities are required to report all their financial flows on the Treasury accounts, at least some of them use additional entities to accept private payments. 11.8% of the facilities interviewed in this study admitted to run separate, off-budget entities, which were used for collecting and using some of the private contributions. These entities were usually registered as charity funds, with separate accounts in commercial banks. This practice is vividly illustrated by the case described in

Box 16 below.

> ### Box 16. The case of using a Charity Fund for collecting private contributions
>
> *"We are a children's facility, so we cannot charge anything for our services. However, we can encourage charity contributions. So, we co-operate with a charity fund. At the moment, this is allowed by the legislation, and this is an optimal way for us to work. This practice means that we co-operate with the non-state sector, and it also means that we can use the money which we raise, in the sense that our views are taken into account in how this money is spent.*
>
> *"The Fund helps us to collect contributions. They are collected right here in the premises of our hospital. The contributions are often made by the patients. We explain the need for such contributions to people. Essentially, people are supposed to receive their medical services for free, and especially children. But in practice, it is impossible. For example, medicine is only funded at 10% of the actual cost of what is needed, and we have to explain to people that in any case the state does not provide this money, so the money has to come from somewhere, someone has to pay. So, if the state does not give this money to you, then you have to find it somewhere.*
>
> *"Besides, there is an order by the State Inspection of Medical Products[157] which forbids us to use medicine brought in directly from patients. So, if the patient buys some medicine he or she is free to use it for self-treatment at home, but if this person comes into in-patient care, s/he has to show us the Quality Certificate, receipt from the pharmacy, and also a signed agreement, which states that s/he bought it. This is all in the law. Otherwise, we are not allowed to administer this medicine on the premises of our hospital, we are a public facility, and if there are any adverse effects from this*

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[157] "Державна інспекція лікарських засобів"

medicine, I would be personally responsible. So, we suggest to the parents that since we know what medicines are needed and how much they cost, approximately, we can tell them this approximate amount which could be donated to the Fund. Of course, this amount would not include the tests and other services, it would be the very minimal amount. But it would be still a good price, because the Fund would buy this medicine at wholesale prices, for example for 50 children, and it would be much cheaper for the parents compared to buying same medicine in a regular pharmacy. And the Fund is also buying this medicine directly from the supplier or even the producer. It saves 30% of the cost.

"So, the Fund collects these contributions, and then buys medicine as the need arises. From the legal point of view, of course what we are doing means that not all the money collected from one person strictly goes to the needs of the same person. We use funds collected from healthier patients on cases of more sick patients, and we can even save and have leftovers. And about 30% of what is left we use for the needs of our facility, for paying for utilities, or on urgent repairs (such as when some of the equipment breaks down, or the ceiling falls down, or the walls are falling down in the surgery).

"Overall, only UAH 200,000 of the Fund's monthly revenue is used for medicine (of an approximate total of UAH 300-360,000). Looking at these numbers, you can compare them to what we get from the state. Essentially, we live at the cost of this Fund. This is our true budget.

"We have not made any purchases for the hospital from the regular budget for 5 months now, because the budget was not approved, the tenders were not announced. Until the month of May we didn't have any procurement whatsoever. But during all the months January to May we were treating patients, everything was working, and no one asked us: how on earth do you survive, at what cost?"

Most facilities regularly collect private contributions into facility operations from their staff. 58.8% of the interviewed doctors and nurses admitted that they have to contribute some personal funds informally to support the facility's operations. The average size of the latest contribution was remembered as UAH 592 (median – UAH 100, mode – UAH 50), but individual cases ranged from a minimum of UAH 2 to the maximum of UAH 10,000. **In 61.3% of the cases, the payment was a regular contribution, rather than a one-off payment.** Some of these contributions are in cash, while others are collected in the Charity Funds operated by the facilities (in one of the case, it was a monthly UAH 5 contribution to the Fund by all employees). Most usually, collections are used to buy stationary and various supplies (instruments, bandages, tests etc.), as well as for refurbishment and reconstruction of the facilities (see Figure 50). However, in many cases the purpose of raising the money is not entirely clear.

- *"We make charity contributions every month. We are told how much exactly we have to contribute by the Chief Doctor. But there is also a constant contribution of UAH 200. We don't know how it is used."*

- *"We contribute a regularly monthly payment of UAH 150 for the water supply, and a monthly payment of UAH 100 for the uniform. Also there is a monthly payment of UAH 200-300 for the stationary."*

- *"Every month we pay UAH 100-200 to the Charity Fund. We have no idea why it is collected. Also, there is a UAH 2.50 monthly payment for the stationary, and UAH 100 annual payment for the key medicines (because there is no funding for medicine)."*

- *"We paid for the refurbishment and associated building moves last year. We constantly pay UAH 200 here or there. Often I don't know where this money is going, these are just ad hoc collections. There is nothing like a regular contribution. In the previous facility where I worked, there was a regular contribution: we gave UAH 200 every month for the operations and for equipment purchases. Nobody cared whether we had this money or not: we had to either collect it as charity contributions from the patients or give our own money."*

- *"The deal is that I have to share an equivalent of my daily (informal) income every month. But I don't know how it is used. Nobody knows. I suppose that it is stolen, like everything in our country."*

Figure 50. "When you last had to contribute funds to support the facility, how was it used?" (% responses by Doctors and Nurses)
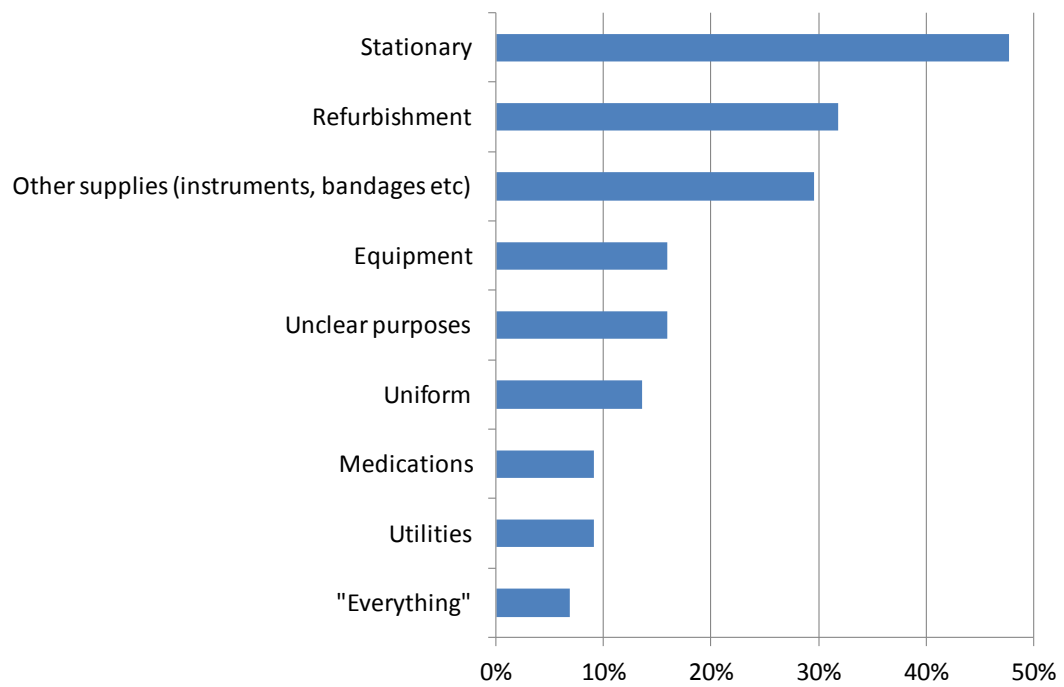
Chapter 5. Information Management

Introduction

Most of the medical statistics in Ukraine are collected via standardized reports and brought together, through several channels, in the MoH Center for Medical Statistics (CMS). National legislation establishes an elaborate system of medical reporting, regulated by the MoH.

- **The MoH is the source of a range of mandatory forms for primary recording of medical information at the facility level and for the production of generalized statistical reports based on collected primary data.** Overall, MoH uses 246 such forms[158]. The MoH also establishes detailed Guidelines on how these forms should be completed and processed[159].

- **As a general rule, primary medical records (medical cards of individual patients) are paper-based.** Original primary records are aggregated and stored in the facilities which complete them, apart from children's medical cards which are transferred to educational facilities together with the respective personal records.

- **However, all generalized statistical reports are standardized and generated automatically with the help of specifically developed software "Medstat".** These standardized forms are submitted to the designated bodies responsible for information management (information and analytical centers, etc.) both through paper and electronic means, and in some cases, by email. In order to produce these generalized reports, some facilities may choose to use electronic means of keeping medical records, which are then transferred into automatic systems for production of formally required generalized statistical reports.

- **The statistical reports which are generated "move up" through the system to the MoH Centre of Medical Statistics (CMS), following three parallel tracks:**

    - From facilities and respective Departments of Healthcare (described in detail in Figure 51) via oblast offices of the CMS;

    - From the Sanitary and Epidemiological Service (which tracks data related to particular infections, vaccinations, environmental public health risks);

    - Through the Medical Investigation Service.

- **A range of specific diseases – mostly contagious but also including cancer – are tracked separately through the system of specialized regional dispensaries.** As shown in Figure 51, most of the primary medical statistics are consolidated by statistical units at the central rayon and municipal hospital level before being sent on to the oblast offices of the CMS. However, a range of "specialized" medical reports (on dermato-venerological diseases, HIV/AIDS, cancer, TB etc.) travel up through a network of specialized facilities, bypassing central rayon and municipal hospitals. Detailed flow-charts of how these diseases are monitored are provided for the example of TB in Figure 52 and for cancer in Figure 53.

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[158] The key MoH Orders regulating for primary recording of medical information at the level of healthcare facilities are the *MoH Order No 369 of 29.12.2000*, which approves medical reporting forms to be used in in-patient and out-patient facilities and *MoH Order No 184 of 26.07.1999, "On Approval of forms for statistical reports to be used in in-patient healthcare facilities".*

[159] The most important of these regulations include MoH Order No 258 of 03.07.2001, "On Approval of typical guidelines on filling in the forms of primary medical documentation for healthcare facilities", which defines time periods for storage and the procedures for filling in for all forms of primary medical records and MoH Order No 1 of 10.01.2006 "On Approval of forms for primary medical records of infectious, dermato-venerologic, and oncological diseases, and of guidelines for filling in such forms

Figure 51. Flows of general medical reports in Ukraine's Healthcare System[160]
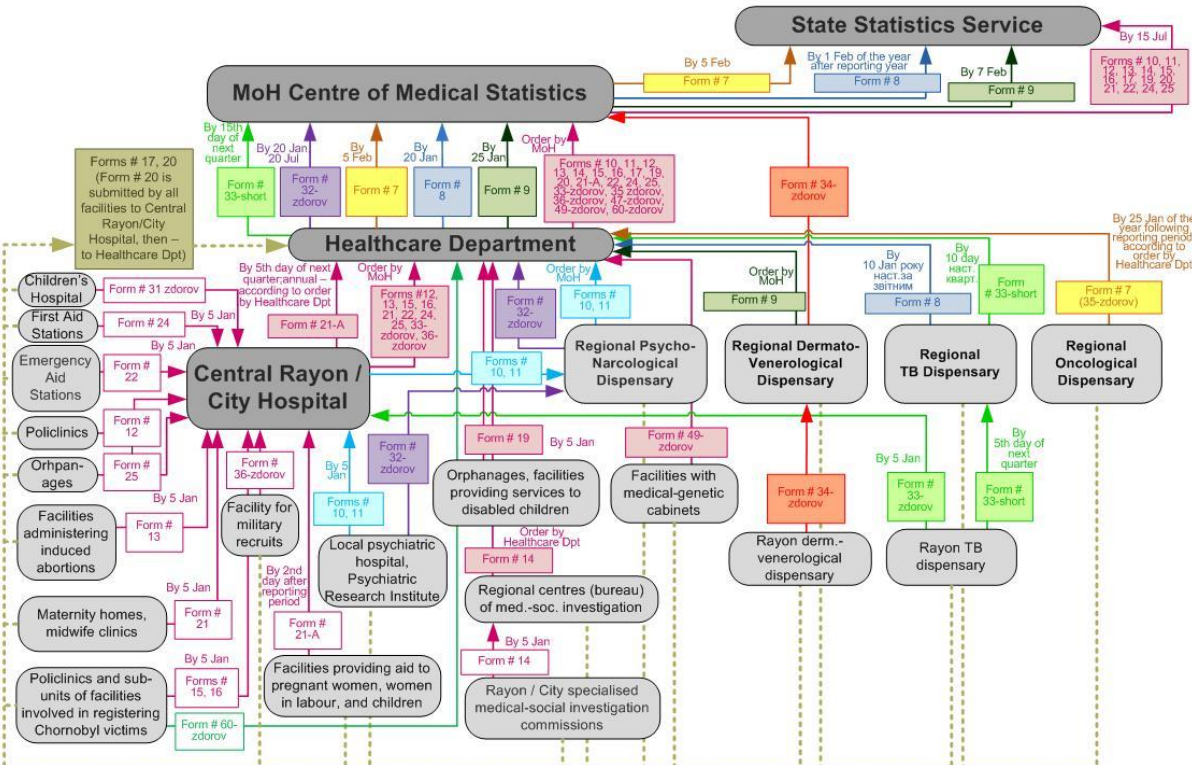
- As **Figure 52 and Figure 53 illustrate, the current medical information management system for data related to cancer follows the same approach used for major contagious diseases.** It is focused on fast and effective centralization of epidemiological data and on ensuring strict control and visibility of all detected cases (all cases of identified malignant neoplasm are immediately referred to a specialized oncological dispensary, which takes over the responsibility for the patient's individual medical record and continues to track his/her medical history within a separate system for monitoring and reporting of patients with malignant neoplasm).

- As **a general rule, there is no two-way exchange of information about patients between facilities, even for conditions where such exchange is highly needed (for example for patients with cancer).** Healthcare facilities are allowed to share medical information with other facilities in the following cases:

  - **If a patient is dispensed from the facility, transferred to in-patient care, or dies**, (s)he is issued with a *Discharge Summary* based on his/her *Medical Card (Form 027/o)*. This *Discharge Summary* is either provided to the patient in person or sent to the in-patient facility by post or express mail. In case of transfer to in-patient care, the patient is registered in the *In-Patient Admission Log* and his/her *Discharge Summary* becomes the basis for issuing his/her *In-patient Medical Card.* The act of completing and issuing (or sending) the *Discharge Summary* essentially stops the information exchange between the medical facilities. In other words, the facility which issued the *Discharge Summary* does not receive any further information about this patient.

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[160] Note: the scheme does not include Reports on Forms # 38-zdorov, 41-zdorov, 42-zdorov, 44-zdorov, and 50-zdorov

- **If a patient is first diagnosed with active or recurrent TB, syphilis, gonococcus or Chlamydia infection, urino-genital mycoplasmosis or trichomoniasis, trichophytia, microspores, favus, scabies, cancer or other malignant neoplasm:**

  ✓ **For all above specified cases -** the facility which made this diagnosis issues a *Notification[161],* sending it to the respective specialized Dispensary, and, in case of fungous and STDs, to the local *sanitary-epidemiological station (SES)*;

  ✓ **In addition, if a patient is diagnosed with cancer,** in addition to the respective *Notification*, the facility which made the diagnosis also issues a *Discharge Summary of In-Patient Medical Card of a Patient with Malignant Neoplasm (Form 027-1/o)*, which – together with the *Form 090/o* – is sent to the *territorial oncological dispensary* located at the place of the patient's residence;

  ✓ **For all above specified cases** – the issuing the respective *Notifications* (and – in case of cancer – the respective *Discharge Summary* as explained above) creates grounds for registering the patient with a dispensary which, in turn, issues him/her a *registration card* or *medical card* for that dispensary. After the above documents have been issued by the facility which made the initial diagnosis, this facility then obtains no further information about this patient and developments in the state of his/her health.

Figure 52. Flow of information related to TB

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[161] Based, respectively, on Forms 089/o, 089-1/o, 089-2/o, or 090/o.
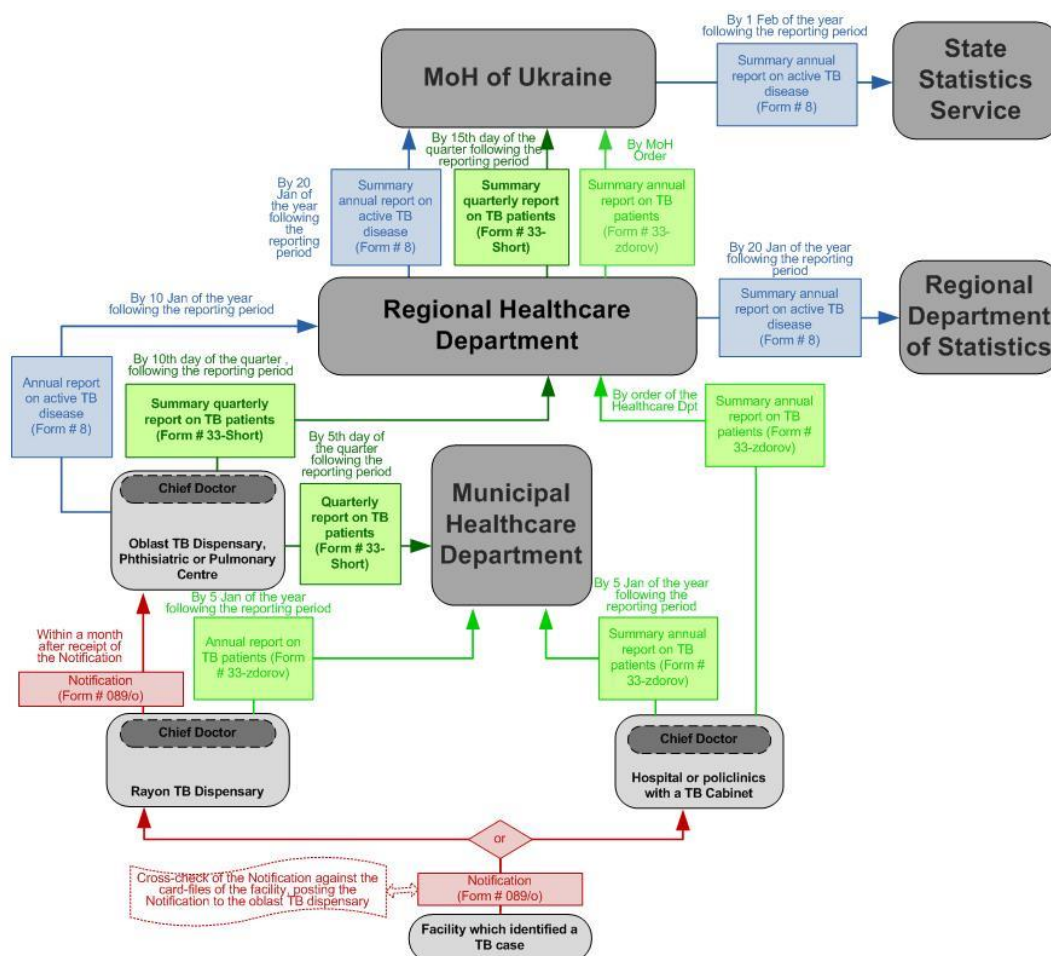
Figure 53. Flow of information related to cancer
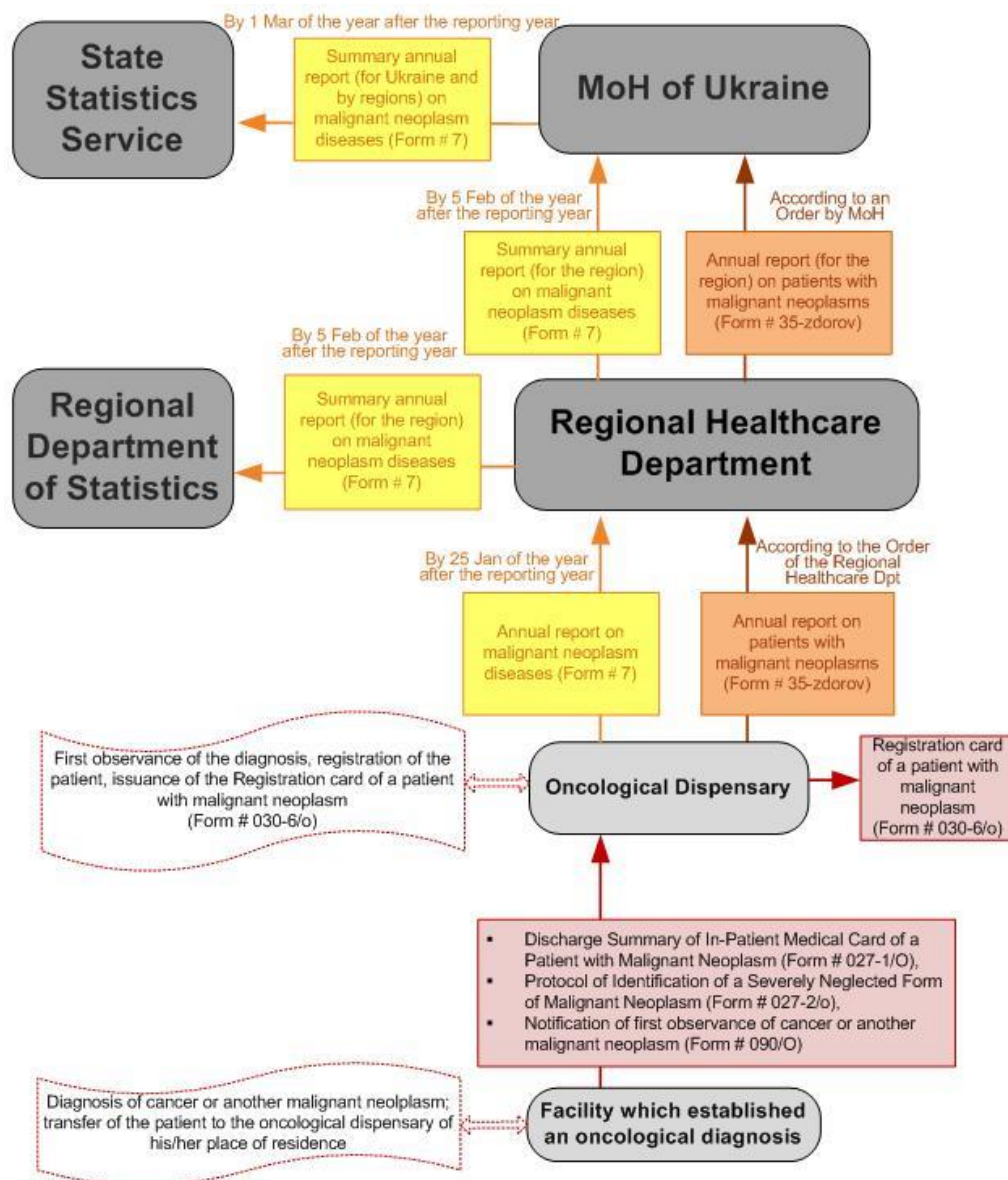
Local authorities, for example local Departments of Healthcare, may ask their medical facilities to submit additional statistical reports. There is no standardized approach to either the content of such additional reports, or their format (although local Healthcare Departments may regulate these through orders). For example, the main Healthcare Department of the Donetsk State Administration produced Order No 380 on 02.12.2011, which requires medical facilities in the oblast to submit, in addition to regular statistical reports, further materials: Progress with the implementation of the Program of Social and Economic Development in relation to healthcare; Reports on implementation of new diagnostic and treatment methods; Information about the work of the counseling and diagnostic brigades; Reports on the visits of oblast-level specialists to medical facilities of sub-oblast level etc[162].

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[162] See Clauses 2.5, 2.6, 2.8, 3.2 of the Order of Donetsk Oblast Main Department of Healthcare № 380 of 2.12.2011 "On submission by healthcare facilities of the oblast of state and sector statistical reports for 2011".

National legislation contains no universal provisions which would define approaches to statistical record keeping at the facility level for in-house uses. There are no universal guidelines concerning the management of information at the facility level, either for administrative purposes or for documenting the treatment process. However, facilities may develop in-house forms and guidelines according to procedures defined by the Statute of each facility.

Data collection

Indicator ME-32. Division of responsibilities and coordination

Effective recording and processing of data requires a concerted effort from engaged parties, with clear division of responsibilities and sufficient institutional weight to ensure action. Collection and analysis of medical data involves a range of functions which should be effectively handled at the facility level. Clear responsibilities must be assigned for gathering the required data, creating statistical reports and duly submitting them to further users. This analysis should cover both production for in-house purposes (facility administration and delivery of services) as well as for generalized medical reporting to the health care authorities. Importantly, to deliver against these tasks, designated statistical units should have sufficient institutional power to request the necessary data from relevant departments and to ensure their quality. Data collection and reporting should cover a coordinated range of indicators and follow agreed and realistic timelines.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Do HMIS units of the facilities cover a comprehensive range of data collection functions? How well are these functions working?	% HMIS specialists who assess at least 6 out of 9 core functions as working "Very well" or "OK"	44.4%	Grade C
Does the HMIS unit have sufficient power to control facility departments for data gathering?	% HMIS specialists who select lack of power to control facility departments for data gathering among top-3 biggest problems in data collection	30.0%	Grade B
Do doctors and nurses understand what happens to the statistics they produce so that they could co-operate effectively?	% Doctors & Nurses who know what happens to the statistical reports which they produce	72.7%	Grade B
Overall Grade			**Grade B**

In less than half of the facilities statistical reporting units effectively cover a full range of key monitoring and evaluation functions. As a rule, the HMIS units are responsible for a comprehensive range of data collection and analysis tasks, including collection and processing of primary data, production of analytical reports in a standardized format as requested by the legislation and their timely submission to the relevant authorities, information support to activities within the facility as well as in support of national health care programs and health-related research. But while most facilities have HMIS units designated to cover all the core functions, only in 44.4% of the cases did the interviewed HMIS specialists believe that most of these functions (at least 6 out of 9) were performed satisfactorily.

One of the biggest barriers to effective collection of data is low motivation of the doctors and weak institutional status of the HMIS units. As shown in Figure 54, one of the most problematic areas in the organization of the ME process is the in-house collection of data. The need for improvement was ranked as second highest (after the need to improve IT-based systems). Moreover, lack of power to request the necessary data was reported as a major problem by 30% of the facility executives. The usual reason given was that facility staff lack sufficient motivation to provide the data that has been requested and to ensure its quality:

- *"It is difficult to organize data collection from the doctors. They don't want to submit their reports on time, because it is not a priority for them. So, we get these reports out of them by shouting and making scenes. Because for us it is a priority and we have very strict deadlines. And one barrier to our cooperation with the doctors is the fact that my rank as a statistician is that of a nurse, so I am lower in the hierarchy, and it makes it difficult for me to demand anything from the doctors."*

- *"Doctors and nurses do not always appreciate the importance of statistical reporting. They are practicing specialists and they consider these reports to be an insignificant part of their work. And our unit has little power to influence them."*

- *"Facility departments may shift responsibilities for data provision from one to another to avoid giving us the data. And when we insist on getting the numbers they would say, 'Who are you to request this from me? Why did you even come to my office?'"*

- *"Doctors are not motivated to give us the data on time. About half of them are diligent in this respect, but others are either ignorant, or they simply don't want to cooperate. They think of us as terrorists".*

Figure 54. How would you assess the work of the HMIS unit against its core functions? (% responses by facility executives)
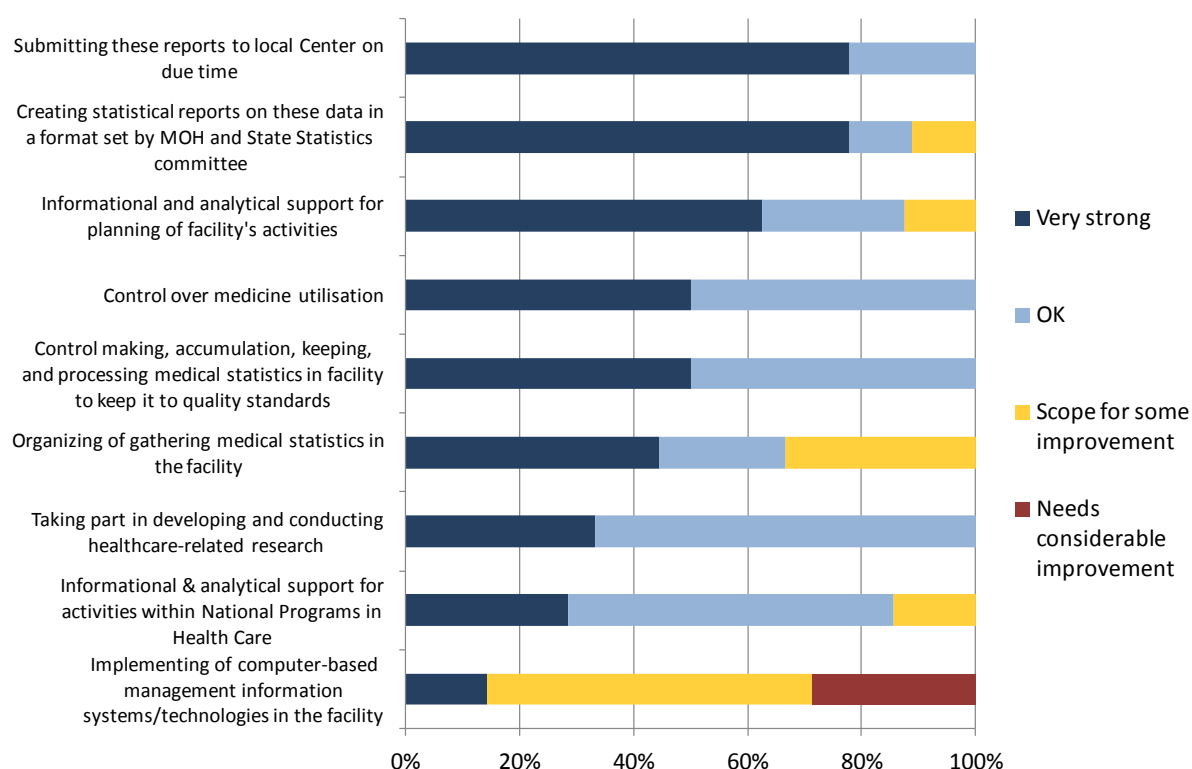
Healthcare workers do not always understand what happens to the data they produce. The problem of doctors and nurses not being motivated to provide the requested data is shown by the fact that only 72.7% of them say that they have some understanding how and why the primary

statistics they collect are used by the HMIS system. As will be discussed further, they rarely find MIS useful for their own work, but they submit the reports because *"This is a normal, daily, mandate task we need to do"*:

- *"I personally do not need it. It is described by the well-known phrase: there are lies, big lies and statistics."*

- *"They put these numbers into computers and somehow use them for their own purposes."*

- *"How are these statistics used? You should probably ask our head of department. I suspect they must be collecting it for the municipal authorities but I am not sure. But there must be someone who needs it, these standards and forms, if they worry about it so much."*

- *"They are submitted somewhere, but I am not sure where."*

- *"I don't know, but probably they are collected and sent all the way to Kyiv."*

- *"I don't know. But most likely, they are eventually going to the World Health Organization. At least this is what we were taught."*

- *"The data goes to the statistical unit, who have to submit their reports and it helps them to do so. Also, it helps the statistical unit to fill in their log."*

- *"Yes, the forms we fill in are stored for 5 years, in our basement."*

- *"Every year we have to collect more and more statistics. We have to calculate some indicators, some weighted numbers, for example the share of retinopathy or gangrenes. Why? What is the purpose of doing it? I don't know. Maybe to evaluate the quality of treatment somehow, but I am not sure. And how would they use this data to estimate or evaluate anything if we see that the social situation does not allow an average patient to go through a basic check-up and to receive full treatment, even if the doctor knows what to do and uses the right approaches. These indicators which we collect have nothing in common with the real quality of the services which we provide."*

Another major coordination problem is the volume and nature of requests received by the facility HMIS specialists from various authorities to which they report. As was discussed in the introduction to this section, facility statisticians have to provide generalized statistics to a range of stakeholders. The bulk of these reports are standardized in line with national requirements imposed by the MoH; however, local authorities usually engage facilities in additional statistical analysis related to their planning, reporting and public health activities. The problems that arise as a result of these additional requests are threefold. First, facilities often find the timelines for these requests unrealistic and poorly coordinated. Secondly, the volumes of requested data may be excessive. Thirdly, the nature of the requested data does not often coincide with the capacities of the HMIS or may be difficult to find because of lacking or unclear guidelines.

- *"On the one hand there are official statistical forms which we need to fill in, but on the other hand the Ministry is asking us to provide other, additional data; and then there are further requests from the oblast, and from the city, and from many others. And we have to respond to them all. And it is up to us to find this information somehow, even if it is unclear where we might find it."*

- *"Our biggest problem is the unplanned urgent requests for data. These requests are made 'today for today': we may receive a letter from the Healthcare department at 14-00 requesting some data, and this letter may have a deadline for provision of this data of 12-00 of that same day! Or, for example, we may receive a letter with an extra request on the 19th day of the month, and it would state that we have three days for preparation of the data with a deadline set for the 20th."*

- *"Short deadlines are a huge problem. We have almost no time at all for compiling the data we have received: the doctors send their numbers to us on 30th -31st, and we have to submit our overall report at 10:00 on the 4th, and if it is an annual report, the deadline is January 10th. We never have New Year holidays as a result."*

Indicator ME-33. Availability, frequency and standardization of data

Integral national systems of data collection require data to be collected regularly and in line with clear, realistic and universal standards. To be able to use medical information for healthcare policy development and implementation, the government needs to collect this data with sufficient frequency and based on a predefined set of quality standards. These standards should be realistic, covering data which are available to those who are responsible for collection, and they should be clear and consistent, ensuring compliance and quality. Notably, these principles are important for effective data collection at any level of healthcare planning, national or sub-national.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Is the information collected from the facilities standardized according to the national requirements?	% HMIS specialists who state that collected data is always or mostly standardized according to the national requirements	88.9%	Grade A
How frequent is data collection?	% HMIS specialists who state that in their facility data is collected on daily or weekly basis	90.0%	Grade A
How clear and easy to use are the standards and procedures?	% HMIS specialists who point at complexity of standards and procedures as one of the top-3 most severe factors constraining the quality of data collection	20.0%	Grade A
Overall Grade			**Grade A**

Data collection and processing in Ukraine's facilities is well organized and follows a clear standardized pattern. As was discussed in the introduction to this chapter, the national regulatory framework for medical data collection in Ukraine is elaborate and detailed. There are highly standardized forms for data collection and this is regulated centrally. There are also strict guidelines for how the forms should be completed and processed. Interviews confirmed that these universal guidelines are diligently applied, with 88.9% of the HMIS specialists confirming that the statistical information they produce is standardized according to national requirements, and only 20.0% mentioned difficulties related to the complexity and lack of clarity of these requirements. Moreover, in line with the current guidelines, medical statistics are collected for generalization at the national level on a weekly or daily basis (confirmed by 90.0% of the facilities).

- *"Our statistical analysis function is working very well. We regularly produce required reports, we fill in all the forms, and we verify all numbers. It all goes splendidly. The information arrives from every department; then the statistical unit checks and verifies it, and inputs it into an automated system.*

And then with the help of this system we generate reports. These reports are then submitted to the required authorities, and also sent back to various departments."

- *"We collect and process required statistics every day. If we miss or delay at least for one day, our reporting tasks will build up and this backlog will smash us".*

Indicator ME-34. Quality of information

The quality of the collected data (in terms of its credibility, relevance, and precision) is of obvious importance to the effective monitoring and evaluation system. Collected data should accurately and objectively reflect the actual situation, and it should be relevant and up-to-date. Data quality assurance systems must include effective mechanisms for data checks, verification, and provision of feedback on data quality, including inspections by healthcare authorities down to the facility levels.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Is the information collected from facility departments objective?	% HMIS specialists who state that the data is rarely or never objective	25.0%	Grade B
Is the information collected from facility departments complete?	% HMIS specialists who state that the data is rarely or never complete	0.0%	Grade A
Is the collected information reliable?	% Doctors & Nurses who say that they would not rely on the medical statistics generated by their facility	25.0%	Grade B
Overall Grade			Grade B+

The local healthcare officials use elaborate data verification mechanisms with frequent in-depth inspections at the level of individual facilities. All of the representatives of the statistical units of the local central hospitals and of the MoH oblast CMSs (the two key bodies responsible for consolidation of generalized medical statistics reports at the sub-national level) stated that they have elaborate systems in place to verify submitted data. As described below, this includes meticulous scrutiny of submitted reports and frequent inspections. The CMSs have strong administrative leverage over the facilities: the need to have statistical reports approved and inspections successfully passed is a considerable incentive. As a result, the CMSs seem to have a significant influence on the nature of submitted reports.

- First, the oblast CMSs, as well as the local central hospital statistical units, designate specialists to analyze submitted reports before they are accepted. Mistakes or gaps are identified at this preliminary stage, corrections made before the reports are accepted, and any resulting recommendations for improved data management are outlined in written notices to the respective facilities. (*"There is no such question as whether our data is complete; we simply do not accept incomplete or low quality data", "Facilities must defend their reports at the stage of submission, and we see whether there are any weaknesses or problems, and we provide our feedback on spot"*).

–   Second, the CMSs regularly inspect facilities to verify submitted data and to inspect data collection and processing methods. The usual number of planned inspections reported by the interviewed CMSs varied from 4 to 24 per year, with every facility undergoing an in-depth audit once in 1-4 years. *"We might even undertake an inspection in non-working hours, to see how the data is stored. Our specialists would go to a rayon hospital without prior warning and manually count how many patients are really there in the in-patient care. Or we can count how many people are sitting in the queue waiting for a visit to their doctor. We do same thing to check the laboratory tests". "All data is stored in primary medical documentation, and so we can check everything. Of course, we cannot check everything, but we check samples of documents. We look at whether the data corresponds to reality and whether it has good quality. Every quarter we conduct such audit in 2-3 facilities."*

–   Thirdly, the CMSs run seminars and other lessons-learning activities for the facility statisticians to improve data quality and to discuss any existing barriers. (*"We conduct seminars at which we draw the attention of the facilities at the problems we identified in their reports. We also try to understand why these problems occurred. Sometimes the reasons are difficult to identify by mathematical methods because life is more complex. Sometimes the reason is a simple human mistake."*)

–   Fourth, the CMSs demand facilities to undertake their own data quality audits: *"We demand that their statistical units spend at least 20% of their working time on checking the quality of data for their facility. We analyze their conclusions, because we want to see what are the bottlenecks in statistical accounting and how to address them."*

Facility level specialists are not always certain about the quality of the data they compile and some of them believe that CMSs scrutiny prompts facilities to distort the real picture. On the one hand, all of the interviewed HMIS specialists in the facilities said that their reports are always complete – which is not surprising given that incomplete data sets would not pass through the CMSs approval. On the other hand, 25% of the statistical specialists at the facility level said that their data is never or rarely objective (and only half of the facilities said that it is always objective).

-   *"To be honest, most often there is a lot of data which is not objective and it is difficult for us to control it. As I understand, this is the situation everywhere and we all understand it. Everybody who compiles the data is correcting it a little bit, because otherwise the picture would have been too sad and we would have all lost our jobs."*

-   *"We are being flogged for some of the indicators if they don't like their levels. Sometimes they don't understand the reasons for the statistical trends and they are not interested, they just demand certain levels. For example, we recently registered a high level of abortions. We have tracked this indicator since 1987. In that time, the number of abortions fell by 8.5 times, but now we have reached a limit and we cannot go below it. This current indicator cannot be decreased any further, because from this point on you can only influence the level of abortions with social and economic levers, not by medical approaches. But they request me to show a lower indicator and if I don't it means that I am not working well. I am annoyed with this, because it is annoying when people request things they don't understand. But they request it, and if they are unhappy, they may organize an unplanned audit of our facility, and we would be punished, people might even get fired. But if you ask my personal opinion, I would say – let's monitor things as they are, at least for 10 years, and then we would see a real, honest picture of how things are with healthcare in this country. Because, if our statistics are manipulated and influenced, if we try to use tricks and nuances, then of course we will see incorrect trends, and our decisions will also be wrong."*

While 84.6% of doctors and nurses believe in the primary records provided by themselves, only 62.5% trust generalized medical statistics. Most of the health workers believe that primary records compiled at the facility level are generally, accurate, but they doubt the reliability of the resulting

generalized records. Of all interviewed doctors and nurses, only 62.5% said that they would rely on this data, while 25.0% said they would rather not.

- *"In reality, it is the statistical specialists who are the key players. In Ukraine, it is not the minister who has the final word, but the statistics committee. And in our hospital, it is not the Chief Doctor who has the final word, but the statistician. And you know why? Because it is the statistician who decides whether the Chief Doctor will go to the jail or not. It all depends on what number the statistician puts into his report."*

- *"It is the statisticians who deal with all the health problems in Ukraine. It is them who reduce mortality. Whether some indicators would go up or down, it all depends on what the statisticians will write and sign. These trends are often not true in reality, but they are true in the statistical reports."*

- *"Numbers are very often played around. And this is not checked very well. I personally think that our statistical department is not too busy, and they do have time to go and check the log for themselves. But they don't."*

- *"I never thought about this question before, but now that you ask me... No, I don't really trust our medical statistics, I doubt they are accurate. I will give you an example: we had a statistical form for several years where we had to show the amounts of patients and separately the amount of complications, and for all these years we were requested to make sure that these two numbers are equal. But this was nonsense, because one patient may have several complications, these numbers are rarely equal in practice. And the reason for this statistical inaccuracy is simply that the reporting software was not designed well: it needed to have same numbers in these two columns. We were struggling with it for several years, and it is still a problem. I suspect that this software is done by specialists who are not too bright."*

- *"No, I don't trust it, all the numbers are pulled out of a hat. Perhaps the only serious numbers are about heart attacks. Everything else – such as numbers of visits, check-ups etc. – they are all taken out of thin air."*

- *"Not all of the statistics are 100% true. For example, in our previous work, we never made tests with specification for the levels of glycosylated hemoglobin. And suddenly we receive an instruction from Kyiv to report how many of these tests we have done during last year. We were not warned that these numbers would be needed, that these specific tests should be done. So, we have to calculate some averages. And I am sure this is what most other hospitals have done, because no one was doing these tests, and they were suddenly introduced. And even this averaging was difficult, because we don't have a computer, so how are we supposed to calculate all this?"*

- *"The numbers are not always true. For example we have a lot of fictitious vaccinations."*

- *"Statistics is a prostitute. You never know what hands it has been through and what happened on the way."*

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Indicator ME-35. Cost-efficiency of the data collection process

As any production process, successful data processing should achieve intended results at a minimum possible cost. Collection and processing of information can impose a considerable burden on the healthcare system, including paperwork, time spent on statistical tasks by doctors and nurses, and various costs related to complying with data collection standards and requirements. While some of these costs may be inevitable, the burden on healthcare professionals should be proportionate and measures should be in place to optimize information flows and responsibilities, including activities to enhance the use of computer- and web-based technologies.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Do HMIS tasks consume proportionate amount of time of the HMIS specialists?	% HMIS specialists who think that tasks which take most effort are the ones which make biggest difference	42.9%	Grade C
Is excessive paperwork related to data collection a significant obstacle to ensuring good quality of information?	% HMIS specialists who believe that paperwork is one of the top-3 strongest barriers to good quality data	50.0%	Grade C
Is the amount of work to be done by HMIS proportionate to their capacity?	% HMIS specialists who believe that the amount of work they have to do is too large to be handled effectively	40.0%	Grade B
Overall Grade			**Grade C+**

Medical information gathering in Ukraine is achieved at a substantial cost. Half of the facility statisticians believe that data processing implies excessive paperwork, which is one of the key barriers to compiling good quality data. 40% of the statistical specialists believe that the workload exceeds their capacity and makes it nearly impossible to handle tasks effectively. Moreover, 50.8% of doctors and nurses said that they too find statistical duties excessively time consuming and 38.5% said that they find the format inconvenient. On average, doctors and nurses reported that they spend 8.5 hours a week on recording and processing data (i.e. about 1/5 of their work time). A popular example of unreasonable workload related to collection of data using "statistical slips" – paper summaries with individual patient data. These are used for primary data collection. In many facilities, the data is compiled manually (for example sorting the slips by types of diseases rather than using software applications and in-build automatic filtering). This is often delegated to doctors and nurses. It requiring significant time, and is almost impossible to verify.

- *"Data collection system is very problematic for a practicing doctor, because we have to spend enormous amounts of time on tasks which are in no way related to the key purpose of our work."*

- *"We are collecting too much unnecessary data."*

- *"We are supposed to spend 6-12 minutes for one consultation with a patient, but most of this time goes on filling required records and forms. The stress on indicators and forms, places too heavy a workload on doctors."*

- *"When the department has to produce aggregated numbers, one of the surgeons is chosen to do the calculations, he goes to the basement to receive packs and packs of paper slips, and then he has to sort them into various piles by types of diagnosis. To be honest, no one actually does this, we look at recent trends, make approximate estimates, and then we take a sample of the slips to see if we are roughly within the true levels, and this is what we report. It is very stupid: if we could enter individual data into the IT system immediately, all this aggregation and calculations would be accurate and fast."*

- *"If only we could input the data into computers immediately and avoid the paperwork. There is so much duplication. We put numbers into the program but we also have to write everything in the medical cards, statistical slips, and forms, and logs."*

- *"Having data is good, but compiling it prevents us from delivering actual treatment. It is very distracting."*

- *"The software we have to use is very problematic. As far as I know, everybody is complaining about it. But tell me again, I won't be prosecuted for what I just said, will I?"*

Doctors and nurses complain that many forms are poorly laid out, which makes it difficult for them to accurately register primary data. The current forms request redundant information, for example in-patient medical cards include a field which classifies the patient based on his/her occupation into "categories" which distinguish between "blue-collar" and "white-collar"; and whether the person lives in rural or urban area. At the same time, the forms may not allow basic medical information such as diagnosis to be properly conveyed. For example, as shown in Figure 55, statistical slips attached to the in-patient cards of those patients who are released from hospitals contain only a small section for description of the full medical diagnosis of the patient.

- *"The data collection system is not effective; it is too formulaic, it does not correspond to the reality of things. The forms are out dated, nothing is revised."*

Figure 55. Statistical card of an in-patient, released from the hospital (Form 066/0)

Field for describing main diagnosis of the in-patient after release from hospital

In many cases, staff believes that the focus of their MIS tasks is misplaced: effort is spent on unnecessary activities and time is wasted. Only 42.9% of the statistical specialists in the facilities think that the tasks that take most of their time are those that also make the biggest difference. The task that takes most time is organization of the data collection process, even though it is not always the task that is perceived to be conducted effectively (see Figure 56). Another frustrating activity is implementation of computer-based technologies: even though this task is generally recognized as highly important and consumes much of the energies, it is not seen as such which is being

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implemented successfully. At the same time, statistical units consider themselves to be highly efficient in producing standardized reports and submitting them in time. Notably, production of data for in-house purposes such as for facility management and planning of internal operations, as well as data for quality assurance, are assessed as highly successful and require relatively little time – if and when these tasks are actually performed.

Figure 56. What tasks take most of your time and what tasks make biggest difference? (% of responses by facility statisticians)
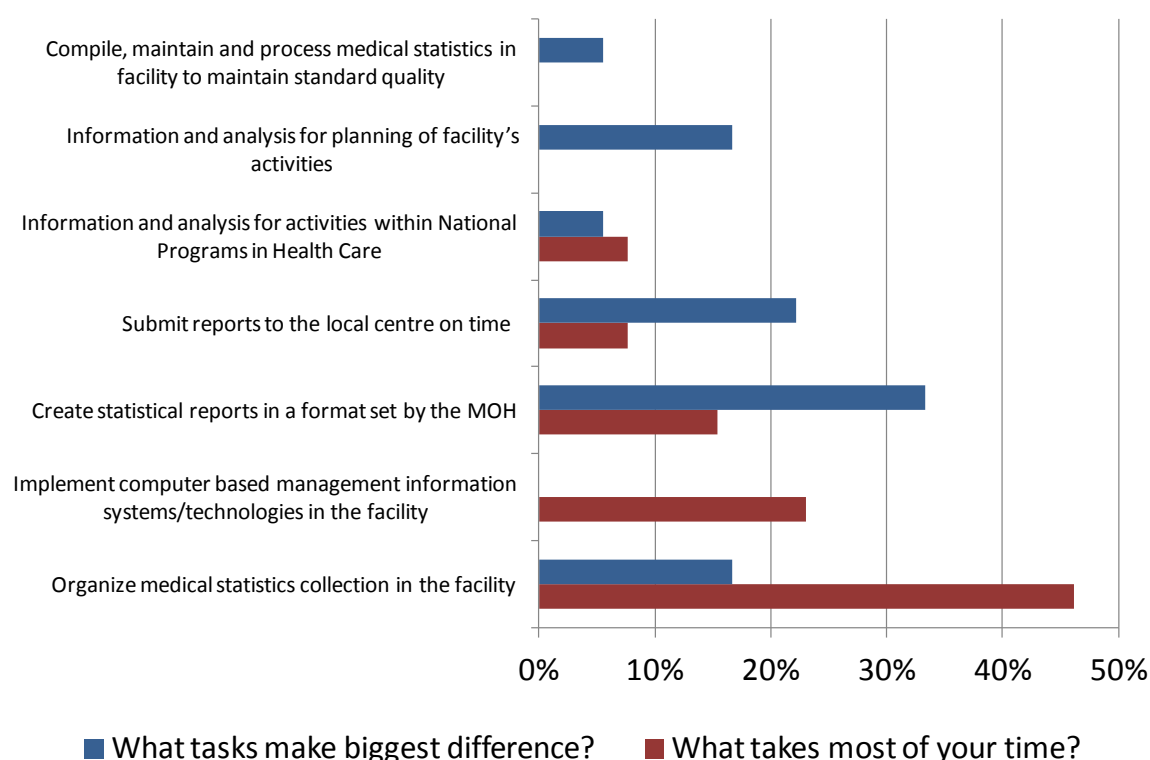
- *"Most of our time goes in organizing data to be used in the statistical reports – quarterly, six-monthly, annual. This takes most of our time and energy. You have to get all the data together, cross-check all numbers. You have to clarify things with people, ask additional questions. Every quarter we have to submit a report, the one which was previously based on Form 071, and now on Form 12. In order to prepare this report, we have to spend a week cross-checking. Our doctors submit their statistical slips and forget about them, but we have to check all these slips and compare every slip with the previous year. This takes a long time".*

- *"We have to find a way to match the data we have with the forms we have to fill in. For example there are different statistics we have to report on children and adults. Earlier, we had to disaggregate data based on Form 071 for children below 7 and for children 7-14 years old. Now we have some new software and but I cannot see what breakdown it is using. I suspect it has a combined number for adults, but it would be wrong for children's hospitals, but it would be correct for sick leave reports. It takes a long time to sort out and match it all together".*

- *"Collecting information takes most time. Because we have several departments and units, and we all have to collect it. We have to show information broken down essentially by every doctor, and on monthly, quarterly and annual basis – this statistics is provided in order to show the workload. This is a very painstaking and very important work. And we have to collect this statistics every single day. For every doctor we fill in a statistical slip and process it. It is an entire analytical system which we use, but we do it all the time".*

Indicator ME-36. Capacity for data collection and statistical analysis

Provision of quality statistics requires sufficiently skilled human resources as well as adequate data processing technologies. The capacity of the facilities for effective healthcare information management relies on two major factors. First, the staff involved in data recording and processing should have relevant knowledge and skills. Second, data recording and exchange should rely, to the extent possible, on effective data processing technologies such as software-based systems, to decrease paperwork, prevent reporting errors, and facilitate data processing to improve service quality.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
How successful is HMIS work on implementation of computer-based MIS and technologies in the facility?	% HMIS who confirm that they work on this issue and believe that it is working very well or ok	12.5%	Grade D
HMIS specialists in the facilities receive effective professional training	% HMIS specialists who participated in professional training by local or regional MEI authorities during the last year and found it really effective or rather effective	80.0%	Grade A
Do doctors and nurses receive any training, support, consulting and advice in how to compile statistical records?	% Doctors & nurses confirming that they receive such support	60.5%	Grade B
How problematic are deficits of qualified personnel, equipment and knowledge of modern approaches in medical statistics in the process of data collection?	% HMIS specialists who list at least one of these problems as top-3 biggest barriers to high quality data collection and processing	70.0%	Grade C
Overall Grade			**Grade C+**

The level of professional training among the HMIS specialists in Ukraine is relatively high. 80.0% of the facility statisticians interviewed for this study have confirmed that they had received professional training by local or regional MEI authorities during the last year and found it very or relatively effective. The HMIS specialists participate in seminars and workshops organized at the regional level. Usually, the training is focused on explanation of the nuances of the latest forms and any new software introduced in the facilities. During the training statisticians can engage in discussions about new forms or indicators proposed for further monitoring. Moreover, support in compilation of statistical records is regularly provided to 60.5% of doctors and nurses.

Whenever statistical units complain about the lack of qualified personnel, they imply that most staff are elderly which, in their view, makes it difficult for them to master new technologies. In many instances, HMIS specialists explained that a significant number of staff are above pensionable age, which makes them less flexible to new approaches as well as to the need to produce data quickly and reliably.

- *"Our facility is full of pensioners; some people are above 80 years. It is sometimes difficult to work with such people and to explain new concepts to them".*

- *"To answer the question on personnel qualifications, I will tell you one thing – and you make your own judgment. In our department there are 7 people, and 2 of them are approaching pensionable age, while all others are pensioners already. If one of them is sick, we are dead, we don't have anyone to fill in. A good medical statistician should be able to produce quality data in a timely and accurate manner. But here we cannot attract qualified, young, competitive IT specialists; because of low salaries (UAH 1000!) What can we say? This is the state of our department."*

However, most of the facilities find utilization of IT unsatisfactory, complaining about problems in using current MoH applications as well as lack of hardware. Most of the facilities say they wish they had more computers, but many are also concerned about weaknesses in the software they currently use for the production of standardized reports. Some are experiencing problems because the MoH software still lacks some applications, while others explain that existing applications are not always compatible and relevant.

- *"Sure we need more computers, but also we have problems with the software. We receive new software applications, but they are inconsistent with the old ones. We need an operating system which will support all of the IT applications we have to use, which will allow all the statistics to match together. Our IT systems need improvement."*

- *"Working with IT applications takes a lot of time. They are not well thought-through."*

- *"Our software needs improvement; we have some applications to manage information on human resources and medical statistics, but we still lack applications for in-patient and out-patient care, we don't yet have an electronic signature."*

- *"IT needs a lot of improvement. I initiated and paid for installing an IT system in our facility at my personal cost, I bought an internet connection with my own funds, and the software. This whole idea was not of any interest to the management."*

- *"Paperwork is a considerable problem, but paper is more reliable. We are not ready to stop using paper documentation yet."*

- *"In principle, our work could be improved if it was better computerized. Here is an example. We installed new software, but it is not really suitable for children's hospitals, it is more suitable for adults. It is called Ukrmedsoft. I receive statistical slips, but working with them takes a lot of time. The reason is because we have to process all of the manually. If only we could input them immediately as we receive them, and the system would automatically cross-check them (e.g. for duplication), this would save so much time. But right now, I have to check for all duplications manually. So, we just hope it will change at some point. You know, in principle we are kind of living in the 21st century... But to achieve it, we need computers in all departments, in the registry, and they all should be connected through the web. At the moment, this is not realistic."*

Use of information

Indicator ME-37. Use of use of statistics by healthcare professionals

An important function of HMIS is to provide epidemiological data and essential feedback to health workers to help them improve treatment quality. While many of the medical statistics may be used at the policy-making level, they also have a critical role for frontline service providers. Up-to-date knowledge of the epidemiological context, including trends, risks and factors, patients' records, as

well as feedback information reflecting the effectiveness of treatment are essential for the doctors to improve the quality of services, avoid medical errors and learn from them. Moreover, collecting relevant and useful primary information increases the motivation of the clinical staff to effectively participate in data management processes.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Do medical workers in the facilities consider that collected data has convenient format, is useful and relevant, allows them to track patient records, and is reliable (in terms of trusted records by other doctors and trusted medical data)?	% Doctors % Nurses who positively assessed least 4 of these 5 criteria?	51.5%	Grade B
Mismatch between data available and data which would be useful to medical workers and particularly physicians in their day to day work	The questionnaire included three questions on data available, data which would be useful; and data which doctors and nurses find useless. These questions revealed a deep mismatch between information collected and information which would be useful		D
Overall Grade			**Grade C**

Although most healthcare staff has easy access to the collected data, they rarely find it useful. The majority of facilities (82.1% of the interviewed sample) have a regular practice of presenting collected data to their medical staff. However, only in 51.5% of the interviewed doctors and nurses find this data useful, relevant and reliable enough to be used in their practical work. Almost half of the health workers consider data collection to be a tax on their time imposed for the purposes of nation-wide analysis, and they do not think that any of these data could be used at the level of practical service delivery.

- *"This information is not for us, it goes up - it is not at all useful for us as practitioners."*

- *"Statistical analysis and actual treatment of patients are not at all related; these are two parallel processes which never intersect."*

- *"These data have no use whatsoever for practical work and for the health of the patients. But it is very useful for the managers because it helps them to plan their activities."*

- *"I personally need this data only once every few years when I have to go through the next recertification cycle; I need to submit a self-assessment form and I use the statistics to illustrate my work with some numbers."*

Of all primary data which doctors and nurses record, some are believed to be especially irrelevant and time-consuming. Healthcare workers mention various statistical tasks, which they find redundant, but some of these are quoted repeatedly as summarized below:

Issue	Background	Opinion of Doctors and Nurses
Duplication		- *"There is a lot of duplication; the same numbers are repeated in several forms that we have to fill in."*
Statistical slips	The statistical Slip for Recording Final and Amended Diagnoses (Form 025-2/o) is one of the elements within the Out-patient medical card. *This* is the key medical document for all patients who receive out-patient or home-based care. It is completed for every patient at the time of his/her first visit to a medical facility. The facility has one medical card for each patient regardless of the number of doctors who attended the case (one or several).	- *"Statistical slips are at all unnecessary, and they really have to be handled by someone else, not doctors."* - *"Annual submission of statistical slips is totally useless. Once we have submitted a statistical slip about one patient, that should be enough, it makes no sense to submit it every year. They should undertake a big review of all statistical slips, remove the slips of those who left in-patient care or died, and maintain one database, rather than request these statistical slips every year. It is a huge waste of paper and a big nonsense."* - *"Statistical slips are so useless; simply copy-pasting the same things from one year to another; I can't think how much paper and how many pens we waste doing it."*
Data on numbers of hospital beds, bed-days (stock and flow)	Summary register for recording the flows of patients, changes in the stock of beds in the in-patient care / department, or profile of beds is filled in by Chief Nurse of the medical facility (in all hospitals, in-patient dispensaries and research institutes, clinics of medical universities, military hospitals etc). The register contains the following information**:** - Number of beds based on the facility budget; - Number of "monthly average beds" and "annual average beds"; - Number of patients admitted; - Number of patients discharged or transferred (noting which amount of them lives in villages and which amount of them are children); - Number of bed-days; - Number of patients at the end of the reporting period. Usage and Storage: Data contained in *Form No 016/o* is used to fill in *Form No 20 "Report of the Treatment and Prevention*	- *"The most useless data is on beds and bed-days. The duration of in-patient stay strongly depends on individual cases, some patients need more time for treatment than others; one person may recover in 5 days, another needs 10-15 days. But we are being tortured to show in our reports that every patient must stay in the hospital precisely for 10 days. This is useless."* - *"The core useless and unnecessary indicator is bed-days".*

	Facility" (Section III "Stock of Beds and its Usage"). [163]	
Cost of medicine	Not covered by national legislation	- *"Our doctors have to submit reports on the cost of utilized medicines. We need to report how much insulin we have used, how much it cost. Why do we have to do it? It should be a task for accountants; doctors should not have anything to do with the money. The medicine is provided by the Chief Nurse, the doctors should not even care about it. But all these reports are made by the doctors – all the prices, for each portion of the medications."*
Utilization of medical supplies and description of medical operations		- *"There are lots of these useless reports; we are fighting with these out dated statistics which originate from orders made during the USSR. For example I have to record how much cotton wool I use every day, how many bandages. At the end of every day I write a report: 'during this day I have issued 100 g of cotton-wool'. Who needs it? And the same for syringes, for gloves. We register each one and then have to report how we used each one, and a report on utilization of every item goes to the accountants, including constant reports on how much is left in stock. But we are talking about tiny items such as plastic non-reusable water-cups! We need to report exactly when we have cleaned the floor, when we sterilized the floor. But it is so easy to write it down even if it was never done! Still, they insist that every light bulb needs to be in the log. We also need to record the temperature in the refrigerators, the humidity in the wards. And we sit and write, and write. But what does it change? I don't know why they need it, it tells so little, but maybe they don't trust us. In this country people don't trust actions, they only trust what is written in paper. And if we make corrections in the reports, we are punished; we have to be very accurate. You see, even if we boil water – we always make a record: at what time and day it happened; we have a little slip on every container – it shows the time at which it was filled and when the content was changed. I can't describe how much time of the nurses is spent on writing all these slips".*

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[163] See MoH Order № 760 of 27.12.2005

Doctors believe that the data currently being gathered data has fundamental gaps which make it difficult to use it for meaningful analysis of service delivery. While medical staff is generally supportive of the need to use statistical analysis to improve services, they believe that current indicators and benchmarks used in the statistical reports are meaningless:

First, the data fails to take into account the complexity of factors which affect service quality at the level of facilities.

- *"The multiplicity of the indicators we help to monitor lack a comprehensive, logical approach to analysis of how medical facilities are working. This data does not show the real picture; these annual reports would leave you puzzled – why do you have so many people dying? Because they fail to show, for example, the state of the patients when we admit them. For example there is a rayon hospital right near the big road, and they accept all those with car accident-related injuries, so they have a very high mortality rate. But we can't see whether it is because of the accident, or because of equipment shortages, or a lack of staff skills."*

Second, the fact that the data collection process largely serves the purpose of blaming and shaming means that data is being manipulated, which makes it useless for the practitioners.

- *"We collect a lot of redundant data, and the main thing we need is to stop evaluating the facilities based on some artificial indicators. Because there are these far-fetched benchmarks and all the statistics are faked to comply with them. For example we have this goal to reduce cancer-related mortality. And our statistic for this indicator is lower than in European countries – in Europe it is 25%, and we have it at 12%. Because if we admit that we also have 25%, it will lead to difficult social consequences."*

- *"These days a person in this country has trouble finding a disease to die of. Because the cardiologist will shout 'No, no, this was not because of my disease!', The oncologist will say 'Oh yeah? Where is the verification?' and so on. So, only if we could suddenly have a universal open autopsy and see all dead people, would we see the true picture. The indicators on fertility and child mortality are used to evaluate facilities and evaluate oblasts, and of course they will reduce the number of deaths and increase the number of still-births".*

Third, the data is being collected based on an out dated vision of treatment analysis: the way medical statistics are compiled often focuses on symptoms and consequences rather than causes of diseases and deaths.

- *"I don't really trust the statistics, because I doubt that they reflect the true picture. And the reason is that they are collected in the wrong way. For example our statistics state that most of our deaths are because of cardio-vascular diseases. But of course the heart has to stop when the person dies! But it does not mean that the heart failure was the cause of death. And if the person is old, especially like 90 years old, usually the records say that she or he died of heart failure."*

- *"Our statistics is not really accurate. For example in Western countries, if a person dies of pneumonia developed as a result of the flu, they say that the cause of death was flu. But in our system, it would be recorded as pneumonia. We record consequences, not true causes. But this is not a problem of statistical systems, it is a bigger problem of our healthcare."*

The biggest problem with using current medical statistics for frontline service delivery is that they lack two principal components needed by the doctors: (a) reliable and relevant epidemiological data and (b) information on a patient's history in other facilities. A majority of the doctors explained that the nature of the information they collect is different from what they actually need in their work: "*morbidity data and data on the consequences of the treatment*". However, this data is lacking, unreliable or strictly classified. While doctors have full access to indicators they don't trust and appreciate, "*useless, meaningless data",* they need and miss information which is *"classified and*

impossible to get". Many of them admit that making this data accessible would require a considerable change in the way data is collected and shared; it needs to focus on other aspects of service delivery and it has to be shared horizontally via new computerized systems of information exchange.

Data collection And data sharing gaps	Opinion for doctors
Personal medical history before admission	*"There should be a computerized database which would help us to understand medical background of our patients. And there is no way to do it without a proper IT system, it should not be written by hand."*
Allergic background	*"Information on allergies of individual patients to be shown in their individual medical records and which would be consistently filled in by all doctors and facilities where this person receives treatment".*
Life history	*"I need to know basic facts: has the patient smoked or was he addicted to alcohol? What is his occupation – perhaps it has affected the illness and/or his condition? What is his financial state? I need to know this because I am prescribing the medications, and I am not sure whether the patients will use it or not, they do not always tell me that they don't have the money to buy it. And if I knew, I would have tried to find an alternative treatment."*
Family medical history	*"For family doctors and nurses it is important to know whether the families of their patients have any issues with substance abuse, mental illnesses, and other important medical facts."*
Medical information collected during the treatment (exchange between staff, departments and facilities)	
Medical history collected by the doctors to be shared with the nurses	*"As a nurse, I would benefit from knowing the patient's previous illnesses, but this information is collected by the doctors and it is not shared with the nurses, unless we become curious and convince the doctors to share it."*
Test results undertaken in other facilities	*"It would be really great to have the test results, but it depends on what kind of tests we can do in our facilities – because we do not have access to tests made in other facilities."*
Nature and results of parallel treatment in other facilities	*"It would be good to know if the patient is seeking help in other facilities in addition to ours. If the patient wants to share, he will share, but if he doesn't, he will not. They go and receive treatment wherever they want: in public or private hospitals, they compare diagnosis, and they don't share it with us. We do not have access to these records. Moreover, patients themselves can distort information and tell us misinformation about their history in other facilities. We don't have access to their medical cards, so the patient may be under treatment somewhere else, and our doctors have no idea, so they prescribe some other parallel treatment, which may be totally different. We don't even know whether it is the first time we are treating the disease or if it was already treated before, where and how."*
Timeliness of medical aid	*"It would be good to see how quickly the help was provided; but no one is monitoring the time between the first request for help and the actual provision of help"*

Frequency and timeliness of reference of patients to in-patient care	*"We need to track when people are referred to in-patient care; how many times they need to request for help before they are sent to the hospitals."*
Severity of patients condition and complexity of surgeries as an indicator of treatment quality and effectiveness	*"These indicators are not used, even though international scales for monitoring of these indicators exist and they are known, we just have to use them, but we don't. We need to use measurable indicators to track the state in which we received a patient and to analyze the treatment which was delivered."*
Information on whether the patient is HIV-positive and/or has other diseases which affect treatment and safety of medical staff, but which the patients have the right to keep secret	*"The patients have a right to not let anyone know that they have HIV and some other infectious diseases. But people with these higher risks have to have some record in their medical histories, someone has to know, because not knowing that the person has HIV is a big risk for the doctors: we work with the blood and we are not protected, we can get infected. We only need some mark to be aware, that's all."*
Personal medical history after release from facility	*"We need some way to see what happens to the patients after they leave. We need to track the stages of their diseases."*
Development of diseases monitored by specialized dispensaries	*"For doctors, it is important to monitor their patients after they go for further treatment in the specialized dispensaries; but we don't have this information".*
Treatment results	*"I would like to know what share of the children released from our facility has developed any disabilities, and what share of the children recovered and led a healthy life".*
Medical data which covers services provided by facilities of 1st, 2nd and 3rd level.	*"We need this data in a unified set. But there is no unified system for analyzing this data, which we could disaggregate by individual patients or cases, so that it would be useful for our medical conclusions".*
Data on surgeries undertaken by other facilities	*"We would like to know where our patients have operations and what the outcomes are. It would be great to have this information centralized and somehow shared across facilities."*
Further check-up results	*"Maybe we could at least take some signed promises from these high risk patients that they will go and have an X-Ray.. I wish we could at least take their mobile phone numbers to check if they have done anything after our recommendations."*

Indicator ME-38. Use of information in managing healthcare facilities

Administration of healthcare facilities increasingly depends on effective management of in-house medical statistics. Provision of services within hospitals and policlinics involves complex managerial decisions which require diverse information covering individual health records, clinical, epidemiological, financial and administrative functions. To efficiently allocate available resources and to improve overall quality of services, facility executives need functional systems of in-house data management.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Is the statistics collected at the facility level in any way useful for the Chief Doctors and other executives in their managerial work?	% Chief Doctors saying that this statistics is very or rather useful	70.0%	Grade B
Are HMIS departments of the facilities working effectively on collecting medical statistics for the purpose of internal governance and management?	% HMIS specialists who believe that this function of their unit is working well or OK	66.7%	Grade B
Are HMIS departments of the facilities providing effective informational and analytical support for planning, reorganizing and developing facility activities?	% HMIS specialists who believe that this function of their unit is working well or OK	87.5%	Grade A
Overall Grade			Grade B+

Ukraine's healthcare executives greatly appreciate the analytical support they receive from their statistical units. The majority of the interviewed facility executives (70.0%) believed that medical data collected by the facilities is useful for in-house administrative purposes. In most cases, this data is successfully used to plan and develop activities within the facilities (confirmed by 87.5% of respondent), but also for wider purposes of internal governance and management (66.7% of the cases). As illustrated in Figure 57, half of the respondents stated that in-house statistical data is used directly to improve the quality of services, and 30% more Chief Doctors use it to develop positive and negative incentives for the staff (identify and reward good performance and, more often, identify and punish non-performers).

- *"We do analyze the statistics, we discuss them at our medical council – we discuss the reasons for the trends we observe. For example if we see that on one of the areas served by our policlinics mortality went up, we may try to explore why. And usually the Chief Doctor then issues an order to design some measures to address the problem."*

Figure 57. How is facility-level statistics used in the managerial process? (% examples provided by Chief Doctors)
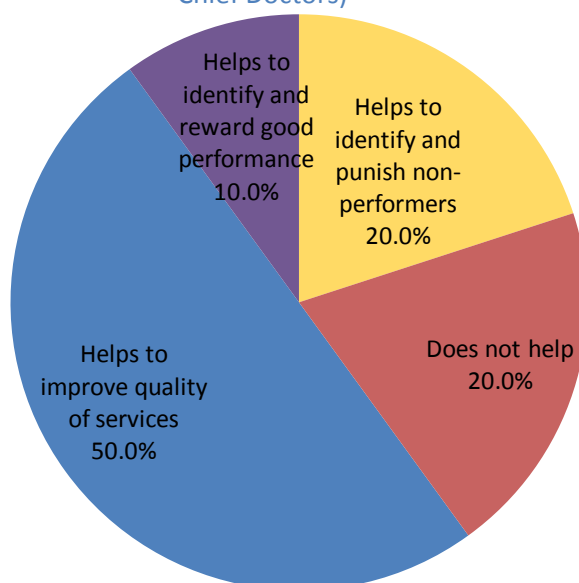
The extent to which statistical data could be used for in-house purposes is somewhat limited by the actual scope of managerial flexibility available to facility executives. The interviewed executives provided examples of using medical information generated by the statistical units for internal governance purposes. These show that Chief Doctors are often underutilizing internal statistical service because they believe that they do not have sufficient influence make relevant managerial decisions. In some cases, they complain that they do not have sufficient flexibility to reallocate funds to acknowledged priorities or to create necessary incentives.

- *"Our Chief Doctor uses data about medical services provision to rank departments in terms of their performance. But then the only chance to use this information is when we receive some gifts from the sponsors, for example a refrigerator or some medicine: these gifts would be allocated to the department which ranked highest."*

- *"The Statistical Unit provides regular reports to the Chief Doctor and others in the team, but it does not really influence any decisions, because there is no funding to implement specific decisions. At the moment, we don't even have enough funds for the wages."*

- *"From the data we see various trends, for example we noticed that people with lower incomes have higher numbers of children, and these children tend to have poorer health, with increased numbers of disabilities and morbidity rates. But there are no decisions or actions in this direction, and there is nothing we can do. Also, we noticed that there is a lot of abuse with people buying fictitious sick leave certificates, but again – there is not much that can be done, and nothing is done. And there are many such examples."*

At the same time, in-house administrative data is routinely used for planning against input-based norms such as utilization of bed-days. Chief Doctors co-operate with the statistical units to plan facility operations. Given that many of the facility operations are dependent on performance against input-based norms such as numbers of occupied beds, these statistics are vital for routine planning and reporting. In other words, facility managers need to track how well they are doing against these norms to provide reports but also to maintain operations at volumes, which would allow them to request sufficient funding:

- *"Of course statistics matters for planning. We compare our operations statistics to previous periods and we see immediately where we need to take action. For example, we might see that in 2011 the execution of our plan for bed-days was 3,000, even though the plan was 3,400; and in 2012 the execution was at 3,800. So, we can immediately report that in the New Year the facility has significantly increased the execution rate of planned bed-days."*

- *"We constantly use statistics to monitor execution of the plan for bed-days."*

Indicator ME-39. Use of information in local healthcare strategic management process

In additional to facility-based clinical consultations, aggregated medical statistics should be effectively shared with the policy makers to inform healthcare priorities at local and national level. Public health information, including aggregated clinical data and facility service statistics, is critical for politicians and healthcare authorities at national and sub-national level to design and evaluate interventions affecting populations of those areas. To supply this data, it is vital for facility-based statistical units to provide complete, timely and standardized returns to their respective authorities. The ultimate test for how well this cooperation is working is whether healthcare policies (local and central) are based on relevant and realistic statistical benchmarks.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Is there any practice of presenting data and/or analysis based on facility medical statistics to local administrators (local state administration including Health Care administrators)?	% Facility Executives confirming that such practice exists	84.6%	Grade A
Is there any practice of presenting data and/or analysis based on facility medical statistics to local political representatives (city / rayon / oblast council)?	% Facility Executives confirming that such practice exists	30.8%	Grade C
Are there performance targets specified in the local health plan (for example, targets on percentage of children who need to be covered with immunization or in terms of prevention and control of non-communicable diseases) and are these targets realistic?	% Oblast CMS specialists who confirm that the local health plan contains targets and these targets are realistic	75.5%	Grade A
Does the local CMS participate in the planning activities of the local Healthcare department, in the decision making process by the Healthcare department, and in any of the monitoring which the department conducts, and is this participation helpful?	% Local CMS specialists who confirm participation in all of these activities and who consider such co-operation always or in most cases effective	100.0%	Grade A
Overall Grade			Grade B+

Local CMSs and local healthcare authorities reported that they always receive complete and timely aggregated reports with facility-level data. Without exception, facility-based statisticians consider that the requirements for timely submission of reports to local authorities are performed very well. Moreover, most statisticians (84.6%) explained that this aggregated data is regularly presented to the local administrations, including healthcare authorities. This is confirmed by the fact that 100.0% of the interviewed representatives of local Healthcare Departments were able to quote up-to-date statistics for their area covering TB detection rate; TB cure rate; measles immunization coverage, maternal mortality rates, and main causes of maternal mortality. Moreover, in 100.0% cases without exception, respondents confirmed that local CMSs regularly participate in decision making processes by local healthcare authorities, their planning and monitoring activities, and that this participation is always or in most cases effective.

Although data is used in local health plans, it is not sufficiently integrated into the local political process and is not always realistic. As was discussed in earlier sections, all of Ukraine's oblast, rayon and city administrations operate on the basis of multi-year healthcare strategy. The survey confirmed that this strategy usually (in 80.0% of interviewed cases) includes up-to-date medical statistics generated with the help of the CMSs; although sometimes development priorities may be specified in general terms and without concrete numerical benchmarks. Examples of indicators used in some strategies include immunization targets, TB check-up targets, or indicators related to maternal and child mortality or cancer detection. Where data is used, many, but not all of the CMSs (75.5%), stated that these targets are realistic vis-a-vis current actual levels of respective indicators. Explanations provided by the CMSs were not certain, sometimes casting doubts over their own

projections. Moreover, as shown in the table below, unlike the CMS, facility level statisticians are not always as confident about the statistics used for local healthcare forecasting. Notably, only 30.8% of the interviews with the CMSs showed that statistical data is shared not only with the administrators but also with local politicians, trying to tangibly influence local priorities.

- *Local Centers for Medical Statistics (CMSs)*	- *Statistical units in the facilities*
- *"Are strategic benchmarks realistic? Well, why would we provoke doctors to fake numbers or take other wrong steps? Nobody needs it. We always try to plan based on the realistic trends which we observe. How do we set these benchmarks? We typically just take the last year's value."* - *"Are the benchmarks realistic? Yes and no. We develop plans, but we don't really know whether they would be achieved. We don't know what will be objective and subjective barriers and obstacles."*	- *"The oblast and city departments often ask us to submit forecasts. But we are statisticians; we are very serious about making forecasts. So, we do our best to make these morbidity forecasts and we submit them as requested. But our forecasts have been returned as unsatisfactory, and instead we have received another set of forecasts. And time had proved that our projections were actually correct, not these imposed on us. But we still had to plan all our activities based on the incorrect forecasts which we received."*

Indicator ME-40. Transparency of performance information

Key service delivery information must be easily available to the general public and civil society, enabling them to voice feedback and influence policies. To effectively engage the population in healthcare policy making and service delivery, representatives of civil society and any other interested parties must have access to information on resources available to healthcare facilities, on facility performance and compliance with service delivery standards. This information should be publicized in a clear and convenient format, and must also be available in more detail upon request.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Are aggregate monitoring/HMIS Reports for whole oblast made public?	% Local HMIS Center specialists who confirm that the information they collect is made public and are able to provide supportive details about frequency, format and examples of such publications	60.0%	Grade B
Is there any practice of presenting data and/or analysis based on facility medical statistics to citizens?	% Chief Doctors who confirm that such practice exists	25.0%	Grade C
Overall Grade			**Grade C+**

Generalized medical statistics are rarely presented to citizens, even though some of it may be specifically requested. Only 25.0% of facility executives are aware of any practices of making medical information available to the general public or civil society. Moreover, many administrators were unwilling to share their facility service delivery plans (*"We cannot share it because we were told by the city Healthcare Department not to share any of our documents with outsiders"*) or, especially, their budgets (*"This is confidential classified information which can only be shared under a special signed order of the Chief Doctor"; "The Budget is not a document to be shared"*). At the level of oblast CMSs, 60.0% of respondents said that aggregated medical data is regularly publicized. Generally, some statistics are shared on ad-hoc basis with the media, and only in few cases are they permanently available on regularly updated web-based sources. For example one of the CMSs considered that the information was freely available, even though it was only accessible as a statistical publication in individual facilities, that citizens could theoretically request to see.

The current supply of public health data is clearly below existing demand levels, since data requests from the public are numerous and growing. Representatives of the CMSs explained that most of the information they share with the public is a response to specific requests, and the number of these requests is very large. This especially rose after the introduction of the new law "On Public Information", which makes it mandatory for all public bodies to respond to information requests.

- *"We are overloaded with requests, and many of them are similar, but we have to respond to each one because of the new Law. During the year after the Law was introduced, the number of requests grew by 60%, including requests from individuals and businesses."*

- *"We receive regular requests and normally we undertake some research in order to respond. For example we had a garbage dump near one of our villages, and the residents of this village sent a request data on the impact of this garbage dump: what types of diseases was the local population suffering from? What were the mortality rates? How many patients?"*

Chapter 6. Procurement

Introduction

Evolution of the current public procurement law

Public procurement has been one of the central issues compromising accountability and transparency of Ukraine's public finance in recent years. Ukraine's current framework Public Procurement Law (PPL) is the product of extensive legislative elaborations including debates with international observers over some of the policies.

- **Until the current PPL was approved in 2010, the country's procurement was suffering from extreme distortions.** A lot of these distortions resulted from lack of transparent state oversight over public procurement. During 2006-2007, central regulatory role in procurement was exercised by a non-public body (the Tender Chamber), which was vulnerable to political influences (through participation of politicians in the Supervisory Commission of the Tender Chamber) and enjoyed disproportional and opaque opportunities to provide commercialized intermediary services to the bidders (e.g. charging them for placing procurement advertisements on its website). The Tender Chamber also had a disproportionate and unaccountable voice in disqualifying particular bidders.

- **In response to strong criticism, the Tender Chamber was eliminated, and during 2008-2009 public procurement was regulated by the Cabinet of Ministers.** This was done under provisional rules and without a comprehensive national legislative framework; the provisional rules ("Provisional regulation on public procurement") could be modified without parliamentary approval and due consultations with any of the stakeholders.

- **Initial attempts to introduce a framework Law during 2010 were also problematic.** The first Draft Law (approved in February 2010) received highly critical feedback from domestic as well as major international observers (including, in particular, the EC and the WB). The draft law planned to establish an Appeals Agency which was highly vulnerable to political influences, introduced excessive control powers for a range of state agencies including the Treasury, the State Financial Inspection, and the Accounting chamber, and contained loopholes such as the potential to remove state enterprises from the remit of the law.

- **Responding to criticism, the President vetoed the initial draft, and after substantial revisions a substantially strengthened PPL was approved in June 2010.** While the approved draft was not perfect, it did reflect most of the recommendations and generally represented a breakthrough in Ukraine's approach to public procurement. The regulatory authority was handed to the national Authorized Agency (the Ministry of Economy); the Appeals Agency lost the chance to include parliamentary and ministerial members and was transferred to work under the Anti-Monopoly committee. Another highly positive change was the introduction of free open access to public procurement information on the official web-site.

- **Since 2010 to this day, the relatively progressive PPL was repeatedly modified, with most changes being highly retrograde.** As was stated in the recent report by Ukraine's Accounting Chamber, the PPL was modified 17 times during 2011-2012, with amendments which "created significant distortions of the principles of competitiveness and efficiency in the use of public funds" (Accounting Chamber of Ukraine 2013). In 2011, the Law was modified to eliminate the requirement to agree non-competitive procurement with the Ministry of Economy. Most alarmingly, the law has been amended to exclude a growing range of

procurement types from the application of the PPL remit. One of the biggest procurement segments which was exempt from application of the PPL competitive bidding requirements included all public procurement related to the county's preparation to hosting Euro 2012 football championship. Moreover, in 2012 the Law was changed to exempt most of state-owned enterprises from procurement through competitive procedures and to allow non-competitive procurement for a new range of goods and services. Information on procurement by state enterprises was removed from free public access.

Overall in public procurement at the moment, the share of competitively procured goods and services is shrinking. This study did not succeed in collecting exact statistics on procurement from the interviews as most respondents felt highly vulnerable in showing any documents or data. However, statistics available in the media (Marusov 2012) shows that in the first half of 2012 open tenders represented less than a half of all procurement (45%) and this number was lower than the share of non-competitive purchases for the first time since 2007 (see Figure 58). The data also shows that these two types of procurement represent the bulk of all operations; other procurement methods (competitive negotiations, two-stage bidding and restricted tenders) are visibly underutilized.

Figure 58. Public procurement in 2007-2012 (reproduced from (Marusov 2012))

	2007	2008	2009	2010	2022	1st half of 2012
Total public procurement (UAH bln)	142.3	167.3	105.3	172.1	325.1	222.7
Including:						
Open tenders (%)	39%	44%	67%	56%	67%	45%
Non-competitive procurement (%)	53%	48%	28%	41%	30%	54%
Competitive negotiations (%)	3%	1%	2%	1.4%	0.5%	0.3%
Two-stage bidding (%)	1%	3%	1%	0.4%	2%	0%
Restricted tenders (%)	-	-	-	-	1%	0.3%
Restricted negotiations (%)	1%	1%	1%	1%	-	-
Reverse auction (%)	3%	3%	1%		-	-

Public procurement in healthcare

Healthcare facilities fall under the remit of the PPL and began to practice sufficiently improved procurement rules since 2010. Procurement of goods and services by medical service providers funded from the budget is regulated by the PPL and does not fall under any of the major retrograde exemptions introduced in 2010-2012. Respectively, most of the procurement (except small value purchases) has to be undertaken through open tenders; following all respective procedures such as open publication of related information, opportunities for appeal, and procurement audit. Even procurement of services from monopolistic providers at the local level (e.g. for utility services) have to be purchased through a tender process (which was strongly criticized by most interviewees in this study).

While some products are procured by the facilities directly, substantial share of the procurement is centralized. As will be discussed in detail in this Chapter, facilities purchase most of their key supplies (medical products, food, utilities) directly and some of their procurement is centralized at the level of local administrations (especially expensive items such as equipment). In addition, facilities use a range of supplies (vaccines, tests and reagents, supplies for treatment of cancer patients, implants and tools and equipment for implant placement, glycaemic level tests, medical products used in treatment of cardio-vascular diseases etc) purchased at the central level through national targeted programs.

Regulatory guidance

Indicator PR-41. Transparency and clarity of regulatory guidelines for public procurement in health sector

Explicit regulations for public procurement of medical products create a level playing field for competing suppliers, ensuring against corruption and helping to get the best prices. Openness, comprehensiveness and quality of procurement regulations are the number one requirement for a well-functioning procurement system. Scope and nature of the legislative framework for public procurement is described by Pillar I of the OECD Methodology for Assessing Procurement Systems (MAPS) (OECD 2010) and identified as the first Indicator (VII.1) within the WHO Instrument for Measuring transparency in public pharmaceutical sector (WHO 2009). Specifically for medical procurement, the WHO best practice recommendation is for the national legislation to provide clear and written guideline instructing procurement officers which of the four key procurement methods they should apply: open tender, restricted tender, competitive negotiations or direct procurement. The OECD Methodology additionally highlights that assessment of regulatory environment should include high-level national legislation as well as implementation procedures used at all lower levels, including the actual rules in use for particular procurement processes and procedures.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Does the central government use transparent and explicit procedures for public procurement in health sector and clearly specify procurement method to be used?	National procurement legislation	Clear guidelines separating four key methods of procurement	Grade A
Is the current guidance on the choice of procurement method sufficiently specified by types of products?	% TC members who confirm that guidelines on the choice of procurement methods are sufficiently specified	37.3%	Grade C
Are current rules for competitive procurement methods operational and working well in practice?	% TC members who believe that legislation guiding competitive procurement is implemented very well or in a way which could be only slightly improved	75.0%	Grade A
Overall Grade			**Grade B+**

Ukraine's Law on Public Procurement describes key procurement methods, clearly separating between grounds for competitive and non-competitive methods. Ukraine's current Public Procurement Law (PPL)[164], introduced in 2010, defines five methods for public procurement above specified threshold[165] and describes situations when each of the five methods should be applied, as well as key requirements and the process. Importantly, the Law clearly distinguishes between competitive and non-competitive procurement, and imposes a strict and clear limit on the application of non-competitive methods.

- The default procurement method is open tender[166] (or restricted tender[167] if but with qualification requirements limited to supplier's material resources, equipment, human capacity in terms of skill and experience, corporate experience and financial capacity).

- Where precise technical specification for the procurement cannot be defined without prior negotiations with the suppliers, the PPL allows two-stage bidding, but only for services related to construction, scientific research and development[168].

- Purchases below UAH 200 thousand for goods and services available through a functional market could be done through competitive negotiations, but, again, based on a clearly regulated procedure (minimum three competitive proposals; publication of the invitation for proposals in a national procurement newspaper and Government website, exact requirements to content and timing of every stage etc).

- Direct single-source procurement is allowed in exceptional cases for strictly specified types of procurement[169] (e.g. procurement works of art, contracts with winners of artistic or research competitions, procurement from monopolistic suppliers, emergency supplies, repeated failure to find suppliers through open tenders, additional procurement from previous suppliers if this is unavoidable for technical reasons etc).

While the PPL clearly specifies cases when competitive methods must be applied, procurement specialists often lack precise guidance on particular modalities of competitive procurement. Surveyed procurement specialists in Ukraine are fully aware of the PPL and the basic requirements related to procurement methods. However, only 37.3% of the interviewed specialists believe that within competitive methods this guidance is always sufficient. In particular, choosing between one-stage and two-stage bidding, open and restricted tenders, and regular or reverse auction tenders is sometimes not straightforward.

At the same time, majority of procurement specialists believe that regulations on competitive procurement are always applied and are working strongly. Most respondents (75.0%) believe that despite some technical questions arising in the process of application of current procurement legislation, the legislation is robust and is routinely applied. In fact, some procurement specialists are rather annoyed with having to comply with the regulations and complain over the additional paperwork they now have to undertake. Some of them mention that with the new procurement legislation, many facilities "lost interest" in being responsible for procurement and they gladly agree to delegate large procurement which requires competitive bidding to centralized purchases via the local administration.

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[164] Law of Ukraine "On Public Procurement" No 2289-VI, approved on 01.06.2010, latest amendments 09.05.2013; http://zakon0.rada.gov.ua/laws/show/2289-17
[165] UAH 100 thousand for procurement of goods (UAH 300 thousand for construction) and UAH 1 million for procurement of works
[166] Chapter IV of the PPL
[167] Chapter VII of the PPL
[168] Chapter V of the PPL
[169] Chapter VIII of the PPL

- *"Hospitals are not very happy to deal with large procurement because of the tenders. They are very happy to give this function away to the administration."*.

Where hospitals complain over the rigidity of the procurement process, the origin of the rigidity is usually budget legislation rather than procurement legislation. The PPL requires all facilities to follow an annual procurement plan which has to be attached to the facilities budget and submitted to the Treasury within the annual budget planning process. Additional regulation by the Ministry of Economic Development and Trade demands that procurement plan must cover both procurement above PPL threshold (as the Plan's main part) and any procurement below the threshold (as an Annex)[170]. This requirement reflects overall rigidity of facility budget preparation guidelines described in the Chapter on Planning and Budget. Lack of flexibility over the planned amounts of individual items to be procured is strongly criticized by the interviewed procurement specialists. However, this dissatisfaction is primarily related to the overall problem of central mandates in the budgeting process rather than procurement legislation as such.

- *"The biggest problem with tenders is that we need to plan every single item in advance, every little ampoule. How can we plan such things? But we have to, and then we cannot change anything."*

Small value procurement which falls below PPL application threshold is conducted without clear rules and often based on opaque approaches (e.g. favouring "traditional suppliers"). As was noted earlier, Ukraine's PPL is applied to procurement above an established threshold: UAH 100 thousand or procurement of goods (UAH 300 thousand for procurement of goods in construction) and UAH 1 million for procurement of works. There are no centrally defined rules for procurement below this threshold. The survey revealed that in the overwhelming amount of cases, neither local governments nor the facilities develop any additional procedures or even broad principles to regulate such small value procurement. Such additional written rules for small value procurement were reported only by one of the respondents, who mentioned that their facility management has an approved procedure which includes analysis of costs and value of alternative options for all purchases below the PPL threshold. In most other cases, decisions were ad hoc and often *"based on established practice"* (implying contracts with traditional suppliers)*.

Procurement cycle

Indicator PR-42. Methodology for determining quantities of pharmaceuticals to be purchased

To minimize risks of kickbacks by suppliers for unjustified purchases of pharmaceuticals, purchased amounts should be determined based on objective quantification method. One of the specific requirement to medical procurement is the need to apply a transparent and objective methodology to calculate the amounts of pharmaceuticals to be purchased. In the absence of such methodology, procurement officers become vulnerable to the risks of accepting payoffs from suppliers for purchasing unjustified amounts of specific pharmaceuticals. This can distort the composition of purchased drugs, creating over-supply of unnecessary products and under-supply of other essential items. To avoid this, hospitals can use several objective quantification methods to define the amounts of their pharmaceutical procurement: consumption (based on historical data), morbidity-based, adjusted consumption, and service-level projection. Regardless of the chosen method or their combination, the methodology should be clearly documented and based on objective criteria (WHO 2009).

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[170] Ministry of Economic Development and Trade, Instruction on filling in the template for annual procurement plan, document number 428, approved 27.12.2011.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Is there a clearly specified rule for quantification to determine the quantity of pharmaceuticals to be purchased?	% Procurement specialists who confirmed that there is such rule (written or informal but regularly applied)	62.5%	Grade B
Does quantification rely on objective parameters (such as historical consumption data, projections of future service amounts and consumption levels, morbidity data) rather than subjective factors?	% Procurement specialists who listed subjective factors among top-three factors influencing their calculations of procured medicines	87.5%	Grade D
Overall Grade			**Grade C**

Calculation of amounts of purchased pharmaceuticals in Ukraine is usually subject to some rules, but they are not complete and sometimes contradicting, leaving space for manipulations. As was discussed earlier in Chapter 3, budget planning at the facility level is subject to a range of detailed input-based norms:

- **On the one hand, this includes several requirements to the types of medications that should be provided by the facilities.** For example, the MoH No 500 establishes a detailed list and amounts of medications which must be available to any emergency aid brigade[171]. Moreover, several privileged population groups (children, disabled, victims of Chornobyl disaster, war and labour veterans, certain categories of pensioners etc) with a specified range of diseases are entitled to free or discounted provision of medications in out-patient care[172], based on the essential drug list approved by the Cabinet of Ministers[173]. Concrete types of medications are also listed in the clinical protocols which are being currently introduced by the MoH[174].

- **On the other hand, budget preparation guidelines[175] require facilities to link their calculation of expenditures of procured drugs[176] to the amount of bed-days and patient**

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[171] Ministry of Health Order No 500 of 29.08.2008 "On measures to improve emergency medical aid to Ukraine's population", http://www.mediline.lviv.ua/html/iieiaeaiiij_idi_noaio3p_oaeaei__iaae_ii__aiiiiiae-_iadae3e_e3e3a.html

[172] Cabinet of Ministers Resolution No 1303 of 17.08.1998. "On procedures for free and privileged provision of medications prescribed by doctors for out-patient treatment of certain population groups with certain disease categories", http://zakon4.rada.gov.ua/laws/show/1303-98-%D0%BF

[173] "List of domestic and foreign medications which could be purchased by budget-funded healthcare facilities", approved by Cabinet of Ministers Resolution No 1071 of 05.09.1996., http://zakon4.rada.gov.ua/laws/show/1071-96-%D0%BF

[174] For an example see http://medstandart.net/browse/2464.

[175] These guidelines are established by the *Methodological recommendations on planning and utilising budget funds for provision of medical help by health facilities (or "Methodological recommendations on expenditure planning)*. While not mandatory in theory, these Recommendations are strongly endorsed by the MoH. The Recommendations do not have a legal mandate and exist as a research paper developed by the MoH jointly with the MoH Institute of Strategic Research. However, this document was developed by the MoH in response to a clear regulatory request from the Cabinet of Ministers (stated within the CoM Resolution No 208 of 17.02.2010 *"On Selected issues for improvement of the Health system"*). None

visits in the facility. As with other types of expenditures, facilities need to explain how these per-bed expenditures were defined, including a specification of respective drugs.

- **Given the limited budgets, facilities are de facto forced to apply the norms selectively, which creates discretion in defining amounts of individual types of drugs.** Given that actual budget allocations are usually much smaller than the amount of drugs demanded by the MoH and CoM norms, the expenditure justifications provided by the facilities usually assume that facility executives will exercise some discretion in the precise choice of essential drugs they would purchase. Chapter 3 provided an example how a hypothetical facility would normally deal with the norms for the use of medications for one emergency aid call for a case of hypertensive crisis based on the options within the essential drug list (Bendazol, Papaverine, Magnesium, Analgin, Lasix, syringes and spirit). This required basic set of medications at current prices might imply spending at UAH 4.62, but the actual amount allocated for this purpose in the budget would be around UAH 1.62 or 35% of the full need. In order to comply with the norms within limited budgets, facilities need to show what reduced essential package of medications would be used instead, perhaps procuring only some of the needed medications rather than the full package. In this way, facility executives receive a leeway in choosing between the individual types of drugs which they can use without particular rules.

This legislative controversy is reflected in mixed responses of procurement specialists, 62.5% of whom confirm that some rules for quantification are routinely applied. Majority of interviewed procurement officers confirmed that they always apply some rule for quantification of procurement amounts; half of the sample said that this rule is informal and 12.5% referred to written procedures. When prompted, they usually mentioned various central regulations (such as the above listed MoH Order No 500) and regulations which establish free drug provision for privileged groups.

At the same time, subjective factors are also playing a strong role in most cases. Majority of procurement officers (87.5%) explained that while calculations take into account a range of rules and follow a certain established pattern, subjective judgment is still one of the three strongest factors influencing the ultimate amounts to be procured. For example, this could be *"opinion of the oblast-level specialists", "negotiations with other hospitals/service providers"* or *"analysis of the budget constraints and finding ways to supply essential drugs within available funds."*

- *"Most of the manipulations happen at the stage of planning… Somehow plans are developed to purchase very questionable amounts of various products. It would be good to make this stage much more transparent".*

Very often, procurement is justified with perceived social priorities, which disguises the fact that it still represents a subjective judgment rather than rules-based approach. Having to find a balance between impossible norms and limited budgets, most procurement officers explain their approaches to defining amounts of procured pharmaceuticals by their understanding of most acute social priorities. For example, in many cases composition of procured drugs is defined *"so that the facility could provide free services to the most deprived population groups"*. While this approach is understandable in principle, it is not based on any transparent formula and easily lends itself to manipulations. Relatively more objective approaches include the rule to *"prioritize"* purchases of narcotic analgesics (opiates) (since these drugs could not be purchased by the patients directly) and/or *"prioritize"* procurement of medications used by the emergency care (again, based on the logic that there are fewer possibilities to request patients to buy these mediations directly).

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of these documents explains whether the Recommendations are mandatory, but the overall tone of the Recommendations is highly imperative.

[176] Code of economic classification 1132

Indicator PR-43. Functionality and independence of the Tender Committee

Review of suppliers and selection of winning bids should be done by a capable Tender Committee, whose functions are clearly separated from those of the Procurement Office. WHO highlights that there are several functions in the procurement cycle which must be clearly separated between a Procurement Office and a Tender Committee[177]. In particular, the Procurement Office must be responsible for the preparation of the tender (including specification of the needs in terms of the composition and amounts of products to be purchased), management of the tender process and actual administration of the contract including supplier performance monitoring. All tasks related to review of information on suppliers and selecting suppliers for participation in the tender, as well as the actual tender awards, must be performed by an institutionally distinct Tender Committee. This separation prevents conflict of interest, limiting the possibilities for the Procurement Office to influence the outcomes of the tender by manipulating with the specification of purchased goods, distorting qualification requirements for the suppliers or artificially increasing quantities of some purchases (WHO 2009).

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Is there a Tender Committee which leads procurement undertaken based on competitive methods?	% Procurement officers which deal with competitive procurement (above PPL threshold) who confirm existence and functionality of a TC	100.0%	Grade A
Are the key functions of the Procurement Office and those of the Tender Committee clearly separated?	% Procurement officers who confirm that the functions of the PO and the TC are separated	0.0%	Grade D
Overall Grade			**Grade C+**

Ukraine's PPL requires every organization engaged in public procurement above the PPL threshold to establish a Tender Committee, and this rule is universally applied. Any procurement above the PPL threshold has to be led by a Tender Committee[178] organized by the procuring agency and composed of its staff. The Tender Committee has to have at least five members, including a chair and a secretary who both must receive training in public procurement (although training for other TC members is also welcome). All facilities interviewed by this study who undertook procurement above PPL threshold had duly organized respective TCs (one of the interviewed facilities was rather small, had all its procurement below the PPL threshold and therefore had no TC).

The PPL does not assume that PO and TC functions should be separated, and essentially understands these two offices as one. The PPL lists TC functions which essentially include the entire procurement cycle[179]. It does not distinguish between preparation of the tender and decisions on awards. In particular, the TC is responsible for: planning of the procurement process; development of the annual procurement plan; choice of procurement method; assessment of prior qualification of the bidders in case of restricted tenders; oversees fairness and transparency of the procurement

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[177] These issues are covered by Indicator VII.5 of the WHO Instrument for Measuring Transparency in the Public Pharmaceutical Sector.

[178] «Комітет з конкурсних торгів»

[179] Article 11

process; selects bidders who receive awards; ensures due procurement records and monitoring. The PPL also states that in cases if procuring agencies have less than five people needed for a TC, all of the procurement office personnel should be enlisted as TC members.

Respectively, in none of the surveyed organizations the TC function related to selection of the bidders were separated from other functions in the procurement cycle. As a rule, facilities do not have procurement offices as such, and TCs are composed of accountants, doctors and other regular staff. The TC covers the whole range of tasks related to procurement and its members are personally responsible for the quality of delivering these tasks. At the same time, membership in a TC does not absolve these staff from their regular duties, which creates an enormous pressure on their time and was the subject of biggest dissatisfaction in the interviews. In some cases, certain functions of the TC may be delegated to specific facility units (e.g. accounting office is frequently helping with the calculations of procured goods and services and reconciles these amounts with the budget constraints; legal units may help with identification of procurement methods based on current regulations; management of the contracts such as inspection of consignments may be done by senior nurses). However, all TCs interviewed in this survey retained at least two or three of the potentially conflicting roles.

- *"For us as a Tender Committee, the biggest problem is that we don't have any special unit which would help us with technical tasks. What we are doing for procurement is usually in strong conflict with our regular duties, it really makes it difficult for us to work on our posts."*

- *"If I had the opportunity to recommend any changes in this system, I would start by introducing specific posts for people to deal exclusively with procurement."*

Indicator PR-44. Objective criteria for Tender Committee membership

Members of the Tender Committee should be selected based on objective criteria reflecting professional merit and absence of conflicting interests. Given the decisive role of the Tender Committee in the procurement process, transparent selection of its members is critical for ensuring against unethical behavior. Most importantly, selection criteria must be clearly outlined and duly implemented. It is also important for these criteria to include a provision against potential conflict of interest. Additionally, the quality of decisions increases if the criteria ensure professional merit and plurality of representation in the Tender Committee, as well as periodic rotation of the members (WHO 2009)[180].

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Are there specific and transparent criteria for Tender Committee membership which include a provision against Conflict of Interest, a requirement of periodic rotation, and a requirement related to professional merit?	National regulations	PPL lists TC membership requirements but they are limited to no-CoI only	Grade C

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[180] These issues are covered by Indicator VII.7 and VII.9 of the WHO Instrument for Measuring Transparency in the Public Pharmaceutical Sector.

Are procurement specialists aware of the regulatory criteria for TC membership?	% respondents confirming that TC members need to be selected based on criteria which coincide or even exceed PPL requirements	12.5%	Grade D
Overall Grade			**Grade D+**

The PPL outlines TC membership criteria but they are limited to a generic requirement of the absence of conflict of interest. The Law states that TC members must be selected "so that the membership does not create a conflict between the interest of the procuring agency and the bidder and/or supplier, which might potentially impact the objectivity of the decisions on the selection of tender winners". It also requires that TC do not include civil servants and their relatives, as well as members of elected councils of any level. There is no requirement of rotation and no requirement to the professional merit of the members.

While most of the interviewed specialists believed that there are specific criteria for TC membership, only one mentioned conflict of interest, while others thought the only criterion is professional merit. Majority of the procurement specialists / members of the TC (75.0%) said that TC members are selected based on specific criteria, but only one of them said that this criteria is clearly written (in the PPL) and relatively accurately quoted the provision against no-conflict of interest (*"According to the PPL, they shouldn't be relatives"*). All other interviews said that selection criteria are specific but not written in any document, half of them said that these criteria are transparent, and most of them (75.0%) said that these criteria are related to the skills, knowledge and personal qualities of the candidates. In other words, most of the field specialists are not aware of the PPL requirements and have been selected with specific but different rules:

- *(The candidate should) "be professionally diligent"; "understand the procurement process", "should have sufficient level of professional responsibility"; "have to have good professional skills in his/her field"; "has to have skills/knowledge which would ensure that there is enough professional diversity among the TC members".*

Indicator PR-45. Compliance with Tender Committee decisions

Decisions of the Tender Committee should be enforced in practice. An obvious requirement to the functionality of the Tender Committee is that its decisions are duly implemented. Experience around the globe shows that this is not often the case (WHO 2009). Other entities involved in the procurement process may find various ways to go around the Tender Committee decisions, starting from slight deviation from the approved quantities or choices of suppliers and including outright violations. While some decisions of the Tender Committees may be revoked for objective reasons and through official legal procedures, excessively frequent cancellation of such decisions would also be alarming and potentially pointing at a fundamental institutional resistance to independent perspective in the tender process[181].

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[181] These issues are covered by Indicator VII.6 of the WHO Instrument for Measuring Transparency in the Public Pharmaceutical Sector.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Are decisions of the Tender Committee always taken into account in the procurement process?	% Procurement specialists stating that TC decisions are always taken into account	100.0%	Grade A
During the past year (2012), have there been any episodes when TC decisions were cancelled?	% Procurement specialists saying that there were some TC decisions which were cancelled during the previous year	0.0%	Grade A
Overall Grade			**Grade A**

Interviewed revealed absolute compliance with the decisions of Tender Committees. Without exception, decisions made by the Tender Committees seem to be always implemented in practice, and there was no episode when they would be cancelled or revoked for any reason. Given that Tender Committees play key role in the procurement process as it is described in the PPL, the respondents saw no possibility of avoiding or in any way going around their decisions. *"Working by the Tender Committee decisions is what is prescribed by the legislation, it is impossible to not implement them, it never happens."*

Indicator PR-46. Appeals

A possibility for the unsuccessful bidders to protest against tender decisions is critical to ensure fair and honest competition for public funds. Effective mechanism for review of complain is an integral part of any procurement system, reinforced both by the OECD for the nation-wide practices (OECD 2010) and by the WHO specifically for the health sector (WHO 2009). Such mechanism must include a formal process for bidders whose candidacies were rejected to voice their protest; the complains must be addressed by a body with sufficient independence and authority to enforce alternative decisions. Importantly, the results of the complaint reviews must be open to any interested party and the general public[182].

Scoring table (Method 1)			
Dimension	Source	Benchmark	Grade
Is there a formal appeals process for applicants who have their bids rejected? **[Weakest link]**	% Procurement specialists who confirmed existence of a formal appeals process	100.0%	Grade A
Is the appeals process actually practiced? How many complaints have been filed against interviewed units during the last financial year?	Binary check on whether there were any procurement specialists providing non-zero number	Yes (25.0%)	Grade A

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[182] These issues are covered by Indicator VII.4 of the WHO Instrument for Measuring Transparency in the Public Pharmaceutical Sector and Indicator 10 of the OECD MAPS.

Are decisions on the complaints properly publicized?	% Procurement specialists confirming that decisions on complains are publicized	37.5%	Grade C
Overall Grade			**Grade A-**

Ukraine's PPL describes a clear and detailed procedure for complains against decisions in procurement process. Bidders who believe that their proposals were rejected unfairly, can complain to a national authority (Commission on Appeals under State Antimonopoly Committee) and, if unsuccessful, to the court. Rules and procedures for the appeal process are clearly described by the PPL, as summarized in Box 17.

There are some precedents showing that appeal mechanism is being applied in practice, even though this study cannot assess the quality of the decisions. A quarter of the interviewed procurement specialists reported that their office had encountered an appeal from one of the bidders during the past year. All these complaints were satisfied; in one of the cases – after repeated appeal to the administrative court. However, since the survey was focused on the procurement specialists rather than the bidders themselves, it is impossible to make any assessment of the quality of the rulings.

While the PPL requires that all decisions on appeals are automatically publicized, not all procurement specialists are aware and/or satisfied with how it is working in practice. As explained in Box 17, the Appeals Commission has to publish all its decisions on its website and to ensure that they are also published in the country's official periodical on Public Procurement. At the same time, only 37.5% of the interviewed facility-level specialists were positive that this is taking place; the rest found it difficult to provide a definite answer. In some cases, the reason was that the specialists found the publication process unsatisfactory: it was too slow and not always reliable.

> **Box 17. Rules for appeals against violations in public procurement in Ukraine**
>
> Procurement related appeals are handled by the Antimonopoly Committee (AC) via its *Permanent Commission on Appeals,* which acts on the AC's behalf. The Permanent Commission on Appeals consists of three AC representatives and is chaired by a person with high legal education. Members of the Commission should have no CoI with regard to the appealing agents, which is defined and addressed by the AC Head (such members must be suspended from the case). The appealing agent or procuring agency may challenge decisions of the Commission in court.
>
> Decisions of the Commission must be delivered in written to the Ministry of Economic Development and Trade (MoEDT) (which is the country's authorized procurement body), the appealing agent, the procuring agency, Ukraine's State Treasury Service and the editorial office of the State Periodical on Public Procurement. All decisions of the Commission must be published in the State Periodical on Public Procurement and posted at the AC web-site the next day after they were made. The decisions should be made within 30 days after they were filed.
>
> Appeals must be submitted to the AC Permanent Commission on Appeals in written and must clearly describe reasons for appeal, including reference to respective legislation which was allegedly violated, and include any circumstances or documents to prove the allegation. A copy must be sent to the party against which the complaint is being filed. Appeals can be submitted exclusively by those whose interests were directly compromised by the alleged violation.
>
> Within three days after the Commission receives the complaint, it has to inform the appealing agent and the agent against whom the complaint was filed about the time and place of the hearing, so that both sides can participate. The Commission may decide to suspend the procurement process,

Indicator PR-47. Procurement information system

Consistent and effective system for procurement information management helps to detect and address problems, but also increases accountability of all parties. Information generated at all stages of the procurement cycle should be properly recorded and collated, enabling public procurement officers to make effective decisions, including detection of poor quality, fraud and abuse. The system should cover all stages of procurement: planned purchases, information on suppliers and their performance (current and historical), product records, status of individual orders and actual amounts of received products. As noted by the WHO, effectiveness of such system is greatly increased when it is computerized (WHO 2009)[183].

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Do facilities have management information systems used to report product problems in procurement?	% Procurement specialists confirming that such system does exist	62.5%	Grade B
Do the existing procurement information systems cover most of the core types of data (product records; suppliers' performance; facilities' performance; quality assurance information; status of individual orders; quantities purchased compared to estimates)?	% Procurement specialists who say that most of the listed functions are covered by the current procurement information management system	37.5%	Grade C
Are current information systems usually computerized?	% Procurement specialists who say that they use procurement information systems in which most of the functions are computerized	12.5%	Grade D
Is there a robust system for tracking and blacklisting poor performing suppliers?	National legislation and implementation procedures contain provisions for disqualification of poor performers	Current regulations contain no provision which would allow purchasing units to disqualify suppliers which provided poor quality in the past	Grade D
Overall Grade			**Grade D+**

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[183] These issues are covered by Indicator VII.10 of the WHO Instrument for Measuring Transparency in the Public Pharmaceutical Sector.

Most of the facilities use some procurement information management systems, but they are rarely complete and operational. Data related to the procurement cycle is routinely collected and archived, but it is rarely consolidated within operational databases which lend themselves easily to cross-checks, analysis and effective use. Some databases were used for procurement purposes in 62.5% of the surveyed facilities, however these systems seem to have significant gaps. The content of the systems was usually limited to the information on the procured products and to the results of product quality inspections, but even this data is only used in 62.5% cases, and in 12.5% cases it was not collected at all. Only half of the procurement officers used their systems to compare actually procured to planned amounts. The systems never contained any information related to the performance of the facility itself.

Existing procurement information management systems are almost never computerized. A computer-based system was used only by one of the interviewed hospitals. This one facility purchased specific software from an specialized IT company along with a contract for regular maintenance and updates, and the database is covering all of the key procurement information collected. All other facilities track their procurement data with the help of paper records and do not have a single electronic system. The data is dispersed through a range of various journals and archives, and there is no practice of extracting indicators from these various sources for analytical purpose. In fact, when this has to be done for some particular reason (e.g. on demand by an auditing agency), compiling necessary data would take time and effort.

- *"If we have an inspection, e.g. from State Financial Inspection, of course we will show them all the data, it is all duly registered. But I would have to go to the archive to find the information, and it would be a headache."*

Most facilities have records reflecting the status of individual orders and the information on individual suppliers, but this data is not aggregated into the databases. Two specific types of information – supplier data and order status – which are both highly important for effective procurement management – are usually recorded via separate paper-based templates and are difficult to match.

Figure 59. Data tracked within the facility-level procurement information management systems (% responses by the procurement specialists)

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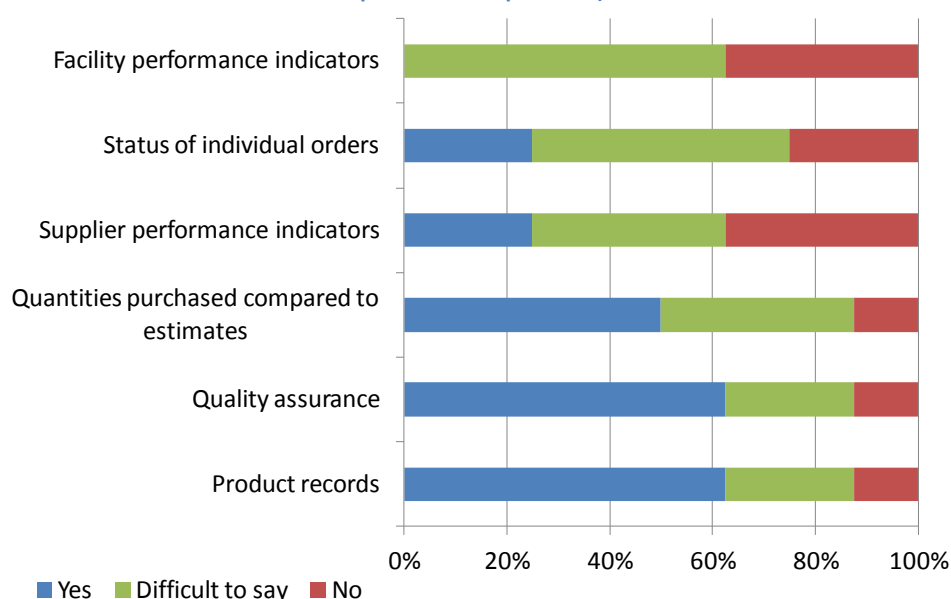
While many facilities do track poor performance, they universally complain that current legislation leaves them no possibility to blacklist such suppliers. Half of the interviewed procurement specialists keep informal in-house lists of poorly performing suppliers. However, they explained that within the current legislative framework, they see almost no opportunity to use this knowledge against these suppliers in future tenders. The PPL requires them to select bidders offering lowest price, and many interviewed specialists shared stories of discovering very low quality behind the products sold to them at dumping prices. Finding ways around signing contracts with these suppliers in the future was difficult and costly (theoretically, it could be done through better specification of qualifying requirements which is sometimes difficult to achieve ex ante before the hidden flaws of the product are discovered).

- *"Just recently we had to buy a batch of butter from one supplier who offered a ridiculously small price. It was obvious that the butter contained some extremely questionable ingredients, nobody could produce butter at this price, it was so below market. But we had to buy it and use it. And my biggest pain is that there is nothing I can do if this supplier shows up for the next tender and offers the lowest price once again!".*

- *"If I was in charge of reforms in procurement, I would start by introducing a blacklist. Or I would introduce some other way to deal with suppliers whose performance was clearly bad in the past."*

Indicator PR-48. Contract administration process for procurement of pharmaceuticals

Management of contracts for purchases of pharmaceuticals must include a range of specific quality assurance measures, ensuring against fraud and counterfeit. Procurement of medicines is highly vulnerable to manipulation with the quality of products and risks of counterfeit and supplies of sub-standard pharmaceuticals. To ensure against these risks, procuring entities must exercise a range of specific checks and measures. By the WHO standards for procurement of pharmaceuticals, each medicine shipment must be physically inspected by checking compliance with product specifications; batch samples should be sent to quality control laboratories (random samples for known suppliers and systemic checks for new suppliers). Results of these inspections must be recorded, archived and made available for the audits and for the post-tender review by the Tender Committee, so that any poor performance is noted for the future through respective black lists (WHO 2009)[184].

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Are there Standard Operating Procedures (SOPs) for routine inspection of consignments?	% Procurement specialists confirming that SOPs exist	62.5%	Grade B
How comprehensive is the coverage of consignments checks (do they include physical checks of shipments; laboratory checks of random samples; laboratory checks of new supplies; systemic recording of results)?	% Procurement specialists confirming that most of the checks are routinely conducted	12.5%	Grade D

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[184] These issues are covered by Indicator VII.11 and Indicator VII.12 of the WHO Instrument for Measuring Transparency in the Public Pharmaceutical Sector.

In perception of the procurement specialists, how significant is the problem of counterfeit drugs in Ukraine?	% Procurement specialists who said that this problem is very significant	50.0%	Grade C
Overall Grade			**Grade C**

Ukraine is a member of PIC/S (since 2011) and signatory to a range of international agreements on ensuring quality of pharmaceutical products. Ukrainian State Administration on Medical Products became a signatory of the Pharmaceutical Inspection Convention and member of the Pharmaceutical Inspection Cooperation Scheme (PIC/S) in 2011. As part of this new aspiration, the country committed to fully introduce PIC/S Good Distribution Practices (GDP) and PIC/S Good Practices for Preparation of Medical Products (GPP) by 2015. In 2012, Ukraine became the first non-EU country to ratify the Medicrime Convention adopted by the Council of Europe, and in 2013 it signed a Memorandum of Understanding with the European Directorate for the Quality of Medicines and Healthcare (EDQM) on inspection of quality of drugs in distribution, committing to introduction of the track-and-trace service (barcode marking) for all medical products in Ukraine's pharmaceutical market.

In line with these international commitments, Ukraine's legislation assumes a comprehensive system for quality inspection of the pharmaceuticals procured by the medical facilities. The system of quality assurance of medications procured by the facilities consists of two layers:

- **Facilities** are responsible for inspection of all consignments, checking for the availability of complete documentation (full details of the pharmaceuticals and supplier information); supplier certification and product registration and certification; visual inspection of each shipment (checking for the quality of the packaging; appropriate marking; availability of instructions in official language; absence of any visible defects and inconsistencies; shelf life and expiry date). By legislation, facilities are not responsible for any random sampling of the shipments for further laboratory tests. However, if they discover defects or problems, they must report to the local inspection representing the State Administration of Medical Products, which then undertakes respective sample tests.

- **The State Administration of Medical Products**, through its local offices, conducts planned and unplanned inspections of the facilities to check for the quality of the procured drugs. First, these inspections are checking whether the facilities comply with their responsibilities for visual control of the incoming medications. Secondly, the inspections may undertake sampled checks of the medications, sending them to accredited laboratories. However, this latter possibility is rather theoretical: it is not directly required but could be used in principle based on the generic Law on State Oversight of Economic Activities (which allows state inspectors to check samples of products produced by enterprises of any sector).

Most of the Ukraine's medical facilities do use routine procedures for quality checks of the consigned pharmaceuticals, but there are exceptions. In the interviewed sample of facilities, 62.5% procurement specialists confirmed that their facilities have certain Standard Operating Procedures (SOPs) for quality inspection of the consigned medications. In all these cases, the interviewees described the standard procedure outlined in the legislation (visual checks and inspection of the documents). Some officers (12.5%) said that such procedures do not exist, and 25.0% found it difficult to respond). In addition to the inspections of incoming shipments, checks of the documents sometimes allow facilities to detect counterfeit suppliers already at the stage of the tenders.

- *"In one of our tenders for pharmaceuticals, one of the suppliers provided a product quality certificate which looked suspicious. At the stage of tender they only provide copies, so we requested an original, and it turned out that it was faked. The supplier was disqualified."*

Both rules and practice for quality inspection of the procured pharmaceuticals do not assume regular sampled laboratory checks of the shipments. As discussed above, such checks are possible in principle but are not required by the standard procedures. Only one of the interviewed facilities stated that they had a sample of the drugs by regular pharmaceuticals tested in the laboratory; and none of the interviewed facilities were aware of systemic laboratory checks of new suppliers. The current legislation assumes that sampled checks must be performed by the State Administration on Medical Products only for those medications which were compromised by prior checks at the facility level (i.e. having some inconsistencies in documentation or packaging). Potentially counterfeited drugs with due packaging and documentation is therefore almost entirely exempt from such checks.

Half of the interviewed specialists stated that they consider the problem of counterfeit medications to be very significant. The question on the extent of manipulation with drug production and distribution is a subject of obvious sensitivity, especially in the interviews with procurement specialists. Yet, a half of the respondents admitted significant problems in this field.

Indicator PR-49. Contract administration process for procurement of equipment and medical supplies

Procured equipment must be clearly registered and supplied with due technical maintenance. Management of contracts for purchases of medical equipment must include clear recording of purchased items in a regularly updated register. Moreover, since most of the medical equipment places high demands on its technical maintenance, these activities and related costs must be duly planned and monitored. It may include specific provisions for technical maintenance within the tendered contracts (such as annual maintenance agreements for new equipment), designation of personnel to equipment maintenance and monitoring tasks, outsourcing of these tasks to other parties, or other alternative solutions.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Do facilities have sufficient possibilities to formulate and monitor technical specifications for the procured equipment?	% Procurement specialists who express concerns over the effectiveness of technical specifications at the stage of purchasing equipment	37.5%	Grade B
Do facilities have registers of procured assets and regularly update them?	% Procurement specialists who confirm that they maintain a regularly updated asset register	100.0%	Grade A
Is procured equipment supplied with due technical maintenance?	% Procurement specialists who say that lack of resources (funds or skilled staff) for technical maintenance of procured equipment is a rather or very significant problem	62.5%	Grade C
Overall Grade			**Grade B**

Many facilities find it difficult to formulate and endorse strong technical specifications for the procured equipment and medical supplies. Interviewed procurement specialists described a range of problems faced by their facilities at the stage of formulating and verifying technical specifications to the non-pharmaceutical medical supplies, including equipment.

- **Some facilities (12.5%) admitted lack of own capacities to formulate high quality technical specifications to new equipment**. Some others revealed lack of such capacities even without admitting it explicitly: they complained about having to purchase "cheaper Chinese equipment which functions poorly" when there are "better quality" domestically produced alternatives, given that the technical specifications of these products listed in the tender documentation are identical (procurement specialists are not able to clearly describe and demand the required difference in quality).

- **Other facilities (25.5%) strongly complained about the quality of products received through centralised procurement and their inability to refuse these supplies.** A considerable share of equipment and medical supplies for the facilities is procured through "State Targeted Programs"[185] designed and implemented by the MoH. These supplies include vaccines, tests and reagents, supplies for treatment of cancer patients, implants and tools and equipment for implant placement, glycaemic level tests, medical products used in treatment of cardio-vascular diseases etc. Majority of the procurement specialists (62.5%) said that facilities do not in any kind authorize the receipt of these supplies and that they therefore have no role in inspecting the quality of these products. The other 37.5% explained that they do have to sign the delivery documents but it is a totally formal process without any significance. In practice, none of the facility level specialists feels that they could refuse to sign the documents approving these consignments even when the quality is visibly questionable.

  - *"Perhaps there is some theoretical possibility that we might decline these consignments, but who would ever dare to start such an open conflict with the central authorities?"*

  - *"We receive very strange supplies; disproportionately big amounts of various products and often with expiry date which is extremely close";*

  - *"What we receive through these programs is often complete rubbish";*

  - *"Once we received a large consignment of angioplasty stents of highly atypical size; they were not suitable for most of our patients, but since we couldn't work without them, we had to work with what we had, using various manual tricks".*

  - *"If I had all the power to reform things in this country, I would suggest to completely decentralize all procurement – I wish we could just do it ourselves and buy what we need, and organize it so that we get good prices! But I understand it would involve lots of technical work, so of course we would need to delegate the paperwork to someone else, we wouldn't be able to cope with it on top of our current duties."*

This finding about suboptimal quality of centralized procurement resonates with previous studies by other authors. USAID assessment of Ukraine's health system in 2011 concluded, for a range of targeted programmes, that "centralized procurement processes often result in provision of drugs that do not meet local needs and may not reduce prices relative to international prices as intended." (USAID 2011)

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[185] Law of Ukraine "On State Targeted Programs", № 1621-IV, approved 18.03.2004 latest amendments 02.12.2012.,
http://zakon2.rada.gov.ua/laws/show/1621-15/print1365526529412610

At the same time, all equipment and other supplies received by the facilities (through own procurement or via centralised purchases) is diligently recorded. Without exception, facilities lead detailed registers of equipment, which are constantly updated to reflect any changes in the inventories: receipt of new products; changes of its book value; changes of the personnel responsible for the maintenance of the equipment etc.".

Technical maintenance of procured equipment is often problematic, given lack of funds and/or skilled staff. Majority of procurement officers (62.5%) believe that ensuring technical maintenance of the equipment is a significant weakness in the procurement process. Half of the facilities complain that they do not have sufficient funds to ensure the oversight or to outsource it to others; and a quarter of the officers admitted that they lack sufficiently skills staff. Only in half of the facilities procurement specialists confirmed that the equipment they received included an annual maintenance service contract.

The quality of new medical equipment in Ukraine's facilities is overseen by at least one specifically created state enterprise ("Politekhmed") whose role in the procurement regulatory framework is unclear. State enterprise Politekhmed established by the Ministry of Health operates on the basis of its corporate statute, which describes a range of functions including evaluation of quality of medical products used in Ukraine, identification of the needs of facilities in medical products and respective procurement of these products, assistance in designing centralized targeted programs, development of equipment quality standards, marketing of new medical products, organisation of technical maintenance of medical equipment, development of certification documents for medical products, advertisement of new medical products, shipment of goods and services, research, trade in medical goods and services, as well as their technical maintenance and supervision[186]. This list of functions is highly alarming in terms of potential conflict of interests. It is also alarming that while the enterprise has no authority to control the facilities (it acts as an evaluator rather than a controlling agency), it regularly undertakes measures against procuring facilities by appealing to the national Appeals Agency (where it considers procured items to be violating law or being of low quality). The Appeals Agency often suspends such procurement, which became a subject of numerous complains described in the media (Layevskiy 2013).

Indicator PR-50. Procurement audit

Procurement decisions must undergo regular internal and external audit, with transparently publicized decisions and effective follow up. Audit is the crucial part of effective procurement in public health sector, strongly endorsed by the OECD and WHO best practice recommendations[187]. Such audit must be regular, undertaken on annual basis for all procurement offices. The audit should have a comprehensive scope, covering the composition of purchased products, the nature of the contracts awarded, and the results of contract management and performance reviews. Importantly, the results of the audits should be openly publicized (OECD 2010) (WHO 2009).

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Does the Procurement Office undergo regular audits?	% Procurement specialists confirming that their office is regularly audited	87.5%	Grade A

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[186] http://mozdocs.kiev.ua/view.php?id=7275

[187] These issues are covered by Indicator VII.13 of the WHO Instrument for Measuring Transparency in the Public Pharmaceutical Sector and Indicator 9 of the OECD MAPS.

Are the results of the audit publicly available?	% Procurement specialists confirming that audit results are publicized	12.5%	Grade D
Does the audit reports pharmaceutical products tendered, quantities of products, and beneficiaries?	% Procurement specialists confirming that all these issues are covered	75.0%	Grade A
Overall Grade			**Grade B**

Procurement undertaken by most hospitals is regularly and compressively audited. Majority of the facilities (87.5%) confirmed that they go through regular inspections, and 75.0% cases these inspections covered a full range of procurement issues, including amounts of individual products tendered, adherence to procurement legislation in organization of the tenders, adherence to budget appropriations, and the details of the selected suppliers.

The range of audits specifically focused on procurement is excessive and could be used as leverage to influence tender results. Interviewed facilities have listed a large number of various authorities who are auditing their work with specific interest in procurement. In addition to the State Financial Inspection and inspections established by the local councils and administrations, this included Prosecutors Office, Police and even National Security Service. Moreover, the focus of the inspections was often limited to the results of concrete tenders, frequently raising concerns that the auditing authorities had particular interest in specific outcomes of the tenders and were using their office to exert pressure on the procurement process.

- *"Whenever we have an audit from the municipal council in our facility, they are basically only interested in procurement and they have only one question: how much did we buy, who were the suppliers and how much did we pay each one."*

- *"When we have a large tender, we know there are bugs installed in our offices".*

- *"Large tenders are such an extreme headache and there are so many interests involved that no facility will ever want to be involved; where possible we prefer to have it all done at a higher level".*

Integrity and transparency of the procurement system

Indicator PR-51. Ethics and anticorruption measures

To minimize incentives for corruption and unethical behavior, procurement system must contain robust mechanisms preventing conflict of interest. Procurement in healthcare sector, and especially procurement of pharmaceuticals, is recognized to be especially vulnerable to corruption and unethical behavior (WHO 2009). Very often, such unethical behavior is promoted by ineffective management of potential conflict of interest, when individuals are entrusted with responsibilities which could be compromised by the possibilities to satisfy a certain secondary interest, including financial, professional or political gain. Given that the conflict of interest as such does not automatically imply that the affected person would necessarily act on the temptation and exercise the corrupt possibility, such situations could and should be voluntarily disclosed and eliminated before corruption occurs. A best practice system would include written guidelines on conflict of interest in the procurement process, including clear explanation of what constitutes a conflict of interest, a mechanism for reporting such cases, penalties for failing to comply, and robust ways to protect informers of the conflict of interest.

Scoring table (Method 2)			
Dimension	Source	Benchmark	Grade
Are there guidelines on conflicts of interest (COI) with regard to the procurement process?	% Procurement specialists confirming that the guidelines exist	12.5%	Grade D
Are there implementation procedures for ensuring against CoI (Forms for declaration of COI, mechanisms to protect informers of CoI, rules for actions to be taken in case of failure to comply with policies on CoI)?	% Procurement specialists confirming existence and application of the listed procedures	0.0%	Grade D
Do procurement specialists understand the concept of "conflict of interest", being able to provide example of what it would hypothetically represent and being aware how to act in case they discover CoI?	% Procurement specialists able to provide accurate responses	0.0%	Grade D
Overall Grade			Grade D

This study revealed complete lack of understanding of the concept of Conflict of Interest (CoI) among facility level procurement specialists. Although the PPL has a generic definition of a Conflict of Interest, none of the interviewed respondents was familiar with the idea. Examples of situations which would represent a CoI were misguided: all of the interviewed specialists believed that a CoI represents an act of power abuse and particular violations in the procurement process. In particular, the procurement officers believed that a CoI means:

- *"Receiving bribes and kickbacks";*
- *"Entering into secret negotiations with the bidders";*
- *"Manipulations with technical specifications of the tendered products";*
- *"Unjustified disqualification of certain bidders";*
- *"Selecting suppliers who offer low quality goods or products";*
- *"Favoring a particular bid from a particular firm".*

Legal definitions of the COI are weak and implementation procedures are absent. The only regulatory opinion on the COI is the generic definition in the PPL, and there are no other rules or procedures which would enable procurement specialists to effectively handle CoI situations. In particular, there are no requirements and templates for a declaration of COI by the procurement specialists, no specific rules for reporting of the COI, or rules for actions to be undertaken in case of failure to comply with the COI policy. Granted, half of the sample state that there is a policy for acceptance of gifts (but did not explain it).

Annex 1: List of Governance Indicators

Human Resources Management

Recruitment

Indicator HRM-1. Publicizing vacancies

A. Information on existing vacancies is freely accessible**.** Positions are generally open also to "outsiders".

B. Personal connections play a significant role in advertising posts, but this is not perceived as a barrier for finding jobs.

C. Personal connections are the predominant channel for learning about posts and in most cases it is often perceived as a barrier to finding jobs.

D. It is impossible for outsiders to learn about existing vacancies except for personal connections.

Indicator HRM-2. Transparency of appointment procedures

A. Selection process involves a plurality of actors (so that they can cross-check each other's conduct during the selection process) and all decisions (including qualification checks) are transparently documented.

B. Only one person takes most selection decisions, even though plurality is required by low and if other stakeholders are formally engaged in the process. Transparent records of new appointments, including qualification details, are kept in most cases.

C. Only one person selects candidates, without oversight, and there is no legal requirement for a different approach. However, at least some record of these subjective decisions is transparently kept (such as the details of qualification checks).

D. Candidates are selected by a single person and in most cases there is no record left about the process and resulting decisions.

Indicator HRM-3. Competitive selection of candidates

A. Most candidates are selected through clearly and transparently regulated competition;

B. Hiring rules require competition but in many cases there are no more than one registered applicant per post;

C. There is no legislative requirement for competitive selection, but in many cases informal rules are applied in cases when there is more than one candidate;

D. There is no transparent competition in selection of candidates (only one registered applicant per vacancy) and no legislative requirement for competitive selection.

Indicator HRM-4. Importance of merit-based criteria for hiring new staff

A. Candidates' selection is mainly done on the basis of merit/qualifications.

B. Merit and qualifications are considered, but together with other criteria as well.

C. Merit and qualifications are formally checked, while connections and bribes play the decisive role in selection.

D. Appointment is usually carried out on the basis of subjective, unrecorded, criteria, and paying bribes for posts, nepotism, personal connections, or other bad practices are frequently reported in interviews.

Indicator HRM-5. Job description

A. There are written clear and regularly revised job descriptions , and frequently used as a reference, for example to solve work-place conflicts equitably and transparently, or to evaluate performance and facilitate professional development.

B. There are written job descriptions but they are not necessarily useful or regularly revised.

C. Written job descriptions exist in less than 50% cases, or they are almost never used and revised.

D. In most cases, there are no written job descriptions or they are essentially out of date and completely useless.

Career Management

Indicator HRM-6. Opportunities for career progression

A. Health workers have a range of opportunities to progress within their organizations, extending their skills and responsibilities;

B. There are some opportunities for career growth but many workers find them either unappealing or impossible to achieve.

C. Career opportunities are very limited and are not enough to motivate staff for professional growth.

D. Career opportunities either do not exist or are essentially impossible to achieve for most health workers.

Indicator HRM-7. Promotion procedures

A. Career progress decisions are merit-based and taken, or at least reviewed, by more than one person;

B. Career progress decisions do not always involve several actors and/or there are some cases when promotion criteria are not explicit and merit-based;

C. In many cases promotions are decided by a single person and/or are based on patronage and favoritism rather than professional qualifications;

D. There are no objective criteria for career progress, and the latter depend mainly on criteria such as paying bribes, personal connections, and other non-merit based criteria. Decision can be taken by one person without any oversight.

Indicator HRM-8. Performance evaluation

A. There is an established and useful system for performance evaluation with a clear record of outcomes complemented with an informal system to quickly identify and learn from mistakes and clearly linked to reward systems (salaries, promotions, trainings or other benefits).

B. There is some system of performance evaluation in most facilities, but it is not always effective and not always clearly linked to rewards or career opportunities.

C. Some elements of performance evaluation exist, but they are not systemic and in most cases not considered useful or linked to reward opportunities.

D. Most facilities function without an operational system for performance evaluation; the latter could be done occasionally and without any follow up.

Indicator HRM-9. Positive stimulation

A. Health workers generally report that they work in an environment where good performance is encouraged and rewarded, either financially or with other means, and where mistakes can be openly discussed and corrected;

B. Most health workers report that they work in an environment where good performance is encouraged and rewarded, either financially or with other means, and where mistakes can be openly discussed and corrected, but there are many exceptions;

C. Generally health workers do not report that they work in an environment where good performance is encouraged and rewarded, and mistakes can be openly discussed and corrected. In some cases , however, such good feedback is given.

D. In general health workers feel that their efforts are not rewarded or stimulated, and they are terrified to report mistakes.

Indicator HRM-10. Timely payment of salaries

A. Salaries are always paid on time or with very few delays;

B. In majority of cases, salaries were paid on time; some delays may happen but due amounts are usually recovered within a few months;

C. In majority of cases salaries were not paid of time; there could be long delays or cases when due amounts are not recovered at all;

D. Salaries are almost never paid on time and delays can last for months without guarantee of repayment.

Indicator HRM-11. Training

A. Healthcare workers feel that they work in an environment which stimulates continuous learning and mutual exchange of information. Training and retraining events are generally considered useful.

B. Majority of healthcare workers feel that they work in an environment which stimulates continuous learning and mutual exchange of information. Training and retraining events are considered useful in most cases.

C. Healthcare workers do not feel that they work in an environment which stimulates continuous learning and mutual exchange of information. Training and retraining events are often considered useless.

D. Healthcare workers do not feel that they work in an environment which stimulates continuous learning and mutual exchange of information. Training and retraining events are generally considered useless.

Indicator HRM-12. Sanctions

A. Healthcare workers feel that poor performers are generally identified, violations punished, and that they are accountable for what they do. They are satisfied with the redress procedures

B. Majority of healthcare workers feel that poor performers are generally identified, violations punished, and that they are accountable for what they do. They are satisfied with the redress procedures

C. Healthcare workers feel that poor performers are generally identified, but violations are almost never punished and they are almost never accountable for what they do. They are not satisfied with the redress procedures.

D. Healthcare workers do not feel that poor performers are generally identified, violations punished, and that they are accountable for what they do. They are not satisfied with the redress procedures.

Retaining qualified staff

Indicator HRM-13. Levels of pay in public versus private sector

A. Public healthcare professionals find their remuneration generally competitive compared to private sector facilities;

B. Public healthcare professionals find their remuneration twice lower than in private facilities;

C. Public healthcare professionals find their remuneration significantly lower than in private facilities;

D. Pay levels in public facilities is negligible in comparison to private sector.

Indicator HRM-14. Turnover

A. Turnover is regularly monitored and is comparable to national average for all categories of staff. Managers are fully aware of the current turnover levels.

B. Turnover is regularly monitored, but managers are not always aware of its levels. Levels of turnover are considerably higher than national average for some categories of staff.

C. Turnover is not always regularly monitored. Where information is available, the levels are significantly higher than national average for some categories of staff.

D. Information on turnover is weak or absent. Where available, it shows that turnover rates are at least 1.5 times higher than the national average for some categories of staff.

Planning and Budgeting

Policy-based budgeting

Indicator PB-15. Strategic guidance

A. There are multiyear healthcare strategic planning documents at national and regional level, which clearly outline priorities and which are understood by majority of healthcare professionals.

B. There are multiyear healthcare strategic planning documents at national and regional level, which outline priorities, but majority of healthcare professionals are not aware of these priorities.

C. There are multiyear healthcare strategic planning documents at national and regional level, but these documents do not identify priorities clearly.

D. There are no strategic documents in the healthcare sector, or there are numerous documents that do not prioritize healthcare policies and investments.

Indicator PB-16. Links between strategic plans and facility budgets

A. National and regional priorities are reflected in strategic plans of the facilities, costed and linked to the budgeting process.

B. Many facilities have service delivery plans, but they are not always properly costed and linked to the actual budgets.

C. Most facilities do not have strategic documents, priorities are rarely discussed in realistic context.

D. Budget allocations are not guided by any strategic documents or priorities.

Indicator PB-17. Staff engagement with the strategic planning process

A. Majority of facilities incorporate feedback from their professionals into the planning process.

B. Majority of facilities apply some tools for consulting with their staff over priorities, but these tools are not always effective.

C. Consultation with healthcare professionals in the planning process is episodic.

D. In majority of facilities there are no practices for consulting with the staff in the planning process.

Indicator PB-18. Capacity for strategic budgeting

A. In majority of facilities, budgeting and planning is led by appropriately trained professionals and involves sufficient amount of time and qualified personnel.

B. In majority of facilities, budgeting and planning is led by well trained managers but they are not always able to engage enough qualified staff or dedicate enough time to this task.

C. About half of facility managers to do not receive proper training and in many cases they lack experienced staff, time, and motivation for this task.

D. Majority of facility managers do not receive appropriate training and in majority of cases they lack experienced staff, time, and motivation for this task.

Indicator PB-19. Results-based budgeting

A. Majority of facilities operate with program-based budgets, regularly evaluate spending efficiency, and use PBB principles to ensure high quality of services.

B. About half of the facilities regularly evaluate efficiency of some programs, but they often find it problematic to successfully apply PBB principles and a large share of their budgets is incremental to last year and/or based on input norms.

C. In most cases, facility budgets are designed almost entirely based on incremental adjustment from previous years and centrally imposed input-based norms. In most cases, spending efficiency is not evaluated.

D. Majority of facilities design their budgets entirely based on incremental adjustment from previous years and centrally imposed input-based norms. Spending efficiency is not evaluated. In many cases, facilities report that current PBB systems are highly inefficient.

Indicator PB-20. Clarity and consistency of budget preparation guidelines

A. Healthcare facilities prepare their budgets based on clear and consistent rules.

B. There are generally reasonable rules for budget preparation, but there could be some gaps and contradictions

C. Because of significant gaps or contradictions in the budgeting rules, many facilities either face unfunded mandates or find it difficult to prepare budget requests

D. Budget preparation rules either do not exist or impose conflicting and unfunded mandates which are nearly impossible to observe.

Capital budgeting

Indicator PB-21. Criteria for prioritizing investment projects

A. Clear criteria exist on prioritizing investment project for budget financing.

B. Criteria are in place that provide some guidance for project prioritization, but there are many instances where the criteria used for project selection are not clear.

C. No formal criteria are in place but implicit criteria usually guide investment decisions. For example, there is a systematic review of infrastructure status before deciding priorities for renovation/maintenance.

D. Criteria for project selection are not explicit or not in place, and it is typically not clear what criteria have been used to select projects.

Indicator PB-22. Project appraisal and selection

A. Most projects are appraised following established procedure with some elements of cost benefit analysis and external oversight. Appraisal is technically informed, incorporates recurrent cost implication of capital projects and prioritizes on-going projects to enable multi-year commitment.

B. Only some projects are appraised following established procedure with insufficient attention to CEA, external scrutiny, or multi-year project implications.

C. Few projects are appraised on basic information such as cost and feasibility. External review almost does not exist.

D. There is essentially no formal appraisal.

Budget execution and management of funds

Indicator PB-23. Predictability and availability of funds

A. Majority of healthcare facilities operate under a cash flow forecast which is updated at least once a quarter and is based on reliable indication of available resources.

B. Most facilities are preparing cash flow forecasts, but they are updated less often than once a quarter and may suffer from unpredictable changes in available resource ceilings.

C. Cash flow forecasts prepared by most facilities are not regularly updated or subject to frequent and unpredictable changes in available resources.

D. Cash flow monitoring and planning are not undertaken or of very poor quality. Healthcare facilities are provided with commitment ceilings which are not credible, or no reliable indication at all of actual resource availability for commitment.

Indicator PB-24. Spending flexibility and transparency of adjustments

A. Facility managers can reallocate across items where this is well justified. If significant in-year adjustments to budget allocations take place due to cash shortages, they occur only once or twice a year and are done in a transparent and predictable way.

B. There is some flexibility for in-year adjustments, but it is either not sufficient or exercised without sufficient transparency.

C. Expenditure controls are either generally too rigid (providing little flexibility even when justified) or too lax, allowing frequent in-year adjustments (but they are undertaken with some transparency).

D. There is either absolutely no flexibility for in-year adjustments or no transparent rules for agreeing and monitoring in-year adjustments.

Indicator PB-25. Authorization of funds and commitment control

A. The system of Treasury control ensures that funds are always used strictly according to allocations and released without delays;

B. Treasury authorization and control of expenditures makes unauthorized spending nearly impossible, but delays sometimes happen, and release of funds may exert extra administrative costs from facility managers;

C. Treasury system is not always effective in ensuring unauthorized spending, delays are frequent, and administrative costs for facilities are substantial;

D. Treasury system is not capable of ensuring against unauthorized use of funds; release of funds is almost never without delay and requires excessive investment of time and effort from facility managers.

Audit

Indicator PB-26. Scope and nature of audits

A. All facilities are audited annually. A full range of financial audits (internal and external) are undertaken, covering a wide range of issues including performance audit.

B. Most facilities undergo a full range of internal audit annually, although there may be little external audit. Audits cover many but not all range of issues.

C. As a rule, facilities are audited less often than once a year, inspections are limited to transaction level testing.

D. Audits are carried out sporadically, and they do not cover the most significant issues.

Indicator PB-27. Administrative burden associated with audits

A. Audits are not a significant burden to the facilities;

B. Audits are generally not a burden, but there are exceptions;

C. Audits are a significant burden;

D. Audits are highly disruptive to the operations of the facilities, representing an obstacle to service delivery.

Indicator PB-28. Extent of follow up

A. In most cases, there is evidence of timely and effective follow-up on audit findings;

B. Audit findings are generally followed up, but sometimes it is limited to punitive rather than corrective action;

C. There is very little evidence of follow up and it usually limited to punitive measures;

D. There is no follow-up.

Indicator PB-29. Redress policies

A. There are clear and operational redress policies in case facility management feels audit results are unfounded;

B. Redress policies exist but their application is rarely effective;

C. Redress policies exist but they are almost never practiced;

D. Redress policies do not exist.

Revenue collection and financial risk pooling

Indicator PB-30. Significance of formal own-source revenues and expenditures

A. Facilities use own-source revenues and expenditures based on clearly defined rules and only insignificant part of such funds is raised as out-of-pocket payments for services.

B. Some share of formal own-source revenues is raised out-of-pocket, but this is done based on transparent rules which are understood by most administrators;

C. About half of formal own source revenues are raised out-of-pocket, and many administrators are not aware of the rules for service pricings and for using such funds;

D. Most of formal own source revenues are raised out-of pocket and without clearly defined rules.

Indicator PB-31. Extent of unreported revenues and expenditures

A. The level of unreported extra-budgetary expenditure (other than "own revenue/expenditure") is insignificant. Complete "own income/expenditure" information is included in fiscal reports. Spending rules for extra-budgetary income are clearly and transparently regulated.

B. The level of unreported extra-budgetary expenditure (other than "own revenue/expenditure") is small. Information on "own income/expenditure" is sometimes not included in fiscal reports. Spending rules for extra-budgetary incomes are not always clearly and transparently regulated.

C. The level of unreported extra-budgetary expenditure (other than "own revenue/expenditure") is significant. Information on "own income/expenditure" is often not included in fiscal reports. Spending of a significant amount of extra-budgetary incomes happens without clear rules and regulation.

D. The level of unreported extra-budgetary expenditure (other than "own revenue/expenditure") is very significant and is spent without due regulation and oversight. Information on "own income/expenditure" is seriously deficient.

Information Management

Data collection

Indicator ME-32. Division of responsibilities and coordination

A. A comprehensive range of data collection and analysis tasks is clearly and effectively divided between relevant departments at facility and local administration level; statistical function is well coordinated with local healthcare planning process;

B. Most tasks in data collection and analysis are divided between relevant stakeholders but with some gaps and overlaps; statistical function is not always well coordinated with the local healthcare planning process;

C. Some tasks in data collection and analysis are divided, but there are significant gaps, overlaps and problems of coordination;

D. Participation of key stakeholders in data collection and analysis is sporadic and not coordinated in any systemic way.

Indicator ME-33. Availability, frequency and standardization of data

A. The facility level information on inputs and outputs is regularly collected through indicators that are clearly defined;

B. The facility level information is collected however the coverage of the information considerably differs from one facility to another and no standard approaches/guidance exist;

C. The facility level information is frequently not collected. Standard information is not defined;

D. No information is collected.

Indicator ME-34. Quality of information

A. There are clear quality standards on the information that is collected, and facility level information on inputs and outputs which is collected goes through a validation filter which is well grounded and reliable. Higher levels of government (rayon, municipality, oblast levels) do an accurate check of the information collected at facility level.

B. There are clear quality standards on the information that is collected, but they are not always respected; facility level information on inputs and outputs which is collected generally goes through a validation filter which is well grounded and reliable. Higher levels of government (rayon, municipality, oblast levels) do some check of the information collected at facility level

C. On paper there are clear quality standards. However, they are not always followed and there is no rigorous mechanism to validate data. As a result, the accuracy of the information considerably differs from one facility to another and no standard approaches/guidance are followed;

D. Whichever information is collected at facility level, it is just sent "upwards" (to higher level of government) without any validation. Quality standards of information are not defined, nor controlled in practice by higher levels of government (rayon, municipality, oblast levels). Collected information may be distorted in response to fiscal or administrative incentives.

Indicator ME-35. Cost-efficiency of the data collection process

A. Information is stored and transmitted with minimum extra costs.

B. Data collection consumes a reasonable amount of staff work time. Improvements are under way to eliminate any existing inefficiencies.

C. Many healthcare professionals complain about the time they need to spend on statistical reporting and in some cases these duties do not correspond to their professional profile. There are multiple inefficiencies in the way data is stored and transmitted.

D. Statistical reporting is a heavy duty on healthcare professionals, taking a considerable amount of time of doctors and managers (rather than statisticians). Information is stored and transmitted in a highly unreliable and inefficient way.

Indicator ME-36. Capacity for data collection and statistical analysis

A. Primary recording of data is done by professionals of appropriate level and skill and with the use of modern technologies.

B. In most cases data is recorded by relevant professionals but training is not always regular and effective. Some facilities report shortages of appropriate equipment.

C. Majority of facilities complain about lack of qualified staff, training and equipment.

D. There are significant shortages of qualified staff and appropriate equipment, and almost no MIS training is provided to the specialists.

Use of information

Indicator ME-37. Use of statistics by healthcare professionals

A. The information from collected data is actively used by those who are collecting data. It helps them in daily work and they believe the data collection is worth of additional effort.

B. The information from collected data is partially used and to some extent helps in daily work of those who are collecting data.

C. Those who are collecting data do not use data collected (except individual patient records that are recorded anyway) for their daily work, but they understand the importance of data collection for decision making on higher levels.

D. The information from collected data does not improve day to day work of those who are collecting data and they see it only as an additional bureaucratic burden with no clear purpose.

Indicator ME-38. Use of information in managing healthcare facilities

A. The information on facility level data and service delivery standards compliance is collected and actively used by the same facility level to inform management decisions.

B. The information on facility level data is collected in a decentralized manner and to some extent informs management and funding decisions

C. The information on facility level data is collected although no rules exist on type and regularity of information. The use of information for management decisions is limited

D. The information on facility level data and service delivery standards is not used by doctors, head of department, hospital administrators and other facility level workers to improve their day to day work.

Indicator ME-39. Use of information in local healthcare strategic management process

A. Health authorities have a solid information collection/validation/use of decision making system in place. Their M&E or HMIS unit has the capacity to systematically collect the information from facility level, train facility doctors and administrators, produce reports, and share them with senior decision makers on a regular basis to inform management decisions.

B. Health authorities have some information collection/validation/use of decision making system in place. However, their M&E or HMIS unit does not have sufficient capacity to systematically collect the information from facility level, train facility doctors and administrators, produce reports and share them with senior decision makers on a regular basis to inform management decisions. As a result, information on facility level data does not regularly inform management and funding decisions.

C. The information at facility level data is collected although no real control exist on type and regularity of information, and no mechanism/standard exist on how to aggregate it at rayon/municipality/oblast level. Information is not generally used for management decisions.

D. The information at facility level data and service delivery standards is not aggregated and used at higher levels.

Indicator ME-40. Transparency of performance information

A. Information on resources available to healthcare facilities, on performance of facilities, on service delivery standards and compliance to standards is easily available to all those who are interested in it.

B. At least some information on resources available to healthcare facilities, on performance of facilities, on service delivery standards and compliance to standards is published and easily accessible for civil society

C. In general information on any of the above dimensions is not available, but in certain cases it is publicized and discussed; in other words, access requires some efforts (i.e., information request or similar action) but it is not practically impossible

D. There is no information on any of the above dimensions which is made available to population/civil society

Procurement

Regulatory guidance

Indicator PR-41. Transparency and clarity of regulatory guidelines for public procurement in health sector

A. Public procurement in health sector is guided by clear and transparent guidelines, including relevant implementing regulations covering processes not included in higher-level legislation.

B. Public procurement legislation contains some loopholes, but it clearly defines cases for competitive procurement. Some implementing rules may be missing.

C. Public procurement legislation exists, but guidelines for application of competitive procurement methods are vague. Issues not covered by national legislation are handled without any transparency.

D. Public procurement legislation is very weak or non-existent.

Procurement cycle

Indicator PR-42. Methodology for determining quantities of pharmaceuticals to be purchased

A. Procurement is done with an objective and transparent quantification method to determine the quantity of pharmaceuticals to be purchased and defined amounts are assessed as adequate to hospital needs;

B. In most cases, quantification of purchased pharmaceutical follows an objective rule, but it is not always written. Calculation is mostly transparent and adequate, although there are exceptions.

C. Quantification of pharmaceuticals to be purchased follows some rules but they could be modified based on circumstances, and resulting amounts are often inadequate.

D. There are no rules for quantification as such; decisions on amounts of pharmaceuticals are often opaque and inadequate.

Indicator PR-43. Functionality and independence of the Tender Committee

A. There is a Tender Committee with sufficient independence and authority to consistently exercise its duties;

B. There is a Tender Committee, but its functions are not clearly separated from those of the Procurement Office;

C. The functions of Tender Committee and Procurement Office are united within one body;

D. The Tender Committee does not exist.

Indicator PR-44. Objective criteria for Tender Committee membership

A. There are specific criteria for TC membership, which are systemically applied in practice;
B. There are specific criteria for TC membership, but they are not always applied in practice;
C. Criteria for TC membership are vaguely specified and rarely applied;
D. There are no formal criteria for TC membership.

Indicator PR-45. Compliance with Tender Committee decisions

A. Procurement process always strictly complies with the decisions of the Tender Committee;
B. Tender Committee decisions are usually implemented, although there are some exceptions;
C. Tender Committee decisions are often ignored or cancelled;
D. Tender Committee either does not exist or has almost no enforcement power over the decisions it makes.

Indicator PR-46. Appeals

A. There is a formal and functional appeals process for applicants who have their bids rejected; decisions are published and made available to all interested parties and to the public;

B. There is a formal appeals process, but it is not frequently applied. Decisions on appeals are not always publicized;

C. Appeals process is vaguely specified and rarely applied in practice; decisions are never publicized;

D. There is no possibility for the applicants to complain over the decisions on awards.

Indicator PR-47. Procurement information system

A. There is a computerized and comprehensive management information system used to report product problems in procurement;

B. There is a computerized procurement information management system, but it has some gaps;

C. There is a procurement information management system, but it is not computerized and has many gaps;

D. There is no procurement information management system.

Indicator PR-48. Contract administration process for procurement of pharmaceuticals

A. Contract administration system includes regular inspection of consignments and systemic monitoring of suppliers;

B. Most medical shipments are inspected, but there are some exceptions and gaps. Monitoring of suppliers is regular but lacks some information;

C. Existing procedures for inspection of consignments are weak and poorly enforced; post-tender supplier information is not systemically gathered;

D. There is no regular practice for monitoring of consignments and suppliers.

Indicator PR-49. Contract administration process for procurement of equipment

A. Procured equipment is monitored through a regularly updated register and supplied with due technical maintenance;

B. There is a register or procured equipment, but it is not regularly updated. Technical maintenance of equipment is sometimes overlooked in the procurement process;

C. Registration of procured equipment is sporadic and irregular; technical maintenance of new equipment is often lacking;

D. There is no registration and no systemic technical maintenance of the procured equipment.

Indicator PR-50. Procurement audit

A. Procurement office undergoes regular internal and external audits, covering key procurement information, and openly publicizing the results;

B. Procurement office undergoes regular internal audit, but not necessarily external audit. There are some gaps in coverage and publicizing of the results;

C. Procurement audit is limited to internal irregular inspections of some issues, and the results are not disclosed to the public.

D. There is no audit of procurement.

Integrity and transparency of the procurement system

Indicator PR-51. Ethics and anticorruption measures

A. There are clear rules addressing conflict of interest and other forms of unethical behaviour, including actions to be taken, secure mechanisms for report of unethical behaviour. These rules are understood and applied by procurement specialists.

B. There are formal rules for addressing unethical behaviour, but they are not comprehensive and not always applied in practice.

C. Rules for major types of unethical behaviour are very weak and rarely applied in practice.

D. Rules for major types of unethical behaviour do not exist or exist but are never applied in practice.