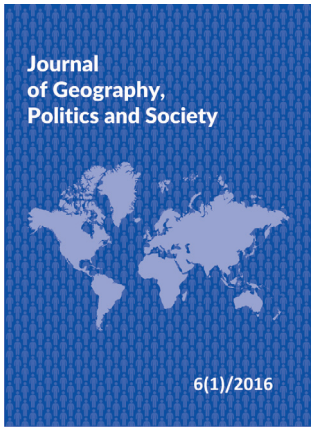

Journal of Geography, Politics and Society

2016, 6(1), 5–9
DOI 10.4467/24512249JG.16.001.5250

FISCAL CONSOLIDATION FOR GRANTING HEALTH SERVICES IN A DECENTRALIZED POWER IN UKRAINE

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Citation
Bilynska M., Kuliginskiy E., 2016, Fiscal consolidation for granting health services in a decentralized power in Ukraine, *Journal of Geography, Politics and Society*, 6(1), 5–9.

Abstract
The aim of the study is to find the optimal model of consolidating financial resources combined communities to ensure effective provision of health care in Ukraine. The proposals on the formation of community expenditures for various kinds of medical care. Investigated and analyzed the positive experience of Poland reforming the health sector under decentralization of power that should be used in Ukraine.

Key words
decentralization of power, healthcare, Ukraine.

1. Introduction

The actuality of the study presented in this article is linked to the announcement of the European vector of Ukraine's development and the initiation of a series of reforms in public administration. "Strategy for sustainable development «Ukraine – 2020» announced in 2014 by Petro Poroshenko, the President of Ukraine, as one among the most important goals defines the reform of management system, and the power decentralisation implementation. This determines new administration mechanisms in the healthcare sector at the local level. Poland during its walk towards European Union implemented a number of reforms in the healthcare sector. It seems to be feasible to learn them and apply in Ukraine. The existing health care system in Ukraine is characterised by outdated methods of delivering primary healthcare (PHC) at the level of villages, and sometimes cities. This is explained by its artificial fragmentarity and atomism. As a result there is a substantial time delay in making diagnosis and providing relevant medical treatment for patients. Oftentimes people have to pay visits to six different doctors. This significantly increases the cost of medical assistance both for private households and local communities in general (Попова, 2015).

This way of proposing specialised medical services in PHC facilities was implemented in Ukraine in the middle of 20th century by building outpatient policlinics. In the total allocated budget of such an establishment traditionally about 41% are

non-formal payments of citizens. In the majority of such institutions the access of public to information on tariffs for medical services is not available. Community-owned facilities are often used for rendering services on a private basis when payments out of patients' pocket do not reach communal budgets (the so-called crawling privatisation) (Ведернікова, 2014).

It should be taken into consideration that today's medical staff of specialized medical care oftentimes resist to any infrastructural changes in favour of preventive PHC based on family medicine practice.

Current underdeveloped state of Ukraine's healthcare system is explained by low responsibility of citizens for their own health, by reduced requirements to quality standards and accessibility of medical assistance, family doctors often lack motivation to do timely preventive medical checks and provide effective treatment to patients. In fact a citizen non-controllably "matures" to the state of being ill with sometimes neglected and deadly dangerous diseases requiring urgent specialized or highly qualified medical treatment. Premature mortality rate is one of the highest in Europe, first of all it concerns men in working age, and it is possible to prevent it by rendering medical assistance.

Accessibility of specialised healthcare to a patient bypassing a family doctor (urgent cases excluding) makes it financially dominant above preventive and PHC.

Ukraine's legislation demonstrates obvious preferences to specialised healthcare based on 'customary law' without taking into consideration 'equitable law'.

In conditions of noticeable aging of population there is a modern form of providing physical and financial accessibility to quality PHC in developed countries, in Poland in particular, and this is a qualified family doctor. This practice enabled in these countries within a space of 30 years to reduce to some extent the premature mortality and disability of population thanks to timely diagnostics and quality treatment of patients by private family doctors first of all.

2. Decentralisation processes and their effect on healthcare system

Today power decentralisation processes are underway in Ukraine; they are mainly focused on strengthening of financial independence and accountability of local communes.

We made an analysis and proposed a forecast on the number of village communes, we calculated their needs in PMC after the reform of local self-government has been implemented (table 1.).

Ukraine has got some success stories of healthcare system reformation, and it would be appropriate to use this experience. One of such examples is the city of Komsomolsk in Poltavska oblast which during 15 years has been a venue for PHC model development. Several pilot projects concerning the family medicine model have been implemented in this city. After adoption of several national laws and orders of the Cabinet of ministers in 2015 a portion of taxes from businesses' and individuals' income tax will likely stay in the city budget of Komsomolsk and it will make up 62.7% of total revenues. While tax on the individuals' revenues will make up 29.6%, local taxes will make up 14% of the total budged revenues. State budget share in the city budget structure will make up 37.3% in a form of transferred subvention. At the same time in monthly deductions from salaries and corporate taxes the share of contributions aimed for healthcare system will not be specified.

Tab. 1. Estimated number of village communes and their needs in PMC after self-governance reform in Ukraine

No.	Before reform	After reform
Evolution of communes		
1.	2015 – 11.5 thousand of city and village councils Each village council accounts for 3 village-type settlements, 47 km^2 of territory; in Ukraine 28% of villagers live 3 to 10 km distant from their village council. One village council accounts for 1.4 thousand permanent population; average population per village makes up 520 people.	2017 – 1.5 thousand communes; 9 thousand people in a commune; average number of settlements in a commune makes up 16; territory = 400 km^2; max distance to administrative centre is 20 km; population of one village is 520 people.
Health care provision in villages		
2.	Three paramedics at three feldsher-midwife stations, or a family doctor and a nurse - rarely; car is rarely available.	As per criteria of family doctors availability in rural areas (1.2 thousand) a commune with 9 thousand people needs 7-8 family doctors, 14–16 nurses and 7 nurse assistants.

Source: Own studies based on: Ведернікова, 2014.

As the experience of Poland showed to give real rights to local communities and rayons to form their own budgets the effective tools were implemented to ensure their filling up. So, a share from the national budget makes up 25% from individuals and 15% from businesses. 100% of proceeds from tax on land, real estate, death-duties and agricultural activities stay in local budgets (Kutzin, 2001).

The base of revenues of poviats and cities made equal to poviats consists of local contributions form sales, parking services and other paid services. A share of state budget in the total budget of local governance only makes up 0.4%. EU contributions make up 9%.

The exceeding limit of budget income per capita is 15%. To level voivodeships' capacities applied are subsidy and grant mechanisms, as well as money of environment protection fund, International investments bank, grants for education, credit lines, bonds are involved.

During 17 year Poland participated in the European programme of creating special economic zones. Today they are 14 effective. Before 2020 there is an existing limit on their space, it should not be more than 20 ha each.

Enterprises enjoy tax holidays on profit and real estate. Compensations for invested costs in the amount of 55% for small and 45% for medium businesses are stipulated. During 15 year period the amounts invested annually in economic zones made up more than 1 Bn Euro and 15 thousand jobs were created (Lekhan et al., 2007).

After joining the EU Poland received in 2004–2006 3 Bln Euro annually to solve the mentioned issues of which 30% were allocated to regions to spend at their own discretion. During the period of 2007–2013 years 37 Bln Euro was spent (about 9 Bln annually). For the next 7 years 2014–2020 more 2 Bln euro were envisaged. Of this amount 25% are allocated to the regions.

These actions provided that Poland increased its GDP per capita by 19% (growth from 49% in 2004 to 68% in 2013). This enabled to create appropriate organisational and financial conditions for developing modern health care system.

1. System risks during reform implementation in Poland should be listed as follows:
2. The government tried to load self-governance with "uncomfortable" powers or to snatch powers and money from local communes. So in this case it is necessary to have clear legal and administrative tools for powers realisation. This concerns the refusal of central government to amend laws in its favour.

Delegation of powers and budget formation to poviats and implementation of relationships: strong gmins and poviat, poviat and strong city, poviat and powiat's territory. Formation of poviat councils is feasible by delegating deputies of gmin councils.

3. New health care system – re-boot

Let's consider a possible strategic action plan of Ukrainian authorities and civil society to create a new health care system.

The essence of administrative-territorial reform in Ukraine should concern the formation of institutional mechanisms enabling effective functioning of social services especially at the level of village and city communes.

Therefore the first steps in creation of new health care system, which will be based on modern socially oriented mechanisms viable in the market environment must be the following:

- to ensure adoption of new legislation facilitating demonopolisation, economy legalisation, respect to property rights in social infrastructure, especially healthcare and its functional and financial structuring according to types of medical services;
- from political point of view – to facilitate creation of policy susceptible to health care system needs by newly elected local government bodies who should provide adequate conditions for priority funding of preventive and PHC based on family medicine practice;
- real separation of local budgets from the state budget, transfer rights to communes for real creation and filling of their budgets and their spending including for the health care sector;
- transfer property rights for land, buildings, medical equipment to local communes, including the health care sector;
- Transparency of medical services purchasing schemes;
- To ensure real independence of village councils chairmen;

We propose to distinguish the following conditions of the development of new health care system in Ukraine:

1. Political will of the state leaders and local-level authorities in justification and modernisation of the country, region, rayon and local communes, their capacity to overcome the resistance to changes.
2. Active involvement of experts community in developing strategies for changes implementation.

3. Support to citizens, first of all to young people below 35.
4. Support to progressive medical community, first of all to young people with statesmanship vision.
5. Professional independent media.
6. Development of professional competencies in modern public management.

From the point of view of ensuring citizens with health care the administrative-territorial and local governance reform should stipulate the creation of:

At a commune level:

- In villages – outpatient clinics of family medicine to render PHC, urgent, palliative and hospice medical assistance. At the same time money transfers should be ensured for patients sent by PHC facilities to institutions of specialized medical services. First of all it concerns children, disabled people, pregnant women and lonely people.
- In cities – deployment of PHC centres based on family medicine practice, growth of specialised medical assistance.

In regions:

- Integration of institutions of specialised medical assistance based on the patients' needs and budget capacities.

In oblast centres:

- Financing patients' needs from communes and rayons and other regions to provide highly qualified medical assistance.

4. Summary

Based on the described above we can outline the following tasks in the area of creating and consolidating financial funds for rendering healthcare services in Ukraine.

Village and city communes should be able to finance outpatient clinics of family medicine, urgent, palliative and hospice medical assistance or to delegate these functions to rayon level. Within a commune the evaluation of inhabitants needs in consultative, diagnostic and other specialised assistance should be carried out (hospitals). In fact this is a justified financial resource at the rayon level. The control over these funds spending should be performed by deputies of village, town and city councils. Based on Poland's experience deputies of local communes should be delegated to rayon councils to control the effective spending of monetary funds, first of all in health care sector. It means secondary level healthcare should be provided by rayon healthcare departments under the control of the rayon council deputy delegated by a commune. Under these conditions the second level healthcare structure will clearly correspond to realistic healthcare needs of village, city, rayon communes with regard to their financial capacities.

Also a 3-fold increase in expenditures for preventive, PHC, palliative and hospice, urgent and rehabilitation assistance should be stipulated. Expenditures for secondary health care should be reduced respectively, first of all for outdated hospital infrastructure. This will enable to partially legalise communes' resources intended for secondary health care funding.

For communes of the cities it will be funds localisation for rendering all types of the abovementioned medical services when they will get respectively from 10% up to 35% of the total funding. In the cities it is feasible to form a general pool consisting of autonomous modules per each type of health care. In villages this approach will concern financing preventive, PHC, urgent, palliative and hospice assistance at their own cost, or this function will be transferred to the rayon level.

There is a controversial discussion on the issue how to finance emergency medical assistance and this requires addition study. Communes should be able to calculate their real needs in such type of service and to control/delegate their financial resources to a rayon or oblast level.

Financial resources of communes (basic level) should be consolidated around a family doctor and family nurse working in outpatient clinics of family medicine or PHC centres. At the regional level responsibility for the specialised health care should be laid on a hospital.

During transition stage from existing to new administrative-territorial and local self-government system it is feasible to consolidate PHC and SHC services purchasing at the level of rayon healthcare departments. This coincides to some extent with ERB WHO recommendations about consolidation of PHC and SHC purchasing.

Taking into consideration the experience of Poland the creation of modern rayon and oblast self-governance levels should become the next step in the management system decentralisation (at least in several years). As this will have a cardinal impact on health care, education, and housing and communal services sector, road and communications sector management, it is necessary to prepare and adopt a number of legislative acts.

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