World Health Organization

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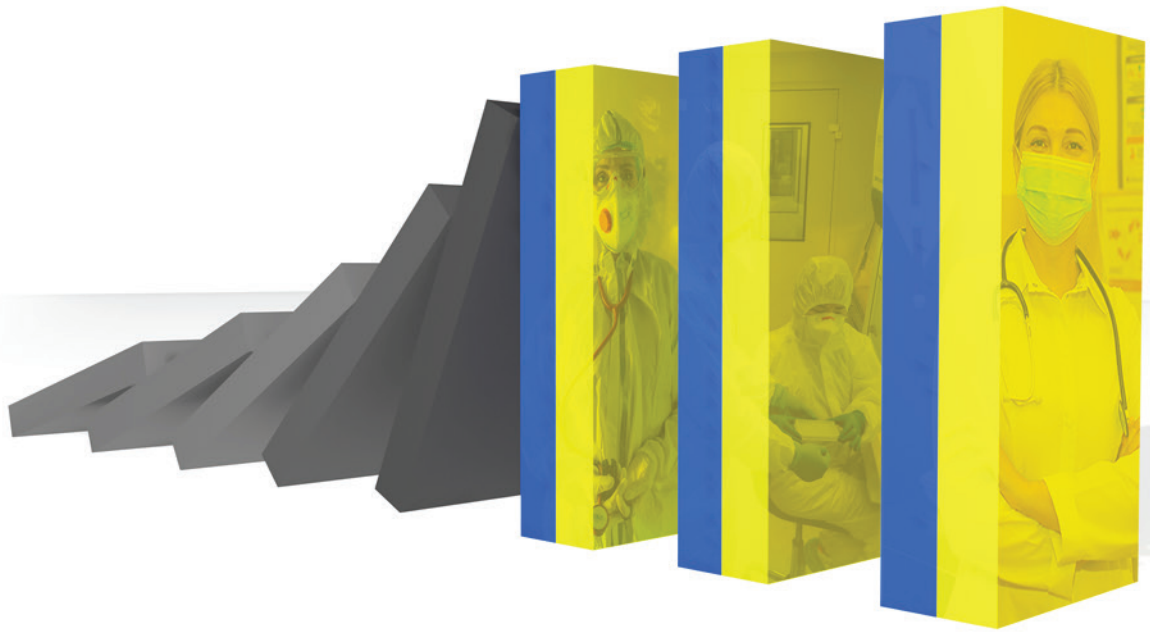
HEALTH FINANCING IN UKRAINE:
RESILIENCE IN THE CONTEXT OF WAR

Health policy paper series



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Document number: WHO/EURO:2022-5882-45647-65535

Suggested citation. Health financing in Ukraine: resilience in the context of war. Copenhagen: WHO Regional Office for Europe; 2022. Licence: CC BY-NC-SA 3.0 IGO.

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

Design by Djordje Dević

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ACKNOWLEDGEMENTS

WHO Country Office in Ukraine would like to thank Alona Goroshko (WHO Country Office in Ukraine) and Solomiya Kasyanchuk (WHO Country Office in Ukraine) for the authorship of this document. Internal review was provided by Tomas Roubal (WHO Country Office in Ukraine), Triin Habicht (WHO Barcelona Office for Health Systems Financing) and Tamás Evetovits (WHO Barcelona Office for Health Systems Financing). Overall technical guidance of the report was provided by Jarno Habicht (WHO Country Office in Ukraine) and Tamás Evetovits (WHO Barcelona Office for Health Systems Financing).

WHO Country Office in Ukraine would like to express gratitude to Elina Dale (Norwegian Institute of Public Health), Olena Doroshenko (World Bank Group), Svitlana Dudnik (National Health Service of Ukraine), David Elkins (USAID Health Reform Support), Anna Fenchak (National Health Service of Ukraine), Loraine Hawkins (WHO Country Office in Ukraine) and Kaija Kasekamp (WHO Country Office in Ukraine) for their technical contributions and review. WHO also express sincere gratitude to the Ministry of Health of Ukraine and the National Health Services of Ukraine for discussions and inputs provided during the process of developing the report.

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

The report was produced with financial support from the Grand Duchy of Luxembourg and the European Union within the EU-Luxembourg-WHO Universal Health Coverage Partnership. Production was also supported by the Government of Switzerland (Swiss Agency for Development and Cooperation).

ABBREVIATIONS AND ACRONYMS

AMP	Affordable Medicines Programme
CBPF	Country-Based Pooled Fund
IDP	internally displaced person
MDTF	Multi-Donor Trust Fund
NHSU	National Health Service of Ukraine
OCHA	United Nations Office for Coordination of Humanitarian Affairs
PHC	primary health care
PMG	Programme of Medical Guarantees
UHC	universal health coverage
UHF	Ukraine Humanitarian Fund

1 INTRODUCTION

Ukraine's health financing system has made significant progress since 2017 through the introduction of new financing mechanisms, continuing even during a period when the world was facing the biggest public health crisis of our lifetime. The country has built up a highly agile and capable purchasing agency, the National Health Service of Ukraine (NHSU). However, the war, which started on 24 February 2022 and is still ongoing, has put all these achievements at risk. There are three major requirements that have been highlighted within this crisis.

Planning how to address long-term consequences based on principles of universal health coverage (UHC). This should start as soon as possible as experience from across countries facing conflict and emergencies has demonstrated that, while the humanitarian response must be prioritized and immediate needs addressed *(1)*, it is imperative to consider the long-term consequences of financing and service delivery arrangements in order to build back better. In this context, it is crucial that the underlying principles of the pre-war health financing system and the existing public institutions are supported, avoiding fragmentation to the extent possible.

Ensuring that the population has access to essential health services without suffering from financial hardship during the war. The war is likely to halt or even reverse Ukraine's progress towards UHC through the worsening economic situation of most households; however, health financing adjustments could soften the effects for those most in need. Public resources must be prioritized and focused to ensure physical access to services of acceptable quality without barriers of financial hardship.

Adapting the major adjustments in the provider payment mechanisms initiated at the beginning of the war with post-war recovery in mind. The financing arrangements before the war have been described in more detail in other publications, such as the WHO–World Bank health financing review in 2021 *(2)* with the general reform direction envisaged a further move towards output-based financing. To adjust the system to the context of war, the Government in March 2022 replaced most of the payment methods with the global monthly budget, which allows for more predictable and stable financing. Adapting this situation to address health needs, available resources and population movements requires further adjustments especially with the post-war recovery in mind.

This technical note provides tailored advice on further adjustments in health financing policy in the context of war based on principles of UHC, solidarity and equity. It summarizes international evidence and accounts for specific features of health financing reform in Ukraine. The primary focus will be on short-term adjustments and to a lesser extent on medium-term measures.

2 OBLAST-LEVEL POPULATION HEALTH NEEDS-BASED AND PROACTIVE PURCHASING APPROACH

An oblast-level purchasing approach that is proactive and based on population health needs is key to ensuring access to care and efficient use of resources. The following main areas are highlighted.

The health financing adjustments at the beginning of the war were necessary and secured financing for health facilities in a rapidly changing situation. The Government adjusted the payment methods in both primary health care (PHC) and specialized services during the first month of the war to allow for permanent and predictable payments to all contracted facilities. More specifically, capitation payments for PHC and case-based payments for hospital care were replaced with global budgets, calculated as one twelfth of the planned contract budget between the NHSU and a provider. Planned budget were defined for 2022 based on the historical number of services provided for most of types of care. These adjustments allowed payments to be quickly disbursed at the beginning of each month to all contracted facilities, securing funds for salaries and other essential inputs while planned care was officially curtailed.

The currently used global budget does not address changes in need and should be adjusted. Significant internal displacement, movement of health-care workers and changing health needs suggest that a budget calculated as one twelfth of the planned contract budget could be inefficient. More funding is needed in regions with increased demand, and less funding is required in facilities without patients or health-care workers. Further adjustments to purchasing of health-care services are required.

Oblast-level population health needs-based contracting adjustments could help to account for regional contexts and needs in the short term. Before the war, the NHSU used a unified approach to purchase health services throughout Ukraine. The war is having varying impact on regions, and the Government may, therefore, need to consider varying approaches to financing health-care services in different oblasts. Oblast-level contracting adjustments could allow the use of a more granular approach in terms of payment methods: the global budget could be adjusted to a facility's current capacity (such as when a significant share of the staff has left or the facility was damaged). In oblasts with high number of internally displaced people (IDPs), the global budget could be combined with output-based payment methods to encourage provision of access for a temporarily displaced population (Tab 1). Adjustment of the number of planned services, as well as use of output-based financing methods, may also create space for the good use of displaced health-care workers.

Macro-Region of Ukraine	Estimated IDPs per macro-region
West	2,900,000
Central	1,666,000
East	1,472,000
North	1,234,000
South	519,000
Kyiv city	238,000

Table 1: Estimated location of IDPs by macro regions, 3 May 2022

Source: International Organization for Migration, 2022 *(3)*.

Soon, a more comprehensive contracting strategy should be introduced to reflect changing population health needs. This mid-term strategy could respond proactively to contracting of providers, using population health needs rather than provider-initiated contracts. Before the war, purchasing of services was largely driven by a facility's willingness to sign contracts for specific service provision, and contract volume was mostly based on the historical number of services provided. This approach was suitable at the initial stage of health financing reform but now creates barriers to full implementation of strategic purchasing of services. Proactive contracting will mean an active role for the NHSU in planning and purchasing health-care services based on local health needs and the best ways to address them. The further development of a selective purchasing approach is also needed and should be based not only on providers' compliance with requirements but also on the strategic vision of how services should be developed across the territory to ensure access to the required services. This will mean that providers

will need to develop and provide these services accordingly. This would allow a better focus on local health needs and would align NHSU financing strategy to oblast provider network (hospital district) development plans. The introduction of multiyear contracting with providers would give providers more predictability for planning their own budgets and larger-scale changes in service delivery to increase quality and efficiency.

2.1 | Financial incentives should enable PHC to play a key role in health-care provision

Since 2017 Ukraine has made significant progress in the prioritization of PHC. The new payment methods, the electronic health system, availability of PHC services in all regions and providers' autonomy have created a solid base for the further strengthening of PHC. Some limitations remain, however, including a rather narrow scope of benefits and a lack of teamwork, which will need to be taken into account when adjusting the PHC financing approach.

PHC will play a key role in ensuring access to care during the war and post-war recovery. In terms of volume, the population's needs for noncommunicable disease management, regular services (vaccination) and other PHC-manageable conditions will represent the main burden of needs/diseases. PHC services are the most easily accessible, affordable and cost-effective type of care available across Ukraine. Furthermore, given possible restricted access to specialized care services, access to PHC for both people fleeing the war and those staying at home is essential.

PHC providers cannot refuse provision of care under Ukrainian law, and financial incentives should support this provision. PHC services were previously paid per capita and are currently financed using a global budget based on the number of patients served as of 1 March 2022. In March 2022 the Ministry of Health mandated PHC facilities to provide care at no cost for IDPs. Because of global budget constraints, the providers in oblasts with increased demand are not compensated for their increased workload and this may create barriers for IDPs in accessing care. This is particularly worrying with regard to the high number of internally displaced children, who usually have higher health needs than adults and now account for 2.5 million patients. Financial incentives should, therefore, be provided to facilities that are seeing increased numbers of patients to ensure access to care for people fleeing the war. Additional consultations with providers could be conducted by the NHSU to suggest the most suitable option.

Additional direct incentives for providers should be considered to promote access to priority services. Priority services may include routine vaccination for children, COVID-19 vaccination or outreach visits by community-based mental

health teams (see Annex 1). When applying these direct incentives, the NHSU should also apply budget controls by either putting caps on monthly service volume or adjusting payment rates in case there is a risk of budget shortage because the number of services is higher than planned.

2.2 | Adjustment of specialized care financing to reflect changed needs

Population movements will have impacts on financing care for chronic and life-threatening diseases, with patients displaced by the war still needing to receive ongoing care for serious chronic and infectious diseases.

Taking population movement into account will be crucial for financing care for chronic and life-threatening diseases. Before the war, the treatment of these diseases was financed based on historical number of patients treated by each facility. Given the population movement, the payment approach for these services should be adjusted based on increased needs in some regions and decreased needs in others.

A case-based payment system is recommended. The diagnosis-related group reimbursement system could be used to help in matching global budget financing of inpatient services with local service utilization. This method would allow better division of payments based on actual activity or response to the war, with those affected by the hostilities increasing their activities and the number of patients served and receiving a higher share of the payments. In oblasts from which people have fled due to the war, combination with payments based on global budget could be used to allow for covering fixed costs and to ensure that services are available when responding to war efforts.

Specific trauma-related services should be prioritized. High-cost medical devices for surgical trauma treatment or assistive technologies already represented a de facto gap in coverage before the war; this gap was partially covered by local budgets. In a situation where the revenues of local budgets decrease and the need for trauma treatment increases, the Government should consider increasing the tariffs in relevant Programme of Medical Guarantees (PMG) packages or increasing the budget for eligible facilities based on data. The payment approach for rehabilitation services should be further developed to account for severity of need and complexity of provided care. A technical assessment to estimate the prevalence of the most common conditions caused by conflict, based on international experience and local data collection, and the interventions required could allow additions to be made to the PMG. Support with such an assessment is currently being provided by the United States Agency for International Development and the United Kingdom Aid Direct Health Reform Support Programme.

Strategic purchasing instruments could be used to promote better access and patient-centred service delivery systems. The potential for improved results in stimulating new service delivery models in Ukraine is showcased by the mental health mobile team model, which was established in 2021 and through which the NHSU contracts 65 teams across all oblasts to provide community-based mental health care (Annex 1). This is planned to expand to 120 teams. Purchasing instruments can stimulate new service modalities that can respond to increased and/or changed needs of the population (such as remote and mobile services, telemedicine and expanded PHC services including for mental health). The NHSU's role in the development and implementation of these financial stimuli will be crucial in the reconstruction period.

Adjustments described above and their effectiveness rest on strong monitoring, which needs to be re-established. The monitoring function provides purchasers with an opportunity to prevent fraud, ensure service availability and ensure compliance with basic quality and safety requirements. At the beginning of the war, this function was suspended. Currently the absence of opportunity to monitor providers deprives the NHSU of the possibility of ensuring protection of patient rights or to prepare for post-war recovery. The absence of a monitoring mandate creates serious risks for the successful development of strategic purchasing in Ukraine. Consequently, the monitoring function should be re-established and strengthened.

3 PRIORITIZATION FOR ACCESS TO MEDICINES

Access to medicines must be improved as medicine costs are a driver of catastrophic expenditure.

Medicines are the major driver of catastrophic expenditure in Ukraine. Such outgoings often leading to the impoverishment of families; in 2015 around half of all catastrophic expenditure in Ukraine was driven by out-of-pocket payments for medicines *(4)*. Given the worsening economic situation for patients in Ukraine and increased health-care needs, prioritization of access to medicines is key to ensure people have access to treatment without suffering financial hardship.

Access to outpatient medicines should be expanded by suspension of copayments for medicines in the benefits package. Copayments for reimbursed insulin have already been suspended because of the war. Given the possible problems with the logistics of provision of medicines, increasing prices and the loss of income by many Ukrainians with chronic diseases, the Government should also allow free access to all medicines included in the Affordable Medicines Programme (AMP).

The list of medicines included in the AMP should be widened to ensure access to outpatient medicines. Expanding the AMP offers the fastest and easiest way to improving access to essential medicines on an outpatient basis that the Government has available. This could include new drugs for treatment of diseases already included in reimbursement, especially for noncommunicable diseases, mental health conditions and for treating new conditions. Given that the reimbursement list is based on the National Essential Medicines List, which is quite narrow in Ukraine, a review of the List will be needed in order to align it with the standards in countries in the European Union and WHO's list of essential medicines.

Medicines for inpatient care should be prioritized. The war has had dramatic effects on supply chains and, along with a high level of inflation, it will negatively affect the availability of medicines in hospitals. According to NHSU data, in 2021 hospitals spent around 19.3 billion UAH on medicines. If inflation of medicine costs was to grow to 25% (current level of inflation of prices for medicines is 13.9%),

it will require an additional 4.8 billion UAH, just to sustain the level of medicines available at the pre-war level.

Information about the prescription of medicines is crucial to improve access to treatment. The development and implementation of medicines modules in the electronic health system will provide important insight into which medicines are prescribed to patients in inpatient and outpatient settings. Further expansion of benefits will be possible based on such data.

Access to centrally procured medicines is crucial for patients with serious conditions. The movement of people, including people who need medicines that are procured centrally, requires rapid adjustments of the regional allocation principles and delivery of these medicines. The principle that the medicines follow the patient should be used for IDPs receiving chemotherapy, immunosuppression or medicines for rare diseases or other conditions.

4 PUBLIC SPENDING ON HEALTH

The level of public spending on health should be sustained and possibly increased to reflect the likely needs of the population.

Health was prioritized in the State Budget for 2022 and remains a Government spending priority. In March 2022 the Parliament adjusted the Budget 2022 and reallocated more resources to defence-related programmes but kept the health-care budget the same in nominal terms. Due to the deterioration of macroeconomic fundamentals (gross domestic product has contracted and inflation increased), the share of health care in gross domestic product is envisaged to increase from 4.1% to 5.6%; health-care spending per capita decreased in real terms from 2860 UAH to 2494 UAH (a decrease of 12.8%). The Government should continue prioritizing health care, given that health needs have increased and that the health budget has decreased in real terms.

Health spending efficiency should be increased. Oblast-level contracting strategies will allow the use of fewer resources in a more efficient manner. However, continuing use of the system of paying one twelfth of annual budget every month will undermine efficiency of spending of public resources in the longer term. Increasing efficiency may require facilities to take measures such as reductions in nonmedical staff and to consider new modalities of meeting health needs through strengthening PHC.

The risk of budget consolidation and cash flow issues should be carefully assessed and different scenarios should be considered. To account for possible risks, the Government should model the possible prioritization options for services under different funding scenarios. Increased needs should also be taken into account, protection of life-saving treatment secured, and priority packages and essential input costs (such as salaries) re-evaluated, set and reflected in payments to providers. Payments to facilities that are not under the control of the Government of Ukraine must be reviewed.

The Government's regulation on minimum salaries is important to provide a sense of security for health workers, but its effective enforcement goes beyond the NHSU's mandate. Currently the NHSU is required to control the "fairness of calculations of salaries" at a facility level, and to account for this salary level when calculating tariffs. While the NHSU can monitor the expenditure of providers, the control function contradicts the principle of purchaser–provider split. Furthermore, the NHSU has no method for altering salary decisions at facility level, unlike local governments, which approve the financial plans of facilities. Consequently, oversight of the remuneration of health workers needs some rethinking. An assessment of financial sustainability of the regulation of minimum salary should be conducted to ensure funds availability in health spending.

5 PROVISION OF RELIABLE HEALTH AND FINANCING DATA

Reliable data are crucial to understand population health needs and to adjust the health financing system.

Ukraine has a well-developed electronic medical records system and it is vital to ensure that data collection continues. A decreased level of data input has been observed in all regions of the country, even those not directly affected by the war. However, the electronic health system has proved to be relatively stable even during the war, as data inputs have been renewed to some extent. Since information is crucial for the strategic purchasing of services, it is important to ensure that all facilities (including, as much as is possible, those located in or close to areas of active hostilities) continue to report data to the record system, including expenditure and cash balances.

Additional information on the availability of health facilities and human resources for health is crucial for future strategic purchasing. Data collection tools from regional and national levels of the medical statistics centres need to be aligned to collect information outside of the e-health system. These data will help in developing new and expanded services and will also inform decisions about how best to pay providers in places where health workers have departed in substantial numbers.

The health needs of the population are changing, and additional information on specific needs should be collected. Ukraine is likely to face an increased burden of diseases and injuries, specifically resurgent infectious diseases, mental health disorders, increased demand for physical rehabilitation and prostheses and delayed demand for foregone services and rehabilitation.


Форма 003
Форма 066
Передати ЕМЗ про ВИПИСКУ до НСЗУ (через eHealth)
Час відправки ЕМЗ до НСЗУ
Причини звернення
Епікриз

6 ROLE OF PUBLIC INSTITUTIONS IN PLANNING POST-WAR RECOVERY

Public institutions should be in the driving seat when planning post-war recovery.

Ukraine has managed to build up a highly agile and capable NHSU and other Government institutions. The NHSU has an information system, regional representation with good knowledge of providers, flexible purchasing mechanisms and high capacity in terms of staff. It also has systems to gather patient complaints. This makes it well positioned to:

- proactively adjust the health financing system using available data and information from its regional offices;
- provide expert support in coordinating humanitarian responses;
- support transparency of service delivery and financing; and
- plan for recovery and further development of the health system.

Well-coordinated donor and humanitarian support should be led by, and rely on, the national health system. If there is no national coordination system in place, there is a risk of fragmentation and incoherence in purchasing and service delivery arrangements, as well as inequalities, duplications or gaps in financial support. An overview of two key coordination mechanisms currently in place in Ukraine is presented in Box 1.

Capital investments should be based on building back better principles, allowing new service delivery models. This approach includes a focus on PHC, its expanded scope and multidisciplinary teamwork approach, community-based health, mental health and rehabilitation services, and the physical integration of vertical programmes into the general service provision system. This offers

Box 1. Good practice for coordinating financial support

Two mechanisms are described that help to avoid fragmentation of funding and support government priorities: the Multi-Donor Trust Fund (MDTF), managed by the World Bank, and the Country-based Pooled Fund (CBPF) for humanitarian financing, managed by the United Nations Office for Coordination of Humanitarian Affairs (OCHA). According to the WHO guidance document on health financing in fragile and conflict-affected settings *(5)*, these mechanisms significantly improve the coordination of external funds and play a pivotal role in minimizing fragmentation and duplication. Importantly, from the perspective of the humanitarian–development nexus, in contexts such as Ukraine where two vehicles are active but have different management, the processes and policies inherent in both should be harmonized both with each other and with existing government systems.

The Ukraine MDTF

The Ukraine MDTF was set up in March 2022 to provide a coordinated financing mechanism to support the Government of Ukraine in its efforts to continue to provide critical public services and protect the most vulnerable groups. The MDTF is linked to the Financing of Recovery of Economic Emergency Ukraine Development Policy Operationa prepared and approved by the World Bank Board 11 days after the invasion *(6,7)*. The package amounted to US$ 723 million, including a pledge of approximately US$ 674 million to the MDTF by eight countries: Austria, Denmark, Iceland, Latvia, Lithuania, Norway, the United Kingdom and the United States of America.

MDTFs can deliver rapid, targeted and secure support. Typically, in MDTFs managed by the World Bank, policies and procedures are based on its normal lending operations. However, in crisis or post-crisis situations, exemptions can be made to facilitate quick disbursements. MDTFs have been used extensively in fragile and conflict-affected settings by the World Bank, including in Afghanistan, the Democratic Republic of the Congo, Mozambique, South Sudan, and the West Bank and Gaza Strip *(8)*. The MDTF plays a particularly important role in better coordinating external funds for longer-term rehabilitation and development assistance. However, for the MDTF to have a real impact on harmonization, a much larger proportion of total funds from bilateral donors should be channelled through these mechanisms.

The CBPF

The Ukraine Humanitarian Fund (UHF) *(9)*, established in 2019, is a United Nation's CBPF where contributions are collected into a single, unearmarked fund and managed locally by the OCHA Humanitarian Financing Unit. Currently, more than 20 countries have made contributions to the UHF *(10)*. Prior to February 2022, it primarily targeted the need for critical humanitarian access in areas not controlled by the Government and supported efforts to bridge humanitarian and development activities in Government-controlled areas.

UHF funding is allocated in accordance with the allocation strategy paper and priorities described in the Humanitarian Response Plan and Flash Appeal, retaining the flexibility to allocate funds to unforeseen events or special requirements. In the case of the 2022 war, the Flash Appeal *(11)* was used as the Humanitarian Response Plan is yet to be developed for this emergency. United Nations agencies, funds and programmes, national and international nongovernmental organizations, and the Red Cross Movement can receive funding from the UHF. Project proposals are prioritized and vetted within the health clusters through the Strategic Review Committee and then recommended to the UHF Advisory Board for comments and final approval. In 2020 CBPFs allocated US$ 909 million to humanitarian operations in 18 countries *(12)*.

In general, CBPFs under OCHA, such as the UHF, are focused on life-saving activities and emergency responses. While the UHF encourages its recipients to work within existing systems (using existing hospitals and working where partners already have access) rather than creating parallel ones, its focus is not on system strengthening. Platforms such as the Health Cluster *(13)* play an important role in this.

[a]A Development Policy Operation is a specific operation using a Development Policy Financing instrument that provides rapidly disbursing financing to help a Member State address actual or anticipated development financing requirements. Development policy operations are supportive of, and consistent with, the Member State's economic and sectoral policies and institutions and aim to help in broad-based sustainable growth and efficient resource allocation *(6)*.

opportunities for replacing costly and inefficient infrastructure with a needs-based, flexible and environmentally friendly provider network. The tenets and priority directions are described in more detail in other publications, such as the WHO consultation draft Principles to Guide Health System Recovery and Transformation in Ukraine *(14)*.

Monitoring of humanitarian assistance should be carried out at the national level. This includes tracking provision of medicines and consumables, as well as investments in equipment. There is anecdotal evidence about facilities trying to receive the equipment in order to comply with the NHSU requirements and qualify for the higher number of packages. This development puts at risk development of the service delivery network and might not be financially sustainable.

Oblast-level monitoring of health needs should inform future decisions on recovery and infrastructure development. Recovery of the infrastructure should prioritize the ability to respond to population health needs in a cost-effective manner, which means that where necessary the damaged infrastructure should be rebuilt in a way that is suitable to meet health needs in the 21st century. Health needs should be monitored at the local level by the NHSU in order to provide a people-centred and efficient health-care system.

7 KEY RECOMMENDED ACTIONS

1. Complement the currently used global budgets with flexible and needs-based financing strategies, contextualized to the situation in different oblasts of Ukraine, including:

- introducing oblast-level contracting strategies to account for differences between regions, including different needs for care, and use different payment strategies depending of the situation in the regions;
- adjusting the budget and planned volume of services based on changes in needs, population movement and facility capacity;
- adjusting PHC financing principles to reimburse PHC providers for increased demand for services;
- prioritizing and expanding the scope of PHC services to take account of increased needs for treatment and rehabilitation;
- reintroducing case-based payments and apply mixed payment methods when appropriate, adjusting the share of case-based payments depending on region context;
- improving the availability of medical devices for patients, specifically for surgical treatment of traumas; and
- re-establishing the provider monitoring system to ensure that the changes in the system result in better outcomes for patients.

2. Prioritize access to medicines by:

- expanding AMP to allow better access to medicines for noncommunicable diseases;
- suspending copayments for already reimbursed medicines; and
- improving access to centrally procured medicines by adjustments of the regional allocation principles and delivery of these medicines based on the principle that medicines follow the patient.

3. Prioritize public spending on health and increase its efficiency by amending payment mechanisms and by investing in more efficient types of service delivery based on outpatient service provision.

4. Continue data collection and monitoring via electronic medical records and other information sources to inform future decisions about financing of care, planning of recovery and further development of a new health-care system.

5. Strengthen the national coordination system for donor and humanitarian support to avoid fragmentation and incoherence in purchasing and service delivery arrangements. Monitor and account for humanitarian in-kind support and its effects on the system.

6. Start planning system recovery using the capacity of national institutions (Ministry of Health, NHSU), based on oblast-level needs assessment and the need to increase the efficiency and responsiveness of the health-care system.

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9 ANNEX 1. BUILDING BACK BETTER MENTAL HEALTH SERVICES

The need for mental health services will increase as a result of the war. The estimated prevalence of mental disorders in conflict-affected populations is 22.1%, elevated from the global mean by 10–21% depending on the disorder *(1)*. These statistics show the heightened importance of strengthening mental health services and improving access to these for the whole population both within an emergency situation and in recovery phases.

Mental health infrastructure is weakened and the systems in place face many challenges with human resources and access to medicines. Furthermore, issues in the system are exacerbated by many agencies and actors coming to provide services through a surge of aid, which is often not well coordinated.

These factors provide an opportunity and an urgency for building back better the service delivery system. The increased needs, increased external support and the disruption of services provide a strong catalyst for providing strengthened, sustainable mental health care through reinvention and strategic planning *(2)*.

Numerous country cases studies provide valuable examples of how countries were able to implement community-based services after conflict or natural disaster. Indonesia's Aceh Province, for example, has been able to move away from dedicated mental hospitals towards a more integrated approach grounded in PHC and supported by general district hospitals. Iraq has established community mental health units within general hospitals, through a comprehensive mental health system that has stable financial resources, human resources and access to essential medications. In Kosovo[1], the conflict was used as a catalyst to create a strategic plan and currently there is a range of community-based services provided across its seven regions.

[1] In accordance with United Nations Security Council Resolution 1244 (1999).

Ukraine has already developed a model of mobile mental health teams purchased by the NHSU for patients with psychoses. Strategic purchasing of services of this new type, along with national planning for rebuilding mental health systems, represents an opportunity for a significant increase in coverage and quality of care. In 2021 the NHSU started procuring community-based care provided by mobile mental health teams in all regions. This experience should be used to further expand availability of community-based outpatient care, with focus on services that could be provided at PHC level by a combination of adjustments to the PMG and training of existing workforce in the shorter term and expansion of multidisciplinary mental health teams at PHC community level in the medium term. This model may provide a platform to build on in developing and expanding services to address mental health needs arising from war-related stress, including post-traumatic stress disorder.

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The WHO Regional Office for Europe

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

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WHO/EURO:2022-5882-45647-65535

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