Question 1: *How have systems thinking approaches and tools been incorporated in activities to improve health equity? Were these approaches useful in achieving health equity goals? If so, what are the pathways by which these approaches helped to address the root causes of inequity?*

Reforming and Stabilizing Primary Health Care in Pre- and Wartime Ukraine

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HEALTH SYSTEMS STRENGTHENING ACCELERATOR

Context

Pre-War PHC Reform (2018-2022)

*Before 2018, Ukraine's health care system had **inequities in the health system, disproportionately disadvantaging low-income and vulnerable populations, including the following problems:***

- Patients were not protected from catastrophic expenditures and financial risks when receiving essential medical services
- Health care services were nominally free to patients based on an input-based funding model, but informal payments were endemic in practice
- Salaries for health care workers were low, which incentivized them to solicit informal payments from patients. Many were forced to have second jobs to earn enough money.
- high out-of-pocket payments while providing poor quality care relative to the European Union (EU).

In 2018, HRS supported the Government of Ukraine (GOU) to reform primary health care using a capitation model that incentivized providers to provide better, higher quality care and mitigated informal payments.

Before the war, the average life expectancy in Ukraine was 70 years, 10 years behind the EU average of 80 years.

Systemic Inequities: Informal Payments

Informal payments are a form of corruption where money or in-kind gifts are given from patients (or other individuals on the patient's behalf) to health care workers in exchange for better care or services that should be free of charge. A USAID HIV Reform in Action project survey conducted in 2018 found that **61.9% of patients reported making at least one informal payment** for primary health care (PHC) services within the previous year. Informal payments contribute to high out-of-pocket costs, potentially undermining patients' willingness to seek care.

War Challenges (2022-present)

The war has **exacerbated health system inequities** by reducing access to care.

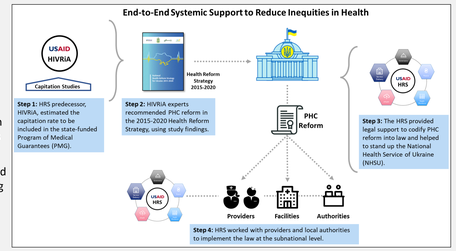
- Challenging macroeconomic conditions imperil the state-funded Program of Medical Guarantees and the financial stability of health facilities.
- Health care workers need new training to address war-related health challenges, like rehabilitation and mental health
- Over 1,400 health care buildings have been damaged, impeding access to care
- Millions of Ukrainians are displaced and lack access to care, which disproportionately impacts vulnerable people (e.g., patients with HIV, TB, newborns and young mothers, etc.)

Activity Description

End-to-End PHC Reform Implementation (2018-2022)

HRS' predecessor, HIV Reform in Action (HIVRiA) helped foster consensus for PHC reform by conducting two capitation studies to estimate state-funded rates under the Program of Medical Guarantees (PMG). HIVRiA experts used the studies to draft health sector strategy documents, which solidified consensus for PHC reform. In 2018, HRS provided legal support to help draft key pieces of PHC reform.

When the reforms were passed, HRS helped providers and local authorities implement the law through the following activities:



Supporting Providers and the Public to Adapt to the New Laws

- Trained over 10% of public primary health care providers (1,500+ regional authorities and 4,300+ health care facilities) contracted under the PMG on managerial, financial, and legal skills.
- Developed multiple tools including InSight and Pay&Care, to help PHC providers generate financial plans and analyze their financial stability based on the PMG.
- Created a Code of Ethics for Medical Workers to change social norms around informal payments.
- Supported a communications campaign with 1,374 publications to educate patients on their right to receive free medical services under the PMG.

Supporting the GOU to Efficiently Allocate Scarce Financial Resources

- Conducted costing studies to help the GOU estimate the cost of services covered under the PMG.
- Supported the introduction of performance-based indicators at the PHC level in 2021 and trained approximately 1,000 representatives of PHC providers.

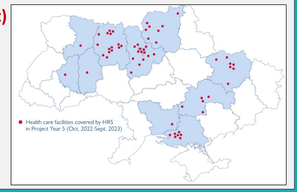
Improving the Quality of Services

- Developed patient-centered innovations, such as supervisory boards and improved quality management practices, in 15 PHC facilities, that served as model "Centers of Excellence" to disseminate best practices nationwide.
- Developed an online course, "Best Practices for Health Care Facility Management," in collaboration with the NHSU Academy.

Stabilizing the System and Restoring Services (2022-Present)

Since the war started, HRS has worked to restore services and prevent reform backsliding, thereby **reducing inequitable access barriers, especially among vulnerable groups.**

- Supported **59** health care facilities to expand services.
- Trained **200** doctors and nurses on new skills to treat vulnerable groups.
- Developed guidance for providers on identifying and treating **vulnerable populations.**
- Facilitated peer groups for health care workers to **mitigate burnout**.
- Provided **legal support** to the GOU to pass war-related health reforms.
- Provided financial recommendations to the MOH and oblast authorities to improve financial stability of **236** health care facilities.



Activity Impact

Impact of PHC Reform (2018-2022)

HRS helped the GOU successfully implement PHC reform. By 2021, 97.4% (1,256) of public PHC facilities had contracted with the NHSU to deliver health care services under the PMG. Additionally, 79% (32.6 million) of Ukrainians had chosen a GP and signed a doctor-patient declaration. PHC reform **helped to create a more equitable and transparent system** and reduced corruption:

*Informal payments decreased from **61.9% to 21.4%** between 2018 and 2021.*

- **Reduced informal payments:** The percentage of patients who reported making at least one informal payment for PHC services within the past year decreased from 61.9% in 2018 to 21.4% in 2021. As a result, patients have improved financial protection and are less likely to refuse medical care due to out-of-pocket costs.
- **Improved health worker salaries:** Average PHC doctor salaries increased by 75% between 2018 and 2020, according to an HRS survey. With an adequate, reliable income stream from the state budget, health care workers are less likely to request informal payments from patients or have second jobs to make ends meet. HCFs are also less likely to experience high staff turnover rates, and health workers now have more time to devote to skill building.

PHC Reform Principles

Money follows the patient: Under the Soviet-era Semashko model, patients were assigned to a general practitioner based on their address. Under a capitation model, the base pay of providers is aligned to the number of patients that have signed a declaration with them. If patients are unhappy with their treatment, they can seek a new GP, thereby incentivizing providers to deliver higher quality care.

General practitioner as the first point of contact: Under the Semashko model, many patients sought medical specialists as their first point of contact, increasing out-of-pocket costs and leaving them vulnerable to informal payments. PHC reform right-sized this relationship by requiring referrals to specialists from GPs.

Expansion of covered care: Under PHC reform, the NHSU developed and implemented the PMG, a list of medical services that would be covered by the state and reimbursed to providers who contract with the NHSU.

Impact of Service Restoration Activities (2022-present)

- Delivered generators to 34 health care facilities that safeguarded services **for approximately 12.6 million civilians** during attacks on energy infrastructure.
- Supported multi-disciplinary PHC teams to provide wrap-around support to over **1,000 displaced Ukrainians**.
- Monitored the distribution of medical equipment for **2,180 health care facilities**.

Health workers from Mykolaiv Oblast Hospital stand beside their USAID-distributed generator.

Evidence

Reduction of Informal Payments due to PHC Reform (2018-2022)

HRS conducted a baseline informal payments study in 2018 and follow-on study in 2021 to compare the frequency and amounts of informal payments before and after the implementation of PHC financing reform. The study showed that the percentage of patients making at least one informal payment for PHC services within the past year decreased from 61.9% (2018) to 21.4% (2021). For PHC services that are now funded by the PMG, these rates decreased from 21.4% in 2018 to 10.4% in 2021.

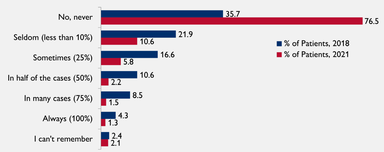


Fig. 1: Responses to "Have you made an informal payment in the past year?"

The motivations for those making informal payments changed between 2018 and 2021. In 2018, 70.5% of patients said they were demanded to make an informal payment by health care facility staff (including medical providers) to receive services, supplies, or medications, compared to 42.2% in 2021. However, in 2021, 50% of patients said their main reason for making an informal payment was their own desire to thank their medical provider, sometimes based on the assumption that they would receive better care (compared to 33.9% in 2018).

Between 2018 and 2020, monthly salaries for health care workers increased significantly. Average monthly salaries for doctors increased from $272 per month in 2018 to $475 in 2020, while nurses' salaries increased from $183 to $294 per month. Increased salaries likely decrease motivation for health workers to request informal payments. The average monthly revenue of a PHC facility also increased from $67,500 in 2018 to $93,300 in 2020.

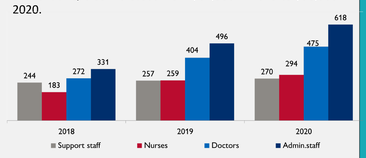


Fig. 2: Average monthly salaries (USD)

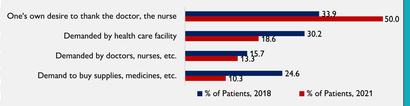


Fig. 3: Responses to "What motivated you to make an informal payment?"

Facilitators

PHC Reform Facilitators (2018-2022)

- **Collaboration with partners**: HRS developed the strategy for primary health care reform in collaboration with international partners, including the WHO and UNICEF, and key national stakeholders. The strategy was built using an internationally accepted PHC financing model, which included the capitation-based payment principle. Setting proposed tariffs for capitation was relatively simple, and the reform was easily understood by providers and patients, which helped secure buy-in from key stakeholders.
- **Working groups**: HRS participated in several sectoral working groups focused on PHC reform and PMG rate setting. These working groups were an opportunity for HRS to share best practices from its pilots and the results of two capitation studies to representatives of the GOU and international donors, including the WHO and World Bank. HRS continues to participate in the NHSU working group on capitation rate improvement.

Restoration Facilitators (2022-present)

- **Relationship development**: HRS developed strong relationships with national government agencies, such as the MOH and the NHSU, as well as health care facility managers and other key stakeholders in each region. These relationships facilitated communication on restoration priorities and collaboration to address providers' needs.
- **Adaptive management and CLA:** HRS developed and honed adaptive management processes during the COVID-19 pandemic to quickly respond to the crisis. When Russia launched its full-scale war, HRS was able to quickly pivot to meet emerging GOU and USAID priorities. HRS has adequately resourced CLA and cultivated a culture of continuous learning that helped it to quickly pause, reflect, and course correct as needed.

Challenges

PHC Reform Challenges (2018-2022)

- **Hesitancy among Survey Respondents**: Both patients and health care workers were hesitant to respond to HRS' baseline study on informal payments. Patients were afraid they would lose access to services and health workers were worried about disciplinary actions if they participated in the study. To address this, HRS transparently communicated the purpose of the study and ensured that respondents' privacy was protected by only reporting aggregated data.
- **Lack of GOU capacity**: Frequent leadership changes and political instability at the MOH and NHSU led to a leadership vacuum when the health system needed a strong vision and voice. This made it difficult for HRS to push forward initiatives that required MOH cooperation, such as legislation on HCF supervisory boards and the introduction of performance indicators. In addition, the NHSU initially lacked the capacity to implement the new contracting system. To address these issues, HRS helped its GOU counterparts coordinate stakeholders, communicate health reform changes, and efficiently allocate limited financial resources.

Restoration Challenges (2022-present)

- **Security and Operational Challenges**: Attacks on energy infrastructure and civilian targets caused winter blackouts that threatened the continuity of operations. To mitigate this, HRS rapidly procured power banks for staff in Ukraine and designated backup activity managers. HRS provided support to staff who wished to evacuate and set up systems to track staff safety.
- **Changing Health System Needs**: The dynamic nature of the war is creating new and complex needs that require urgent attention. Early in the war, providers needed burnout prevention. As the war progressed, facilities encountered financial challenges and then were subject to energy blackouts. Since the war started, HRS has flexibly revised its workplan to meet these emerging challenges.

Lessons Learned

Future implementers should consider the following lessons learned to achieve health equity goals.

- **Support end-to-end implementation**: Working across the entire theory of change -- from national to sub-national, from strategy document to patient -- was critical to successfully implementing PHC reform. HRS' predecessor project, HIVRiA, developed capitation studies that provided an evidence base for PHC reform. HRS sensitized the studies with reformers, helping to include the scheme into national health strategies. HRS provided legal support for the legislation, and then made sure the reforms were implemented at the local level by providing hands-on support to providers. HRS also conducted a communications campaigns to educate patients on their right to receive free medical services under the PMG. Since the war started, HRS has continued to support health reform policymakers and implementers at different levels. At the national level, HRS provided legal support to new war-related reforms and financial analyses of facilities to help the GOU manage financial instability of the health system during these challenging times. At the local level, HRS provided capacity development trainings to local authorities and managerial teams of health care facilities to help them adapt to the war. Additionally, HRS grants supported facilities to restore the population's access to medical care.
- **Prioritize a multi-disciplinary approach**: The HRS team is composed of a wide range of disciplines: from economists, to doctors, to lawyers, to health workforce specialists and IT experts, all of whom benefit from the expertise of each other. HRS instituted processes and tools to encourage internal collaboration and complementarity. This enabled team members to use a systems approach to analyze problems and validate their approach with other team members.
- **Disseminate resources to expand impact**: HRS shared the results of its studies and surveys with a variety of stakeholders, including public institutions, to secure buy-in and provide evidence for the proposed reforms. HRS also uploaded its studies, tools, and other materials to the MOH's website to ensure open access and facilitate the implementation of reforms. Centers of Excellence proved to be a successful model for other health care facilities to emulate and to highlight the success of PHC reform.
- **Reform can improve resilience:** An HRS survey of providers found that they have been highly resilient during the war, and reform may have contributed to this. Health reforms decentralized financial and operational management of facilities to managerial teams of facilities and local authorities, allowing them more flexibility to connect patients to care. When the war reduced access to care, over two-thirds of facilities leveraged alternative service modalities, like mobile teams and telemedicine, to connect patients to care, according to an HRS assessment of providers.

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