Who Cares?

The Institutional Framework for Long term Social Care Benefits

A Survey by the Local Government and Public Service Reform Initiative of the Open Society Institute and the Council of Europe

Observations for UKRAINE

Revised in response to comments from coordination meeting in Budapest (17-18 Feb 2011)

Prepared by FISCO id
Authors: Kateryna Maynzyuk and Yuriy Dzhygyr
www.fisco-id.com
10 March 2011

Content

List of Tables

List of Figures

List of Annexes

Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARC	Autonomous Republic of Crimea
CE	Central Europe
CIS	Commonwealth of Independent States
CMU	Cabinet of Ministers of Ukraine
COPD	Chronic Obstructive Pulmonary Disease
DALY	Disability - Adjusted Life Year
DFID	UK Department for International Development
DG ESAI	EC Directorate General for Employment, Social Affairs and Inclusion
EC	European Commission
ECA	Europe and Central Asia
ENPI	European Neighbourhood Partnership Instrument
EU	European Union
GBD	Global Burden of Disease
GDP	Gross Domestic Product
GNP	Gross National Product
HALE	Health-Adjusted Life Expectancy
HFA	Health for All
HIV	Human Immunodeficiency Virus
IDSS	Institute for Demography and Social Studies of Ukraine
IHD	Ischemic Heart Disease
LE	Life Expectancy
LSS	Law on Social Services
LTC	Long Term Care
MDB	Mortality Database
MoH	Ministry of Health
MoLSP	Ministry of Labour and Social Policy of Ukraine
NGO	Non - Governmental Organization
OMC	Open Method of Coordination
OOP	Out of Pocket
PAYG	Pay As You Go
PIT	Personal Income Tax
PPL	Public Procurement Legislation
SDR	Standardized Death Rate
UAH	Ukraine Hryvnia
UN	United Nations
UNPFA	United Nations Population Fund
VR	Verkhovna Rada
WB	World Bank
WHO	World Health Organization
WHOSIS	WHO Statistical Information System

Part I. National policy framework and demographic trends

1. Is there a national policy framework for provision of LTC to the elderly in Ukraine?

Ukraine's view on ageing: National Strategy of Demographic Development

Ukraine's Demographic Strategy acknowledges the problem of ageing and related challenges, but proposes measures which are not well prioritised. In 2006, Ukrainian Government has approved the country's current Demographic Strategy to 2015 (Cabinet of Ministers of Ukraine 2006). The document admits a critical state of the population statistics, elements of which include decreasing longevity (68.2 at the time), increased likelihood of premature death among working age men (around 38% at the time), low fertility and relatively high infant mortality rate.

One objective set by the Strategy is to address the consequences of Ageing. It includes 19 general tasks which includes cultural, economic, and institutional measures "to help Ukraine's society adapt to the demographic change and ensure harmonic relations between generations." All tasks are very broad (e.g. "to improve the system of social protection for the elderly") and do not contain exact and measurable tasks and benchmarks.

Policy documents related specifically to LTC

LTC-related legislation suffers from basic weaknesses of Ukraine's policy process: rights-based legalistic tradition; lack of consensus behind policies; evasive division of executive responsibilities. Ukraine's Constitution establishes a wide range of rights for social security including medical help and social protection. Respectively, legislative trend throughout Ukraine's independent history was to establish wide ranges of rights for various categories of population, including a separate set of acts concerned with elderly citizens. As with most policies in Ukraine, these legislative acts lack basic attributes of policy frameworks:

- They are not consensual (despite formal agreement across ministries, there is no essential agreement about division of responsibilities for delivery of established rights and freedoms, especially in terms of their financing and regulation); In particular, one key line of debate is the nature of social service quality standards and financing norms (whether such norms represent a centrally-funded mandate on local governments or national policy benchmark to be achieved in cost-efficient ways by flexible local solutions).
- Division of responsibilities is often declarative or evasive (especially in cases when tasks are allocated to sub-national governments);
- Legislation is often fragmented and lacks a clear policy direction.

Policy framework related to LTC for the elderly is based on three key laws which define scope and coverage of the intended system:

- National Law "On key principles of social protection of labour veterans and other elderly citizens of Ukraine" (approved in 1993, repeatedly amended, latest changes introduced in December 2009) (Verkhovna Rada of Ukraine 1993);
- National Law "On the status of war veterans and on guarantees of their social protection" (Verkhovna Rada of Ukraine 1993);

- National Law on Social Services (approved in 2003, repeatedly amended, latest changes introduced in December 2009) (Verkhovna Rada of Ukraine 2003);

Ukraine's law identifies two specific sub-categories among Ukraine's elderly, covered by specific policies (labour and war veterans). The laws define population categories covered by respective policies and the key principles of the state's approach to provision of care and protection of rights of such population groups. As implied by the names of the laws, apart from "elderly population" (defined as men over 58.5 and women over 53.5), Ukraine's legislation provides a special status to two types of veterans, both likely to include people of older age, and covered by privileged sets of policies:

- Labour veterans (pensioners with work experience over 40 years for men and over 35 years for women);
- War veterans (the very broad definition for this category includes those who had various types of military engagement in active wars but also those who were employed during war times, as well as members of their families). In 2002, the number of people classified as war veterans was 4.57 million, of which actual participants of active wars amounted to 555 thousand, including 136 thousand – of the war in Afghanistan (President of Ukraine 2002).

Apart from the Constitution and the basic laws, legislative framework includes a series of additional programmatic documents, which define directions for change and indented policy actions. Such "Concepts of reform" normally cover a specified multi-year period and are often followed by a respective action plan, which may include tasks designed for individual stakeholders. Core LTC-related policy plans to this date are listed below:

1997-2002	Programme "Health of Elderly People" (President of Ukraine 1997)	Activities (by ministries) listed in the Programme
2002-2005	State Complex Programme for social and medical care of veterans (President of Ukraine 2002)	Activities (by ministries) listed in the Programme
2007	Social Service Reform Concept (Cabinet of Ministers of Ukraine 2007);	Action Plan for 2008-2012 to Implement the Social Service Reform Concept (Cabinet of Ministers of Ukraine 2008).

Individual issue-based programmes

Numerous individual issues related to LTC feature in national programmes, approved by the central government, and in individual framework laws.

Examples of such programmes and framework laws include:

- State Programme for Fighting Oncologic Diseases to 2016, which includes development of palliative care and hospices (Verkhovna Rada of Ukraine 2009);

- State Programme for Prevention and Therapy of Cardiovascular and Vascular-Cerebral Diseases for 2006-2010, which includes measures to prevent complications in acquired cardiovascular diseases, treatment and rehabilitation services (Cabinet of Ministers of Ukraine 2006);
- State Targeted Programme "Diabetes" for 2009-2013, which includes measures to improve life quality of life of people suffering from type II diabetes, assistance to patients in self-control of the disease etc. (Cabinet of Ministers of Ukraine 2009);
- Law on Social Housing, which defines principles of provision of social housing to the elderly (Verkhovna Rada of Ukraine 2006).

Regulation of life-long care provided based on reverse mortgage contracts

An increasingly popular LTC arrangement in Ukraine is based on reverse mortgage contracts, which may include financial and/or in-kind provision of life-term care (Verkhovna Rada of Ukraine 2003). LTC based on reverse mortgages can be provided by commercial entities and have been promoted by some of Ukraine's local authorities (Kotomkina, O. 2006). Given the still developing legal framework for licensing and accreditation of social service providers, this range of services remains somewhat isolated in terms of legal regulation and policy oversight. Apart from the Civil Code, which describes formal procedures for concluding such contracts, and the Guidelines which explain that elderly covered by mortgage-based LTC are not eligible to receive public social services at home (Cabinet of Ministers of Ukraine 2009), no other policy document clearly addresses this issue.

Participation in International Conventions related to Ageing

Ukraine is not a formal signatory to any international convention related to protection of the rights of elderly, but its policy framework respects international commitments. In particular, the basic Law "On key principles of social protection of labour veterans and other elderly citizens of Ukraine" states that if Ukraine ratifies an international law or agreement with higher requirements on social protection of elderly people than those contained in the Law, then international commitments would prevail ((Verkhovna Rada of Ukraine 1993), Article 5).

Observers note that there has been no systemic analysis of the compliance of Ukraine's legislation to internationally recommended standards, contained in the policy documents developed and promoted under the UN, G8 and other global fora (Krentovska 2009). In particular, although UNPFA and other donors have sponsored significant work in Ukraine in support of the Madrid Action Plan (2002) and its implementation was included into the list of measures to implement EU-Ukraine Action Plan (Cabinet of Ministers of Ukraine 2008), systemic reporting on progress is absent. Notably, around 1998 Ukraine participated in a regional initiative led by the CIS Inter-Parliamentary Assembly, which had approved an *Elderly Charter* and recommended it for inclusion into national legislation of all CIS countries (Inter-Parliamentary Assembly of the CIS 1998). (Although Ukraine is not formally part of the CIS, it has de facto participated in numerous CIS initiatives and agendas).

2. To what extent are national policies towards LTC affected by the EU's OMC policies and structural funds or pre-accession funds?

Ukraine is not a candidate country, but negotiates for an Association Agreement and is part of the ENPI. The impact of OMC is therefore indirect. Ukraine is not an EU candidate country and is not directly affected by policy guidelines established through OMC, or any of the structural programmes potentially related to LTC. However, as an EU neighbour, Ukraine is an active participant in the EU Eastern Partnership and, since 2007, is in negotiations over an Association Agreement with the EU. Until the Association Agreement is signed, political and economic cooperation between EU and Ukraine is based on an Association Agenda, which includes annually updated lists of priorities. EU provides technical and financial support to related reforms in Ukraine via the European Neighbourhood Partnership Instrument (ENPI) (the ENPI Country Indicative Programme for 2011-2013 closely resonates with the Association Agenda priorities).

Although EU-Ukraine Association Agenda does not address LTC-related issues as a priority, it opens some opportunities for policy dialogue and capacity building. Association Agenda strongly focuses on political dialogue around effectiveness of fundamental democratic institutions, as well as trade cooperation and energy security. Social co-operation is a priority strongly linked to the objective of improving efficiency of labour markets, co-ordinating policies for social security for Ukrainian workers employed in EU Member States, while public health cooperation is closely focused on prevention and control of communicable diseases. Co-operation in the area of social protection (including its systemic efficiency, financial sustainability and reduction of poor and vulnerable people) is limited to exchange of best practices, dialogue, and capacity building (EU-Ukraine Cooperation Council 2009) (Joint Committee at Senior Official's Level of the EU-Ukraine Association Agenda 2010). Respectively, the Social co-operation priorities in the 2011-2013 ENPI Indicative Programme are limited to sub-priority for social cohesion (3.2), which is focused on Regional and Rural Development to address the problems of disadvantaged areas (European Union n.d.).

As a step in policy dialogue, DG ESAI has commissioned a diagnostic policy report on social protection and social inclusion in Ukraine, which identified acute challenges (including for LTC) and very low capacity to deal with them. Within the broader capacity building and information exchange, although OMC is not applied directly to Ukraine, the EC Directorate General for Employment, Social Affairs and Inclusion participates in policy dialogue with EU Neighbours on social protection and social inclusion. By now, this dialogue included EU support to a diagnostic policy study on Ukraine's key challenges and reform plans related to poverty reduction, social exclusion, pension and health/long-term care (The Vienna Institute for International Economic Studies (wiiw) 2010). Thereby, challenges related to ageing population were addressed by this analysis despite it being outside Ukraine's Association Agenda priorities.

Synthesis report based on this study, and covering also Belarus and Moldova, concluded that key challenges in social area for Ukraine were:

- Problems of overall economic development which led to poverty among lone elderly women in rural areas,

- "Weak or non-existent administrative capacity of the government" and weak policy coordination between ministries and between sectors (state and NGOs) in provision of social services;
- Regional disparities and rural poverty because of low productivity of agriculture,
- Extreme inefficiency of the Pension System;
- Ageing population;
- Inefficient healthcare system with widely prevalent out-of-pocket financing;
- Fiscal complications after economic recession.

The report also concluded that at the moment there is little evidence that Ukraine (as well as two other countries covered by the report) is prepared to tackle identified challenges.

3. What is the interface (if any) between Healthcare and LTC for the elderly?

Note on healthcare demand among the elderly in Ukraine

Publicly available data for Ukraine does not provide evidence on the prevalence of disability and various diseases by age groups and on age-specific patterns of consumption of healthcare services. However, MoH estimates of overall current demand for medical support by older cohorts were quoted in academic papers by its experts (Chaykovska 2010). These include:

In need of:	**Percentage of population older than active age**	**Percentage of population older than 70**	**Percentage of population older than 80**
Periodic medical assessment, preventive check-ups	43.1% (41.8% urban, 45.0% rural)		
Active medical oversight and rehabilitation	40.7% (43.3% urban, 37.2% rural)		
Intensive in-patient care, followed by medical and social rehabilitation	9.7% (10.6% urban, 8.3% rural)		
Constant medical help	6.5% (4.3% urban, 9.5% rural)		
Everyday constant assistance with daily living	6.5% (4.3% urban, 9.5% rural)	18.3%	
Constantly consuming medications		82%	
Specialised psychiatric help			20%

Note on specific issues in Healthcare supply in Ukraine

Organisation of healthcare service provision in Ukraine is typical for Middle-Income former Soviet countries and suffers from several key weaknesses, with salient implications on quality and availability of services, disability rates, and the LTC:

- **The country's Constitution and legal tradition assumes universal coverage and free access to unspecified range of health care services**;
- **Formal healthcare system in Ukraine is mostly funded through the government's consolidated budget, which allocates to this sector over 4% of GDP.** Although Government's spending on healthcare gradually increased in the recent years as a % of GDP, it remained at about the same level as a share of overall consolidated budget (somewhat above 11%), as illustrated in **TABLE 1**. If these expenditures are combined with estimated size of out-of-pocket payments (at the 2005 level), Ukraine's overall healthcare budget would reach 7% of GDP which would take Ukraine above the ECA average but still below the EU average.

TABLE 1. SPENDING ON HEALTHCARE IN UKRAINE'S CONSOLIDATED BUDGET IN 2004-2010 (UAH MLN)

	2004	2005	2006	2007	2008	2009	2010 Plan	2010 Jan - Oct
Total Healthcare expenditures								
Consolidated budget	**12,159**	**15,476**	**19,738**	**26,718**	**33,560**	**36,565**	**44,025**	**33,981**
State (central) budget	3,448	3,508	4,100	6,321	7,366	7,535	8,733	5,887
Local (sub-national) budgets	8,712	11,968	15,638	20,397	26,194	29,030	35,292	28,095
Local exp. as % of total	**71.64%**	**77.33%**	**79.23%**	**76.34%**	**78.05%**	**79.39%**	**80.16%**	**82.68%**
Consolidated Healthcare expenditures as % of:								
GDP	3.52%	3.51%	3.63%	3.71%	3.54%	4.00%	4.07%	
Total consolidated expenditures	11.99%	10.92%	11.26%	11.82%	10.85%	11.89%	11.07%	11.53%

- **Only about 60% of healthcare budget in Ukraine is raised via taxes, while the rest represents OOPs.** Based on current estimates, only about 60% of Ukraine's overall healthcare spending is raised through the general government budget. With the private insurance still being a very narrow source of funding, the rest of costs represent out-of-pocket payments by the population. The World Bank estimated that, despite constitutional provisions which guarantee free healthcare to Ukraine's citizens, out-of-pocket spending (i.e., "voluntary/formal" and informal payments) in public medical facilities were around 2.8% of GDP in 2005 (which at the time was about the same size as overall government's spending on this sector) (World Bank February 2008). More recent figures quoted by the WHO for 2007 suggest that the share of tax-funded spending had slightly increased (to about 60%). Although this level of government spending compared to out-of-pocket financing is the highest compared to other low and low-middle income countries of the CIS-plus (Georgia, Azerbaijan, Kyrgyzstan, Uzbekistan and Armenia) it is still a dangerously low figure.
- **Healthcare is one of the key "delegated" functions, implying that the bulk of spending on this sector is allocated by the sub-national budgets. Yet, there is a sharp mismatch between administrative and financial responsibilities allocated to local budgets in the area of healthcare** Local governments spend over 80% of the Healthcare Budget. On the one hand, Healthcare is one of the sectors which went through a progressive intergovernmental financing reform in 2001, which started to allocate equalization transfers to fund delegated expenditures based on demographic variables rather than based on existing infrastructure (such as number of

hospital beds). This reform implied that allocation of finances across local budgets based on objective indicators of relative demand for services (such as share of population living in respective city, rayon or oblast) would lead to more cost-beneficial choices in organisation and provision of healthcare at sub-national level. However, despite these reforms, local administrations remained subject to very strict and detailed input-based norms established by the Ministry of Health, which indicate very exact numbers of staff, beds and other inputs which should be available in each facility. Moreover, the reform left untouched the Constitutional prohibition to close Healthcare facilities (Article 49), which made it nearly impossible for local administrators to exercise the assumed flexibility in implementing delegated programmes. Other remaining regulations kept it very difficult for local authorities to fire medical personnel, which was possible only based on very complex rules established by the central ministry.

- **Healthcare provision in Ukraine is dominated by the Government and managed through a centralised system under the Ministry of Health (MoH).** State providers are dominant players in the healthcare delivery system. They are managed through an extremely hierarchical structure, accountable to the line ministry as well as to sub-national administrations of respective levels (given their role in the system's financing). Regulatory functions are tightly concentrated at the central level (with the MoH also being responsible for licensing of healthcare professionals and pharmaceutical manufacturers and distributors). (World Bank February 2008)

- **Input-based budgeting leads to excessive and inefficient use of inputs, including excessive hospitalisation and specialisation.** Inefficient input-based norms result in excessive utilization of inputs, which, based on WB data (World Bank February 2008), are larger in Ukraine than in EU-10 and other EU countries. This relates to such inputs as number of hospitals (5.6 per per 100 000 in 2005 compared to 2.6 in EU-10) or hospital beds (868 beds per 100 000 people in Ukraine in 2005 compared to 644 in EU-10). Respectively, the system is heavily biased towards excessive, costly and counterprioductive specialisation and hospitalization. The average length of stay in hospitals in Ukraine 2005, based on the same source, was 15 days, compared to 9 days in EU average. According to the WB, Ukraine has, on average, more than 30% more hospital beds per population than in the EU member states (World Bank 2007). Doctors are also inclined to specialise, and as a result primary care physicians comprise about a quarter of all doctors, while general practicioners represent less than 2% of all physicians.

TABLE 2. WB: HEALTH CARE RESOURCES AND THEIR UTILISATION IN UKRAINE AND EU, 2004

	Ukraine	EU
Hospitals per 100,000	5.6	3.1
Hospital beds per 100,000	872.9	585.5
In-patient care admissions per 100 population	21.1	18.0
Average length of hospital stay, days	13.9	9.3
Outpatient contacts per person, per year	10.5	6.8
Physicians per 100,000	301.3	320.0

Source: HFA Database, 2008, analysis of WB (World Bank 2010)

- **As a result of these inefficiencies, access to medical support by the elderly is limited, especially in rural areas.** According to MoH experts, morbidity rates among elderly are twice higher in the statistics collected via medical inspections as compared to official statistics based on self-reporting (the difference is 6.4 times for rural population older than 70).

Description of the interface between Healthcare and the LTC

There is no conceptual document or legislation which would provide a clear picture or coordinated guidelines on provision of healthcare services specifically for the elderly in Ukraine. At the same time, the country's Health sector, led by the Ministry of Health, is closely linked to provision of LTC both directly and indirectly, as listed below and described in detail in respective subsections:

a) National Healthcare system directly provides a range of long-term care services for the elderly, some of them predominantly non-medical;

b) On top of these, the Ministry also shares responsibility for a number of medical tasks in support to LTC services overseen by other ministries;

c) Healthcare policies implemented through the healthcare system under the guidance of the Ministry of Health strongly affect population's morbidity profile and, therefore, the levels of present and future demand for LTC.

(a). Direct provision of LTC services by the Healthcare sector

Since there is no overarching policy or programme specifically addressing LTC, and it is difficult to separate out relevant administrative or public expenditure data, which is not publicly presented in age-specific breakdown. Medical assistance to the elderly (in-patient, out-patient, preventive and rehabilitation services) is provided through the general healthcare system, as well as in a range of specialised geriatric institutions (hospitals for war veterans, specialised geriatric hospitals, and specialised long-term care wards for chronically ill patients within general hospitals). Aside from services to patients with age-specific diseases provided though the general system (Diabetes mellitus, cardio-vasclular and vascular-cerebral diseases, chronic obstructive pulmonary disease etc), some elements of the Healthcare sector should be noted as especially closely linked to LTC:

- Palliative care. Conceptual framework for palliative care developed since 2009 via several programmatic documents, including several new programmes to establish hospices and new out-patient services for the terminally ill (Ministry of Health of Ukraine 2009) (Ministry of Health of Ukraine 2010). At the moment, the system includes:
  - In-patient palliative care (palliative beds in general hospitals; palliative departments of specialised hospitals such as oncologic, phtisiologic, geriatric etc; hospitals of nurse care; oblast, municipal and inter-rayon hospices).
  - Out-patient palliative care (district and family doctors; multidisciplinary medical brigades; home-care hospices; services provided in policlinics including "pain rooms", daytime hospices etc).
- Mental health care. Psychiatric services to the elderly are provided through the general network of related medical facilities (psychiatric hospitals and centres, day patient mental hospitals, specialised offices in general clinics, as well as specialised psychoneurological boarding houses.
- Quasi LTC provided by the in-patient care for chronic diseases. Most hospitals provide services of conservative care "for patients with various diseases of internal organs" (general and specialised "therapeutic wards of hospitals"). Although there is no official data on the composition of patients served by

such wards, ample anecdotic evidence confirms that the bulk of people staying in such wards are "people of old age, who are poor, have problems with housing, and often belonging to marginal population groups" (Mykolaiv Emergency Care Hospital 2011). Domestic literature rather explicitly distinguishes "medical hospital beds" from "social hospital beds", which are routinely allocated in most hospitals to provide long-term care for patients unable to receive such support from other sources (e.g. homeless people, lonely disabled people etc).

(b) Medical support to LTC in boarding homes and at home

Existing LTC services for the elderly (elderly homes and territorial centres) are defined by Ukraine's law as providers of "medical-social services". Although these institutions are regulated by the Ministry of Labour and Social Policy, their activities include medical aspects which should be overseen "jointly with the respective Healthcare authorities" (Ministry of Labour and Social Policy of Ukraine 2001). These inter-sectoral measures and linkages include:

- Provision of advice and issuance of expert medical certificate by assigned Healthcare facilities for disabled elderly who apply for social services by territorial centers to be provided at home; (Cabinet of Ministers of Ukraine 2009)
- Provision of advice and issuance of expert medical certificate by assigned Healthcare facilities for applicants to residential care in elderly homes;
- Access to medical support, at any time, by the residents of elderly homes, to be provided by the assigned Healthcare facilities;
- Provision of medications, medical aid equipment, prosthetic and orthopedic aid etc, based on specialised medical advice;
- Professional support to the residents of elderly homes by a recently introduced post of "geriatric doctor" (since 2006).

(c) Impact on morbidity profile and LTC demand

As discussed in Question 9, efficiency of Healthcare system and related policies has strong implications on the prevalence rates and burden of disease among the older population, with resulting impact on the dependency rates and the demand for LTC.

4. Who decides which elderly people are eligible for access to LTC and on what basis?

Who decides which elderly people are eligible for access to LTC and on what basis?

- **Overall legal definition of who is classified as "elderly people"** (which opens access to a set of related privileges) is provided in the Law "On key principles of social protection of labour veterans and other elderly citizens of Ukraine" (Verkhovna Rada of Ukraine 1993). The Law defines elderly as men over 60, women over 55, and everybody whose age is 1.5 years away from general pension age (Article 10). As discussed earlier, the same law provides additional definition/privileges to the elderly who are also veterans of labour.

- **General right to receive social services** is defined in the Law on Social Services, which is provided to "citizens of Ukraine, but also foreigners and persons without citizenship, including refugees, who legally reside in Ukraine and face complicated life circumstances" (Verkhovna Rada of Ukraine 2003) (Article 6). The same law defines "complicated life circumstances" which imply a need for social services as conditions of objective obstacles to normal life activities which (s)he is not able to independently resolve and which include old age, related disabilities, and isolated dwelling) (Article 1).
- **Eligibility to receive LTC in residential homes for elderly.** Legal definition of the eligibility criteria are provided in the Guidelines issued by the MoLSP (Ministry of Labour and Social Policy of Ukraine 2001), Article 3. According to the Guidelines, LTC should be provided to pensioners or disabled who require external support, whose medical condition allows staying in an elderly home (not a specialised medical institution), and who do not have family members who are legally responsible for providing LTC to their elderly relatives. Strictly speaking, the criteria include:
  - A personal application signed by the elderly person;
  - Personal identification (passport or other document);
  - Medical certificate which recommends external care (verification of the need for external care is conducted based on the national guidelines issued separately by the Ministry of Healthcare);
  - Legal evidence on the size of pension;
  - Legal evidence on the family composition;
  - For disabled applicants: a certificate from a special medical-social commission identifying the degree of disability.

  Authorities which can check eligibility based on these criteria and which can issue a voucher directing the person into an elderly home include:
  - Oblast state administrations (main departments for labour and social protection) or ARC Ministry of labour and social protection;
  - Kyiv city state administration (main department for labour and social protection);
  - Sevastopol city state administration (department for labour and social protection).

- **Eligibility to receive LTC services from the territorial centers.** Legal definition of the eligibility criteria are provided in the Guidelines issued by the CMU (Cabinet of Ministers of Ukraine 2009) (Article 3). There are two basic criteria:
  - Medical certificate which recommends external care (verification of the need for external care is conducted based on the national guidelines issued separately by the Ministry of Healthcare);
  - Notary evidence on the absence of a reverse mortgage contract for the applicant to receive lifelong care.

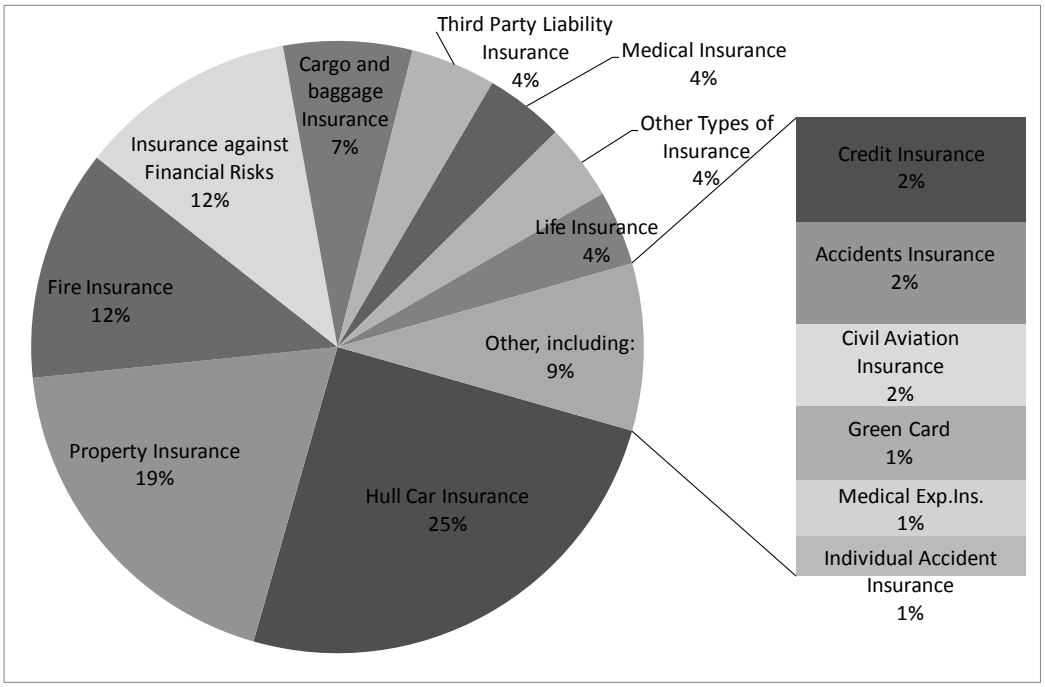
The procedure of verification is as follows:

- Elderly person submits a written application for services to the local department for labour and social protection;
- The local department for labour and social protection submits an enquiry to the local Healthcare facility (to which the applicant is assigned based on his/her residence) to verify dependency level (which should be confirmed in an issued Medical Certificate).
- The local department for labour and social protection submits an enquiry to the Notary to confirm the absence of a reverse mortgage contract for the applicant to receive lifelong care;
- Based on the received evidence, the local department for labour and social protection decides on whether services should be provided or rejected. In case of favourable decision, the department forwards the application to the Territorial Centre.
- The Territorial Centre is then responsible for identifying individual needs of the applicant, the range of services to be provided, and signs a contract for provision of social care.

5. To what extent is private LTC insurance available in Ukraine?

Private LTC insurance is either negligibly small or non-existent. Although Ukraine's legislation does not prohibit private LTC insurance, and availability of some such services by some insurance companies cannot be excluded, any possible size of LTC insurance in Ukraine is negligibly small (and, most likely, non-existent). Figure 1 illustrates the current structure of Ukraine's insurance market, which suggests no visible role for LTC.

FIGURE 1. INSURANCE PREMIUMS BY TYPE OF INSURANCE, JAN-SEP 2010



Source: Ukraine's Insurance Organisations League

6. What are the challenges and opportunities for the provision of private LTC insurance in Ukraine?

At the same time, there is a growing unregulated market of quasi-insurance based on reverse mortgages. An important quasi-insurance service available on Ukraine's market is provision of LTC based on reverse mortgage agreements, described in Q1 and Q4. As mentioned in the Q1, Ukraine's Civil Code allows legal entities (including commercial companies) to provide life-long financial payments or in-kind care services based on reverse mortgage agreements. Although such legal entities would act as both providers of insurance services and providers of social services, they are not covered by respective framework law or respectively licensed. At the same time, given the deficit and scarce menu of available LTC services in Ukraine, and the fact that real estate is often the biggest disposable asset of the elderly, the market for private reverse mortgage arrangements is growing. At the same time, because of its weak regulation and lack of accountability, it is impossible to assess the size of respective services based on the publicly available data.

Ukraine's insurance market is highly peculiar because of the irregular tax regime which it enjoys. Under the current taxation system, insurance companies are not subject to the regular enterprise profit tax (of 25%, to be reduced to 16% during 2011-2013). Instead, turnover of insurance companies is taxed at 3%. This means that any company can deduct billions of profits as insurance of non-existent risks in a captive insurance company, which would pay a much lower tax on these amounts. Moreover, insurance companies can avoid even these tax liabilities by re-insuring non-existent risks in foreign off-shores. This loophole allows Ukrainian companies to use the national taxation system as a legal national offshore and avoid very significant tax liabilities. The newly approved Tax Code made a promise to change the system, but preserved it for at least one more year.

Distorted taxation regime is the key and major obstacle to the prospect of development of LTC insurance market. This major tax loophole has fundamental implications for the profitability structure of Ukraine's insurance companies. Insurance of non-existent risks for the sake of tax optimisation is, by definition, unbeatably more profitable compared to any other legitimate type of insurance. Respectively, quasi-insurance is bound to crowd out alternative insurance services to the institutionally tolerable extent. As of October 2010, major types of individual insurance – including medical insurance, life insurance, or accidents insurance – had minor roles in the overall market. Moreover, many of them had very low profitability (e.g. for medical insurance, payments have been at 71% of collected premiums in 9 months of 2010) (see Figure 1 and Table 3). In this setting, the prospect for development of LTC insurance is bleak and would not change without major reformation of the taxation and institutional environment.

TABLE 3. PREMIUMS AND PAYMENTS BY MAJOR TYPES OF INSURANCE IN UKRAINE (JAN-SEP 2010)

	Premiums	Payments	Payments as % of Premiums
Total	**15,435**	**3,954**	**26%**
including:			
Medical Insurance	644	459	71%
Property Insurance	2,928	106	4%
Hull Car Insurance	3,861	1,874	49%
Fire Insurance	1,888	96	5%
Insurance against Financial Risks	1,779	1,074	60%
Cargo and baggage Insurance	1,049	17	2%

Source: Ukraine's Insurance Organisations League

Activity Report for Ukraine's Insurance Companies for 9 months of 2010

http://uainsur.com/wp-content/uploads/2010/01/SK_3kv_2010.pdf

7. What quantitative data in Ukraine is available to support decisions on funding and planning LTC – for example, disaggregated demographic data at sub national levels; number of residential institutions; number and distribution of home care services; number of elderly people in hospital with strokes, falls, dementia; disability prevalence rates; low income; pension benefits etc.

All types of data listed in this question, in respective breakdowns, are routinely collected by Ukraine's State Statistics Committee, the Ministry of Health, and the Ministry of Labour and Social Policy. While some of the indicators are not regularly disclosed in the public domain, or not regularly presented by age groups as would be required for the purpose of LTC policies, they are fully available to the policy makers to support their decision-making.

The key types of relevant databases are listed below:

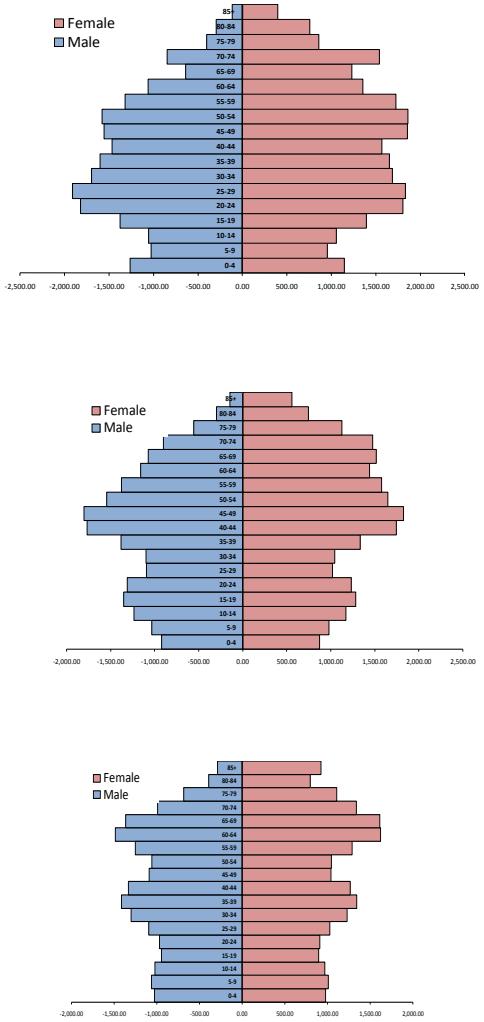
Type of Survey / Statistical Database	Agency in charge	Regularity
Population Statistics	SSC	
▪ Census	SSC	10 years (exp. 2011)
▪ First Ukrainian Agricultural Census	SSC	(exp. 2012)
▪ Birth rates	SSC	Annual
▪ Mortality and life expectancy (by gender, age, cause of death)	SSC	Monthly, Annual
▪ Marriages and divorces	SSC	Monthly, Annual
▪ Migration	SSC	Monthly, Annual
▪ Population size and gender-age composition	SSC	Monthly, Annual
Employment Statistics	SSC	
▪ Economic activity of popul. 15-70 old, by age groups & gender, rural/urban, types of activity	SSC	
▪ Estimates of informal employment by age groups & gender, rural/urban, types of activity	SSC	
National Health Accounts (for Ukraine)	SSC	Annual
National Social Protection Accounts (for Ukraine)	SSC	Annual
Household living conditions	SSC	
▪ Household living conditions by types of households, types of settlement	SSC	Quarterly
▪ Self-assessment of health condition and level of access to certain types of medical services	SSC	Annual
▪ Access of households to certain goods and services	SSC	Once in 2 years
▪ Self-assessment of income level	SSC	Annual
Health and Morbidity	MoH*	
▪ General Health and Morbidity data	MoH	Annual
▪ Mental Health morbidity data	MoH	Annual
▪ Cancer-related data	MoH	Annual
▪ TB-related data	MoH	Annual
▪ Infectious disease morbidity data	MoH	Monthly, Annual
Social assistance to elderly who do not receive pension and disabled	MoLSP	Half-annual, Annual
Provision of Social Transport to Disabled	MoLSP	Annual
Low-income social benefits	MoLSP	Annual
Results of activities of shelters for homeless people	MoLSP	Annual
Results of activities of prisons	MoLSP	Annual
Results of provision of social services to pensioners, lonely elderly, and disabled	MoLSP	Half-annual, Annual
Results of activities of boarding homes	MoLSP	Annual
Budget Execution Statistics, including financing of social services and benefits	MoF	Monthly, Annual

*Health, mortality and morbidity data collected from facilities regulated by other line ministries – e.g. Ministry of Health, Ministry of Education and Science, Ministry of Transport etc. – are forwarded to the MoH by respective line ministries (authorities).

8. What changes in the age composition of the population and in age dependency ratios are predicted by 2030?

Average age will increase because of shrinking sizes of younger segments, but without significant expansion of older categories. By 2030, and especially by 2050, age structure Ukraine's population is expected to change very significantly. As shown in **FIGURE 2**, **FIGURE 3** and **FIGURE 3**, the biggest change is a dramatic reduction of the population aged 20-39 (and especially 25-29) (reflecting the drop in fertility rates observed since independence). At the same time, there will be some increase in older population groups: most visibly, in the 65-69 segment. However, the increase in the amount of people aged 65+ will be much smaller than the decrease in the population of working age. In other words, the average age of the population will increase – but mostly as a result of shrinking middle-age segments, rather than as a result of increasing longevity.

FIGURE 2. AGE STRUCTURE OF UKRAINE'S POPULATION IN 2010, 2030 AND 2050



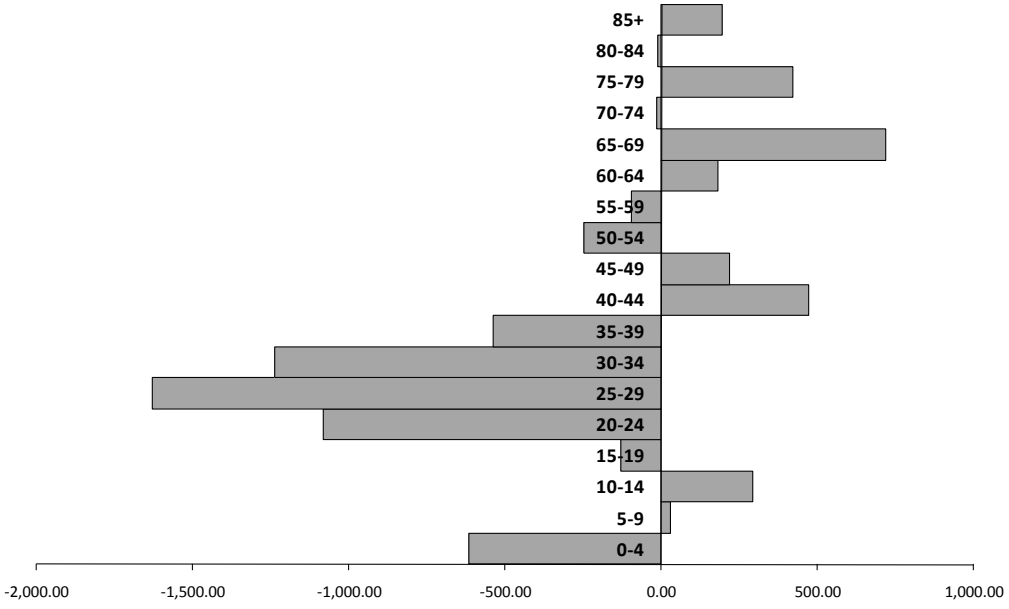
Source: Ukraine's IDSS

TABLE 4. EXPECTED CHANGES IN GENDER-AGE COMPOSITION IN UKRAINE BETWEEN 2010-2050 (THOUSAND PERSONS)

	2010		2020		2030		2050	
	Male	Female	Male	Female	Male	Female	Male	Female
0-4	1,265	1,144	1,231	1,167	921	872	1,030	975
5-9	1,029	953	1,345	1,275	1,032	978	1,065	1,008
10-14	1,058	1,056	1,265	1,195	1,236	1,172	1,021	968
15-19	1,377	1,391	1,034	976	1,355	1,285	946	896
20-24	1,822	1,805	1,072	1,018	1,312	1,233	967	908
25-29	1,914	1,833	1,378	1,318	1,093	1,022	1,095	1,026
30-34	1,698	1,686	1,796	1,740	1,099	1,045	1,304	1,228
35-39	1,599	1,654	1,869	1,843	1,380	1,334	1,417	1,342
40-44	1,466	1,570	1,641	1,683	1,766	1,743	1,336	1,266
45-49	1,555	1,857	1,519	1,635	1,803	1,826	1,090	1,040
50-54	1,580	1,862	1,355	1,533	1,544	1,649	1,058	1,042
55-59	1,319	1,727	1,375	1,690	1,377	1,575	1,255	1,290
60-64	1,060	1,354	1,309	1,766	1,159	1,438	1,487	1,621
65-69	641	1,229	989	1,521	1,073	1,516	1,366	1,613
70-74	850	1,539	693	1,235	899	1,476	992	1,338
75-79	403	859	333	755	559	1,124	686	1,107
80-84	294	759	328	886	296	746	394	795
85+	114	395	147	501	147	558	291	922

Source: Ukraine's IDSS

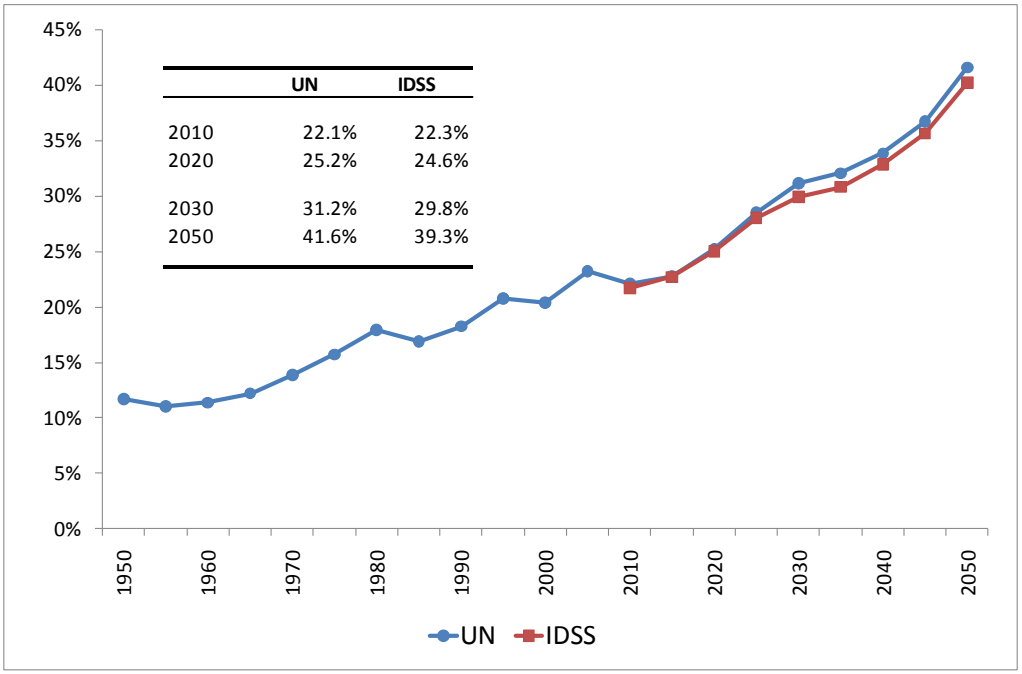
FIGURE 3. CHANGES IN THE AGE STRUCTURE OF UKRAINE'S POPULATION BETWEEN 2010 AND 2030



Source: Ukraine's IDSS, calculations by FISCO id

As a result of population ageing, dependency ratios will increase. Forecasted changes (based on forecasts by the UN and Ukraine's Institute for Demography and Social Studies) are illustrated in **FIGURE 4**. It shows that the current ratio of about 22% is expected to grow to 30-31% by 2030 and nearly double by 2050 (growing to 40-41%).

FIGURE 4. DEPENDENCY RATIOS (POPULATION 15-64 TO 65+) BETWEEN 1950 AND 2050 (INCLUDING FORECAST)

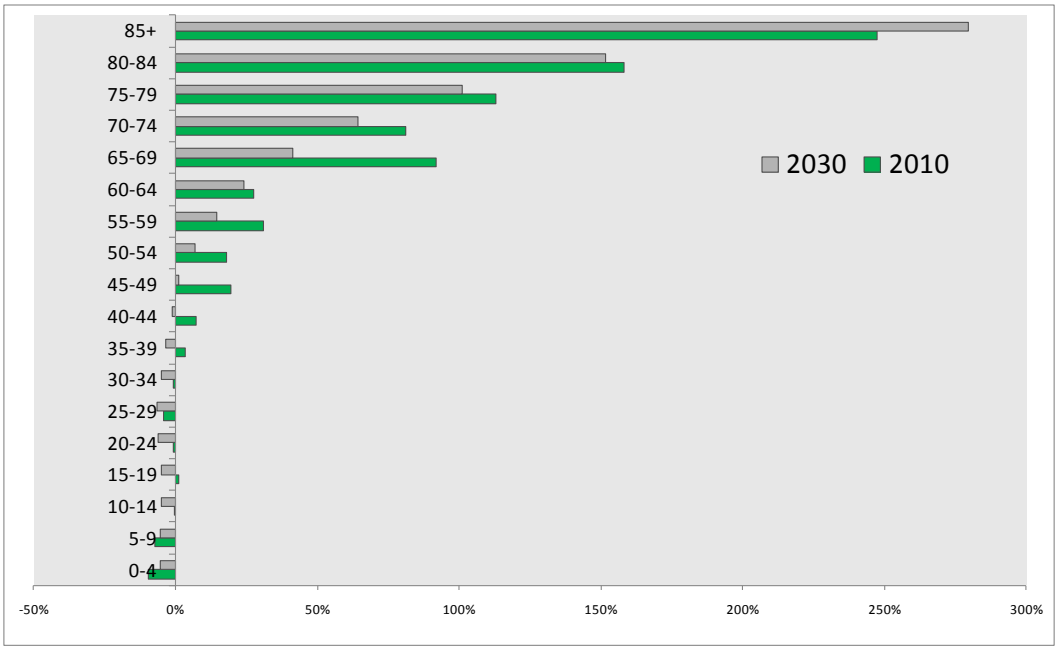


	UN	IDSS
2010	22.1%	22.3%
2020	25.2%	24.6%
2030	31.2%	29.8%
2050	41.6%	39.3%

Source: World Population Prospects: The 2008 Revision (United Nations); Ukraine's IDSS

Age-gender structure is expected to improve. The ratio of females to males will decrease in most age segments, except 85+ (where women will outnumber men by 3.79 times compared to 3.47 in 2010) and 0-9. The biggest rebalancing is expected for population aged 65-69 (where the percentage of women over men will decrease more than 2 times) (see **FIGURE 5**).

FIGURE 5. PERCENT OF FEMALES MORE THAN MALES IN THE POPULATION IN UKRAINE: EXPECTED CHANGES BETWEEN 2030 AND 3050

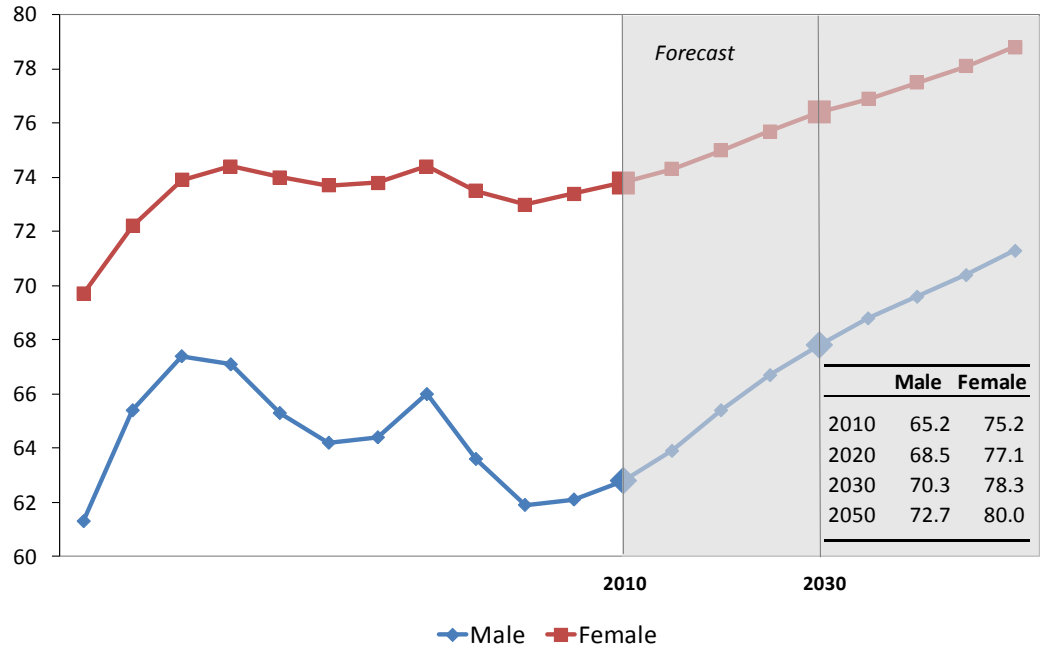


Source: Ukraine's IDSS

Changes in longevity between 2010 and 2030

Overall trend in longevity of Ukraine's population since 1950 and with a forecast to 2050 is illustrated in **FIGURE 6**. It shows that while life expectancy for women has stagnated but somewhat increased in the last two years, male longevity has decreased dramatically in the last decade, with only two episodes of slight improvement (around 1985 Prohibition and in the last two years).

FIGURE 6. LIFE EXPECTANCY AT BIRTH BY GENDER IN UKRAINE (1950-2050)



	Male	Female
2010	65.2	75.2
2020	68.5	77.1
2030	70.3	78.3
2050	72.7	80.0

Source: World Population Prospects: The 2008 Revision (United Nations)

Divergence from EU trends

Data and literature attest that Ukraine strongly diverges from the Central European countries in terms of mortality, morbidity and longevity trends, as well as in terms of their impact on the age-gender structure (World Bank 2009). The core overall difference is extremely low life expectancy, lost mostly at the working age, and especially among males. According to the WB, one third of Ukrainians die before the age of 65, which represents an adult male mortality rate at the level of low income countries, whose GNP per capita is less than one fifth of that for Ukraine (**TABLE 5**). High mortality among working age men is the primary cause of the life expectancy losses in this segment of population, as illustrated in **TABLE 6**.

TABLE 5. WB: MALE ADULT MORTALITY RATE AND GNP PER CAPITA, UKRAINE AND SELECTED COUNTRIES

Countries	GNP per capita	Male Adult Mortality Rates
Benin	1250	349
Togo	770	371
Guinea	1130	380
Haiti	1070	329
Ghana	1240	350
Ukraine	**6110**	**384**

Source: (World Bank 2009)

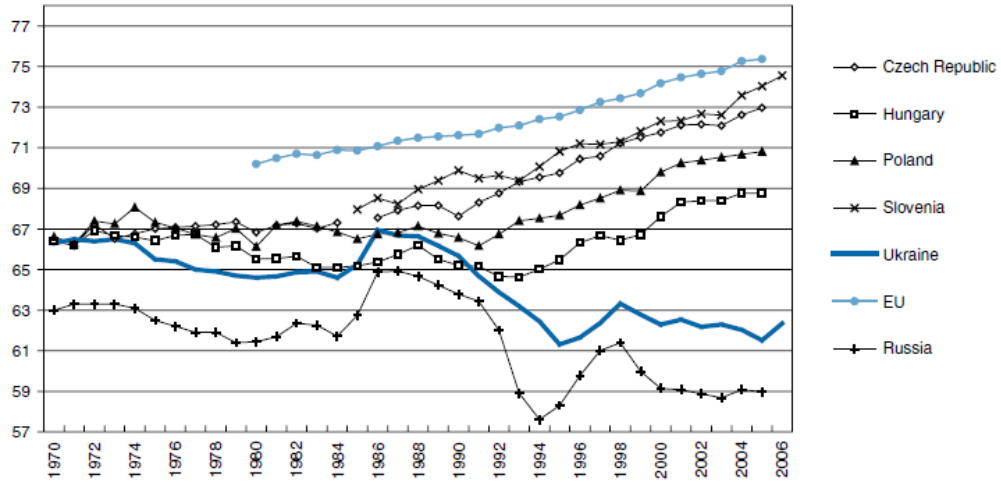
TABLE 6. WB LIFE EXPECTANCY AT DIFFERENT AGES IN UKRAINE AND SELECTED EUROPEAN COUNTRIES, 2005

Countries	LE at birth	LE at age 1	LE at age 15	LE at age 45	LE at age 65
Czech Republic	76.2	75.4	61.6	32.8	16.4
Hungary	73.0	72.5	58.7	30.3	15.6
Poland	75.1	74.6	60.8	32.4	16.8
Slovenia	77.6	76.9	63.1	34.4	17.6
Ukraine	**67.3**	**67.0**	**53.4**	**27.2**	**13.8**
EU	78.5	77.9	64.1	35.3	18.4

Source: HFA Database 2008, presented in the (World Bank 2009)

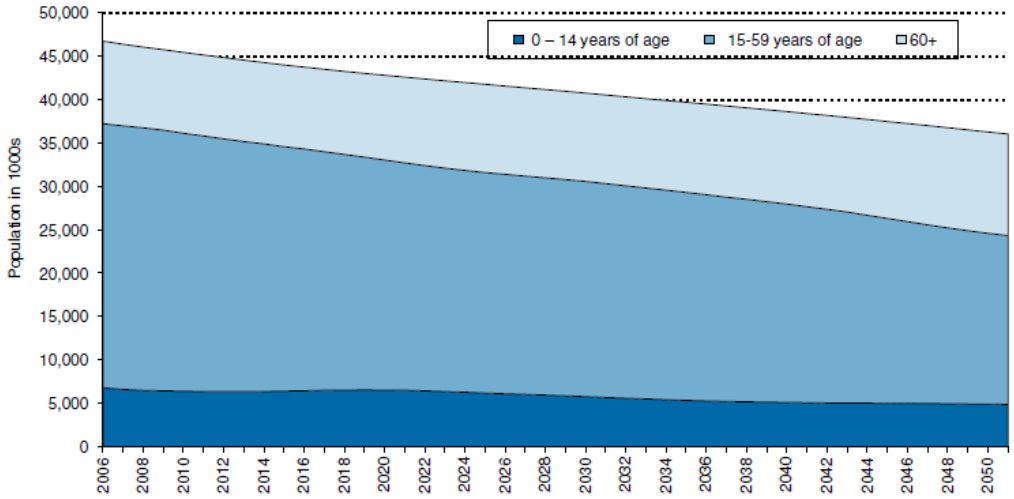
As a result of these trends, Ukraine's population is shrinking at rates which are the highest in Europe (since Independence and before 2007 it declined by 12%) – the trend which is forecasted to continue to 2050 (**FIGURE 7**). At the same time, because of the dramatic increases in mortality rates in the active age groups (especially males), the proportion of the older people is growing sharply despite declining longevity (**FIGURE 8**). Moreover, because of the mortality structure, the gap between male and female longevity is increasing (from 9 years in 1989 to 12 years in 2005) (World Bank 2009).

FIGURE 7. WB: LIFE EXPECTANCY AT BIRTH IN UKRAINE AND SELECTED COUNTRIES, MALES, 1970-2006



Source: HFA Database 2008, analysis of (World Bank 2009)

FIGURE 8. WB: UKRAINE'S POPULATION FORECAST BASED ON CURRENT TRENDS, 2006-2050



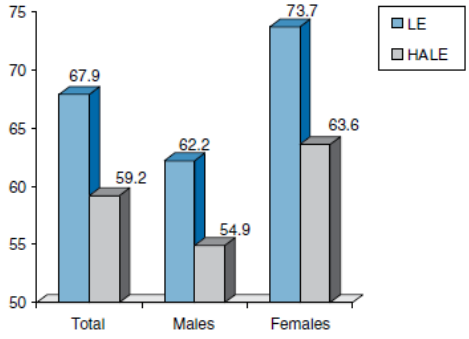
Source: State Statistics Committee of Ukraine, analysis of (World Bank 2009)

This difference from the major EU trends makes it problematic for Ukraine to immediately apply European fiscal/demographic models to project likely impact of demographic change. Application of these models is contingent on assumptions about improvements in Ukraine's public health and changed patterns of morbidity, which would put the country on the path of increasing longevity and acquiring a European ageing profile.

Morbidity and Quality of Life

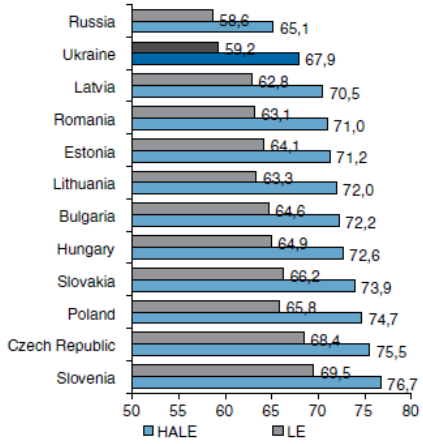
WB research shows that Ukrainians not only die younger than people in Europe, but also live their lives in poorer health: the number of years spent in imperfect health constitutes, on average, 13% of overall life span (compared to 8% in Poland). As illustrated in the WB charts below (**FIGURE 9** and **FIGURE 10**), Ukraine is second only after Russia among all countries in the region in terms of the low rate of Health-Adjusted Life Expectancy, and is second after Poland in terms of the difference between LE and HALE.

FIGURE 9. LIFE EXPECTANCY AND HEALTH ADJUSTED LIFE EXPECTANCY IN YEARS, UKRAINE, 2002



Source: HFA database 2008, analysis in (World Bank 2009)

FIGURE 10. LIFE EXPECTANCY AND HEALTH ADJUSTED LIFE EXPECTANCY IN UKRAINE AND SELECTED EUROPEAN COUNRIES, IN YEARS, 2002



Source: WHO Statistical Information System (WHOSIS), analysis in (World Bank 2009)

Age-specific Morbidity and Mortality

The patterns of age-specific mortality by diseases in Ukraine is also different from the CE neighbours. On the one hand, the leading conditions responsible to highest percentage of deaths across all ages is similar: the number one killer is Ischemic heart disease, followed by Cerebrovascular disease (see **TABLE 7**). However:

- Overall rate of mortality from cardio-vascular and cerebrovascular diseases is much higher in Ukraine compared to Central European countries (see **TABLE 8**);
- Age-specific mortality by diseases is very different:
  - Mortality tends to be much higher than EU average for working age segment of population for deaths from diseases of circulatory system and from external causes (see **FIGURE 11**). Mortality from cardio-vascular and cerebrovascular diseases also remains at a much higher rate for people aged 75+.
  - At the same time, mortality rates from cancer are much higher in younger age but actually decrease for older groups. As noted by the WB, this situation is abnormal, since cancer is typically views as a disease of the elderly, implying that the risk of dying from cancer normally increases, rather than decreases, with age – which is not the case in Ukraine. One possible explanation suggested by the WB is the weak capacity of Ukraine's healthcare system to diagnose cancer at early stages and the fact that because of low life expectancy the pool of elderly is so short that exposure to risks of cancer becomes lower with age than the risk of death from cardio-vascular, vascular cerebral disease or from an external cause (World Bank 2009).
  - Unusually high share of mortality in working age (compared to Central Europe) is caused by unintended poisonings, HIV/AIDS and Tuberculosis. In contrast to European countries, where dying from unintended poisoning becomes increasingly unlikely, this cause of death is increasingly frequent in Ukraine, for both males and females, and especially in rural areas. Moreover, mortality from HIV/AIDS and Tuberculosis, which was gradually decreasing elsewhere in Europe, had skyrocketed in Ukraine since 1990 (see **FIGURE 13** and **FIGURE 14**). And while in case of Tuberculosis Ukraine shared the highest score with Russia, the steep increase in mortality from HIV/AIDS in Ukraine is unprecedented.

TABLE 7. WB: TOP TWELVE CAUSES OF DEATH AND DISABILITY IN UKRAINE, 2005

Top twelve causes of death (%)		Top Twelve Causes of DALYs (%)	
Ischemic heart disease	39.6	Ischemic heart disease	15.2
Cerebrovascular disease (stroke)	12.9	Cerebrovascular disease (stroke)	5.4
Cirrhosis of the liver	3.0	Other unintentional injuries	1.8
Poisonings	2.9	Unipolar depressive disorders	4.1
Other unintentional injuries	2.6	HIV/AIDS	3.8
Self-inflicted injuries	2.1	Poisonings	2.9
Trachea, bronchus, lung cancers	2.1	Alcohol use disorders	3.3
HIV/AIDS	2.0	Cirrhosis of the liver	3.3
COPD	1.9	Congenital anomalies	2.8
Tuberculosis	1.9	Road traffic accidents	2.7
Road traffic accidents	1.6	Nutritional deficiencies	2.5
Stomach cancer	1.5	Tuberculosis	2.4

Source: WHO Global Burden of Disease (GBD) Estimates, 2008, analysis in (World Bank 2010)

TABLE 8. WB: 10 LEADING IN THE AGE-STANDARDISED DEATH IN UKRAINE AND SELECTED EU COUNTRIES (% OF TOTAL)

	Top Ten Causes of Death	Czech Republic	Hungary	Poland	Russia	Slovenia	Ukraine
1	Ischemic heart disease	23.85	22.38	20.99	27.58	14.68	38.42
2	Cerebrovascular disease (stroke)	14.14	12.61	11.59	20.17	10.39	14.57
3	COPD	1.64	2.16	1.57	1.30	3.05	2.90
4	Self-inflicted injuries	2.08	2.90	2.26	2.89	3.94	2.80
5	Poisonings	0.41	0.09	0.55	3.19	0.26	2.72
6	Other unintentional injuries	1.69	0.82	1.14	3.39	1.22	2.66
7	Trachea, bronchus, lung cancers	5.63	6.37	6.51	2.34	5.34	2.33
8	HIV/AIDS	0.00	0.01	0.05	0.76	0.06	2.19
9	Cirrhosis of the liver	1.96	5.37	1.71	1.65	4.73	1.82
10	Stomach cancer	1.41	1.59	1.96	1.75	2.09	1.55

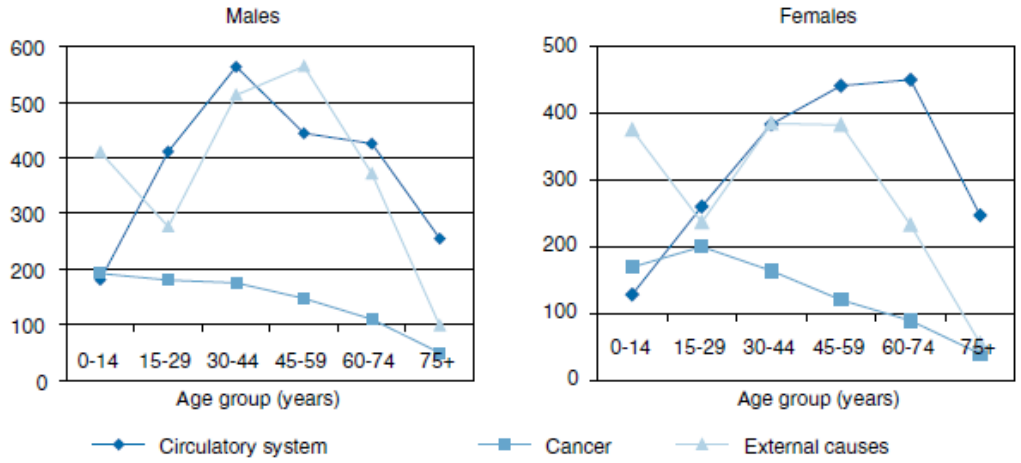
Source: WHO Global Burden of Disease (GBD) Estimates, 2002, analysis in (World Bank 2009)

TABLE 9. WB: 10 LEADING CONDITIONS IN DALYS IN UKRAINE AND SELECTED EUROPEAN COUNTRIES (% OF TOTAL)

	Top Ten Causes of DALYs	Czech Republic	Hungary	Poland	Russia	Slovenia	Ukraine
1	Ischemic heart disease	8.26	7.75	7.27	10.91	4.73	12.65
2	Cerebrovascular disease	5.50	4.98	4.58	7.25	4.49	6.02
3	Unipolar depressive disorders	8.68	7.03	8.91	4.30	11.34	5.18
4	Other unintentional injuries	4.10	1.96	4.40	5.62	3.09	4.81
5	HIV/AIDS	0.16	0.12	0.10	1.50	0.08	3.62
6	Self-inflicted injuries	2.52	3.04	2.55	3.55	4.08	3.28
7	Poisonings	0.53	0.13	0.59	3.33	0.30	3.02
8	Congenital anomalies	1.26	2.04	1.93	2.09	2.00	2.94
9	Nutritional deficiencies	0.69	1.16	0.84	2.16	0.71	2.82
10	Violence	0.39	1.11	0.55	4.07	0.38	2.48

Source: WHO Global Burden of Disease (GBD) Estimates, 2002, analysis in (World Bank 2009)

FIGURE 11. WB: AGE-SPECIFIC MORTALITY DISEASES IN UKRAINE IN COMPARISON WITH EU (EU=100), 2005

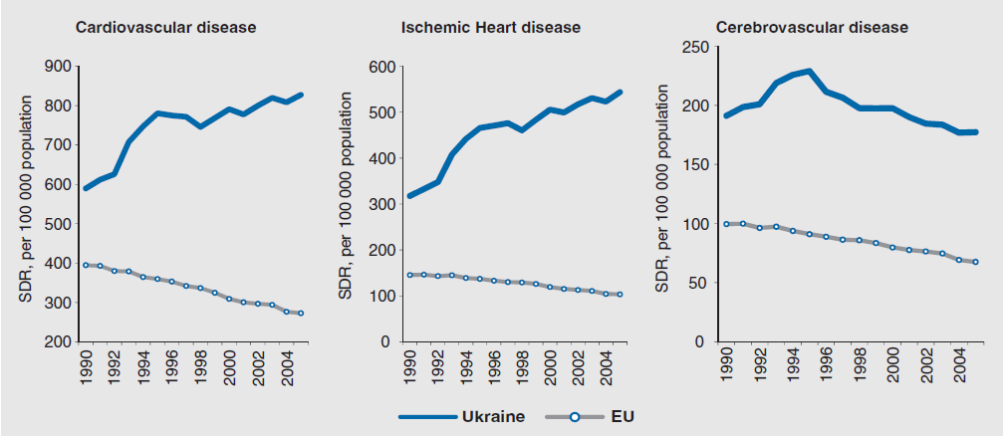


Source: (World Bank 2009)

It is notable that most of the deaths in Ukraine originate from modifiable behavioural risk-factors such as hypertension, alcohol and smoking. Moreover, the rising prevalence of, and mortality from, the diseases of circulatory system (see **FIGURE 12**), is explained to a significant extent with low awareness, indifference and very weak compliance of the population with prescribed treatment and self-control measures (World Bank 2010). The WB survey showed that "about a quarter do not take the drugs according the dosage and frequency prescribed, while the rest do not take their medication at all. Key reasons given for lack of compliance include forgetting to take

medication and respondent's own view that they no longer need the medication. Therefore, it is not surprising as the data shows that one-fifth of hypertensive men and 36 percent of hypertensive women, while aware and being treated still have stage one or two level hypertension. Less than a quarter of those who are obese and diagnosed as such are following any program to lose weight" (World Bank 2010).

FIGURE 12. WB: SDR FOR CARDIOVASCULAR DISEASE, IHD AND CEREBROOVASCULAR DISEASE IN UKRAINE AND EU, 1990–2005

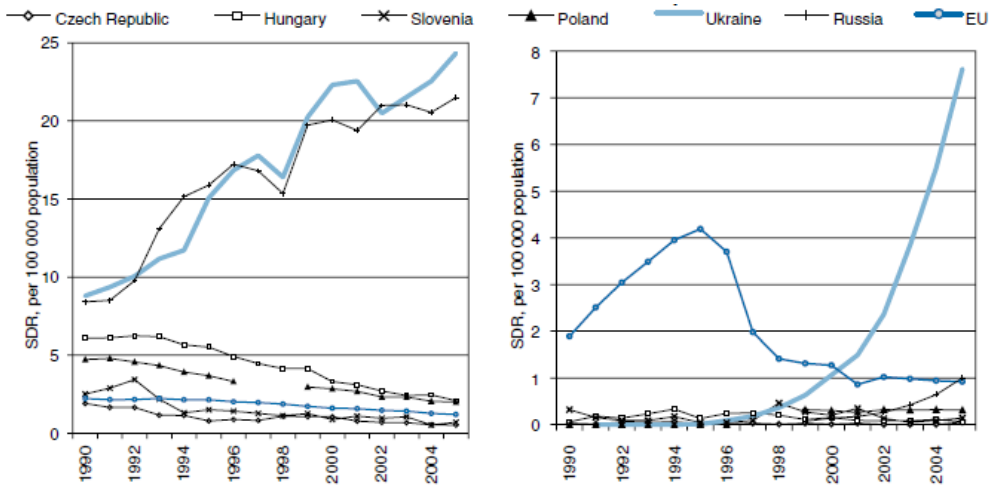


Source: MDB Database, 2008, analysis in (World Bank 2010)

Does local government in your country bear any responsibility for long term social care benefits/services aimed at older people?

FIGURE 13. WB: SDR FOR TUBERCULOSIS, UKRAINE AND SELECTED EUROPEAN COUNTRIES, 1990-2005

FIGURE 14. SDR FOR HIV/AIDS (AS RECORDED BY ROUTINE) MORTALITY STATISTICS SYSTEM), UKRAINE AND SELECTED EUROPEAN COUNTRIES (1990-2005)



Source: MDB Database, 2008, analysis in (World Bank 2009)

Part 2. Providers

1. Role of Local Government in Long Term Social Care

Note on overall weakness in alignment of spending responsibilities among levels of government in Ukraine

As in the Healthcare sector, described earlier, intergovernmental relations in provision of Social Services (including LTC) suffer from a range of similar weaknesses, which make services extremely cost-inefficient. This problem is described in detail in this plug-in section, to which references are made in answers to several questions in this Questionnaire.

Most of the spending on social services in Ukraine is delegated to sub-national budgets. This means that all respective services are financed by a local administration, but the central government compensates some of these costs with a financial transfer. Unlike social assistance (whose expenditures are "deconcentrated"), "delegated" funding assumes that local governments have some flexibility in utilising central funds provided for delegate programmes, in order to make sure that services are provided in ways which are most suitable for local conditions and are therefore most cost-efficient. In principle, the way it is achieved is through dividing a pool of funds across sub-national units based on objective criteria of their relative expenditure need (such as share of population residing on their territory), and providing local governments with sufficient administrative and regulatory autonomy to organise service provision in ways which utilises available funding in an optimal way.

The key spending units who administer the bulk of social service expenditures are local administrations (not line ministries). According to Ukraine's Budget Code, this "delegated" arrangement is used for most expenditures in Education, Healthcare, Culture, Sports and Social Services to vulnerable groups: in 2008, combined spending on these functions was around 85% of local budget expenditures (World Bank February 2008). As mentioned earlier, in Healthcare only, local expenditures in the 2010 budget represent 80% of total consolidated healthcare spending. As we will discuss later, the two key LTC services (elderly homes and territorial centres) are funded entirely from local budgets. One implication from this arrangement is that key spending units responsible for these programmes are respective sub-national administrations (rather than line ministries), and ministry-level spending statistics available at the central level is not suitable to assess local expenditures by type of institutions. While central ministries (who are themselves key spending units) do provide some services directly (via some central programmes), these expenditures are insignificant. For example, the MoLSP spends most of its budget on social assistance programmes (around 93% in 2005), another 6% on Research and Regulatory Activities, and only slightly less than 1% - on direct funding for two institutions and several national level service-providing NGOs (Joshua 2006).

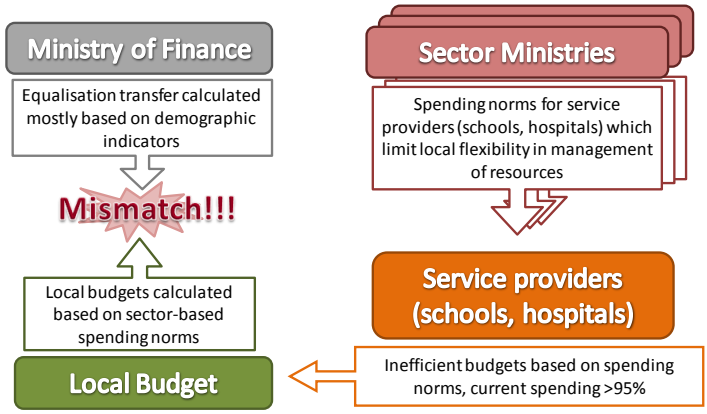
Delegated expenditures are covered by unconditional transfer of funds from the central budget. According to a "delegated" principle, the central government estimates the amount of funds it is prepared to allocate to these combined delegated programmes, which is allocated to sub-national governments through a combination of shared revenues and an equalisation grant scheme. Equalisation transfers are

unconditional: theoretically, they can be utilised for any of the delegated sub-programme (although there are numerous practical barriers to this rule).

The system of intergovernmental funding of social services is inefficient in a number of ways, outlined below:

- **Mismatch between financial and administrative responsibilities for social services delegated to local authorities, and resulting unfunded mandates on local budgets.** Local governments have very low discretion in allocating funds and administering respective programmes. Administrative decision-making (including facility-level budgeting) is subject to a rigid vertical structure of input norms, dictated by central line ministries (see **FIGURE 15**). These norms are intrinsically input-based, and include requirements for priority and full-time funding of a significant range of recurrent expenditures (such as wages and utilities), exact amounts of food to be provided to the residents, etc (e.g. (Cabinet of Ministers of Ukraine 2002). One consequence is imposition on local governments of vertically protected recurrent spending, including half of the total public wages.
- **Financial incentives to residential provision of social services.** Some decisions on local approaches to service provision are also stimulated by incentives built in the transfer formula: although most variables in the formula are linked to demographic variables, some other variables still allocate funding based on existing infrastructure of service providers. In particular, the formula allocates funds for social care based on the number of clients registered with particular residential institutions, reinforcing their domination, because stimulates local governments to continue funding traditional residential providers, since re-allocating resources to alternative services would decrease respective equalisation transfer to such local budget.

FIGURE 15. THE MISMATCH BETWEEN FINANCIAL AND ADMINISTRATIVE RESPONSIBILITIES AT THE LOCAL LEVEL

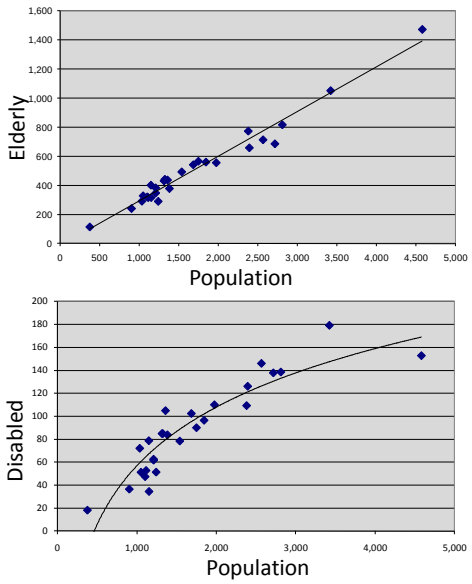


- **Input-based equalisation formula for social services stimulates not only domination of residential institutions as service providers, but also creates considerable disproportions in service funding across oblasts.** Allocating funds based not on objective demographic indicators but based on already existing infrastructure (represented by the number of registered clients) means that oblasts receive funding which is proportional to their existing network of institutions, rather than objective demand.

  This problem is illustrated in Figure 16 for social services for elderly and disabled: but entirely the same situation is observed in other social services including territorial centres since they are funded based on the same principle. The left side of the Figure shows that, on the one hand, proportion

of elderly and disabled population is approximately the same in all oblasts. Each point on these two graphs on the left side represents the share of respective categories in overall population in each oblast. However, as illustrated by the table in right side of the Figure, oblasts with almost identical population sizes can receive very different amount of funding for social services for elderly and disabled (territorial centers and internats).

FIGURE 16. DISPROPORTIONS IN SOCIAL SERVICE FINANCING ACROSS OBLASTS



Oblasts, paired based on similar population size	Population (2007)	Estimated expenditures for 2007, defined based on the number of registered clients	
		Territorial Centres	Inernats
Dnipropetrovska	3,447	35,972	51,741
Kharkivska	2,829	48,716	48,053
Lvivska	2,577	46,634	26,811
Luganska	2,409	27,335	49,918
AR Crimea	1,984	36,930	26,831
Zaporizka	1,861	21,420	33,769
Iv.-Frankivska	1,389	18,104	15,546
Khmelnytska	1,373	34,055	25,178
Cherkaska	1,342	29,948	32,158
Zhytomyrska	1,330	15,086	39,873
Sumska	1,226	18,816	26,139
Chernigivska	1,168	34,334	28,371
Khersonska	1,127	15,512	23,087
Volunska	1,040	31,854	11,077

Implication: the role of sub-national governments in funding LTC

In the light of the overall situation with intergovernmental alignment of spending responsibilities in Ukraine, the table below summarises the ways in which the country's sub-national governments participate in financing and delivery of the LTC:

Type of service		The nature or responsibility in service provision		
Type in question	**Ukrainian equivalent**	**Financial**	**Administra-tive**	**Coordination**
Long-term residential care				
	Homes for the Elderly and Disabled	Fully funded from sub-national budgets (oblast level), covered by equalisation transfer based on number of registered clients	Subject to national input-based mandates	Policy and conceptual coordination fully at national level; local executive decisions based on criteria and procedures

	Territorial centres for social services (residential/respite care departments)	Fully funded from sub-national (rayon and city) budgets, covered by equalisation transfer based on number of clients registered (in residential/respite care departments)	Subject to national input-based mandates	defined by national legislation (e.g. checking eligibility for services) could be made locally
Home care				
– Day care	Territorial centres for social services	Fully funded from sub-national (rayon and city) budgets, covered by equalisation transfer based on number of clients registered as recipients of non-residential services in the territorial centre	Subject to national input-based mandates	Policy and conceptual coordination fully at national level; local executive decisions based on criteria and procedures defined by national legislation (e.g. checking eligibility for services) could be made locally
– Respite care	Territorial centres for social services (residential/respite care departments)	Fully funded from sub-national (rayon and city) budgets, covered by equalisation transfer based on number of clients registered (in residential/respite care departments)	Subject to national input-based mandates	
Care Benefits				
– Attendance / care allowance	– Allowance to individuals who provide social services to elderly, disabled or other persons requiring external care (see Box 1). – Attendance allowance to caregivers of mentally disabled (any age)	Funded from sub-national (rayon and city) budgets, covered by equalisation transfer based on the number of persons who provide care	Administered by the department of social protection of the local administration	

	– Care allowance to elderly not eligible to receive pension and to disabled pensioners – Additional fixed-amount care allowance to disabled and lonely pensioners	Fully funded from the Central Budget via earmarked transfer to local budgets	Distribution of earmarked transfer funds from the central budgets based on national eligibility criteria	Policy and conceptual coordination fully at national level; local executive decisions based on criteria and procedures defined by national legislation
	– Quasi-allowances via payment of wages to specifically created posts in territorial centers	TCs are allowed to create special posts for social workers to provide care for eligible categories of people in need of care, including elderly. Their wages are treated as de facto allowances to care givers. They are funded from respective local budgets, covered by equalisation formula based on the number of registered clients.	Local territorial centres	
– Care leave	Not available	Not applicable	Not applicable	Not applicable
Preventive measures				
Vaccinations	– Regular (once in 10 years) re-vaccinations for adults against diphtheria, tetanus, pertussis – Vaccinations of adults exposed to specific risks and in specific health conditions (Ministry of Healthcare of Ukraine 2006) (Verkhovna Rada of Ukraine 2000)	– Vaccines procured directly from the state budget (MoH), and distributed to the medical facilities; – Vaccinations undertaken by, and at the cost of, local medical facilities (= local budgets), as well as medical posts in public and private organisations (= local budgets and private funds), which	Administered by local healthcare providers (funded by local budgets, reporting to the MoH) and private healthcare providers	Calendar of mandatory vaccinations, recommended types of other vaccinations, procedures for their administration, financing, purchases of vaccines, and oversight fully regulated by national legislation. (Verkhovna Rada of Ukraine 1994)

		should provide this service to their staff, students or residents.		
	– Vaccination of adults in cases of epidemics (Ministry of Healthcare of Ukraine 2006) (Verkhovna Rada of Ukraine 2000)	– Vaccines purchased by local budgets or by other legal sources. – Vaccinations undertaken by, and at the cost of, local medical facilities (= local budgets), as well as medical posts in public and private organisations (= local budgets and private funds), which should provide this service to their staff, students or residents.	Administered by local healthcare providers (funded by local budgets, reporting to the MoH) and private healthcare providers	Purchases of vaccines and control of their quality is supervised by the Ministry of Health. (Verkhovna Rada of Ukraine 1994)
Promotion of physical and mental activities	Sub-national programmes in culture and sports	Funded from sub-national budgets of all levels including villages (as delegated expenditures, covered by the equalisation transfer formula, and as local programmes funded by local revenues).	Administered by local culture and sports facilities	Combination of national and local policies

BOX 1. ALLOWANCE TO INDIVIDUALS PROVIDING CARE TO THE ELDERLY: HOW VAGUE NATIONAL COMMITMENTS TURN INTO FURTIVE UNFUNDED MANDATES ON LOCAL BUDGETS

- **In 2001**, Ukraine adopted its first Budget Code which listed "delegated programmes in social protection" (to be covered by equalisation formula) and "own programmes", which are not covered by the formula but could include local social protection measures.
- **In 2003,** Ukraine adopted a Law on Social Services (Verkhovna Rada of Ukraine 2003), which established that individuals can provide social services to elderly, disabled and chronically ill, and that such individuals should receive financial compensation, "in amounts and based on procedures established by the Cabinet of Ministers".
- **In 2004,** The Cabinet of Ministers approved Procedures for payment of financial compensation to individuals who provide social services to elderly, disabled and chronically ill (Cabinet of Ministers of Ukraine 2004). It established:
  - due amounts (for elderly: monthly payment of 10% of subsistence minimum for active age persons) and
  - that such payments should be paid by local governments from their local budgets, based on the Budget Code which presumes the possibility of local social protection programmes, not covered by equalisation formula.
- **Between 2004-2010,** an MOLSP working group pointed that it is difficult for local budgets to come up with own funds to pay out this financial compensation to individual providers of care. It recommended "to take into account respective expenditures in calculation of the equalisation transfer".
- **In 2010,** Ukraine approved a new Budget Code and a new formula, which included financial compensation to individual providers of social services into the equalisation formula. The formula calculates relative expenditure needs of each local budget for this programme based on the number of registered individual providers, multiplied by a coefficient which includes 10% of the subsistence minimum, but ultimately linked to the single absolute amount of resources allocated to overall spending on social protection at the central level. In other words, inclusion of an additional variable into the formula is not legislatively linked to the extension of the pool of resources available to this purpose. Without such extension, the change represents a new, but disguised, unfunded mandate on local budgets.

How are such responsibilities apportioned between tiers of local government (if any)? Are they subject to inter-municipal co-operation?

- Distribution of responsibilities across tiers of sub-national government was described in the previous section.
- There is no legal foundation or practical evidence of inter-municipal co-operation.

Is local government responsible for the distribution of cash-based benefits and they means tested?

The range of available cash-based benefits, allocation of responsibilities across tiers of government, and the nature of these benefits in terms of universal or means-tested allocation is summarised in the table below. Detailed overview of Ukraine's system of social security including social insurance, assistance and protection payments and its intergovernmental financing aspects is available in a separate paper (FISCO id 2010).

Type of benefit	Available range	Allocation of responsibility across tiers of government	Universal, categorical or means-tested
1. Pensions [old age, disability and survivor benefits]	Old age, disability and survivor pensions	Funded via pay-as-you-go national pension system, administered by the Ukraine's Pension Fund (and heavily subsidised by the central budget). No role of sub-national budgets.	National system of old age pension insurance is a PAYG defined benefits scheme (a guarantee that the pension agency will pay a benefit based on a prescribed formula which takes into account the person's working experience and salary history). It has numerous special early retirement procedures and privileged provision for defined categories of pensioners. People not eligible to receive pensions are entitled to a financial allowance calculated based on a combined approach (means-tested and categorical).
2. Housing subsidies [including utilities]	Housing and utilities subsidies to low-income groups (0.8% of GDP)	Funded by the Central Budget via earmarked transfer to local budgets	Combined (categorical and means-tested) These programmes are widely recognised as extremely inefficient because of their poor targeting and distortive because of their non-monetary nature. In particular, out of all spending on housing and utilities privileges, the biggest share (16.1%) is provided to population in the richest income decile. Overall distribution of these programmes across income deciles shows complete absence of pro-poor focus and the fact that

			many programmes actually benefit the rich more than the poor.
3. Unemploy-ment benefits	Contributory unemployment insurance (0.64% of GDP) is used to provide a variety of types of support, mostly cash benefits to unemployed but also training, retraining, civil works, counseling & career development services, as well as subsidies to employers who decide to take up staff out of those who were previously unemployed.	National unemployment insurance scheme is operated by Ukraine's Unemployment Insurance Fund. No role for sub-national governments.	The system of unemployment benefits is based on a rather complex regulatory system, linked to a set of eligibility criteria for registration in the Public Employment Service.
4. Disability benefits	The two national social insurance schemes which provide disability-related benefits (Temporary disability insurance (0.72% of GDP) and Occupational Injuries insurance (0.4% of GDP) are mostly related to working age groups.	Operated by national insurance funds, no role for local governments	Contributory insurance scheme
	People disabled from childhood and their caregivers receive specific benefits/allowances	Funded by the Central Budget via earmarked transfer to local budgets	Categorical (no means-testing)
	Support to disabled who reached pension age (Verkhovna Rada of Ukraine 2004)).	Funded by the Central Budget via earmarked transfer to local budgets	Combined (eligibility and size of benefits depends on level of disability and low income)
5. Low income support benefits ["safety nets"] including care allowances or attendance allowances	Allowance to families with low-income Note: The national law allows local governments to establish additional benefits to low-income families at the cost of local budgets.	Funded by the Central Budget via earmarked transfer to local budgets	Means-tested

How are local budget expenditures on long term social care benefits funded?

Detailed overview of the system of intergovernmental funding of Ukraine's long-term social care benefits and services was described in previous sections.

As discussed earlier, In Ukraine's case, the LTC benefits include:

Type of LTC benefit	Amount Due (Monthly)		Intergovernmental Funding Arrangement
	Rule	Equivalent in Euro*	
– Allowance to physical persons who provide social services to elderly, disabled or other persons requiring external care (see Box 1).	10% of subsistence minimum for active age persons (UAH 941 from 1 Jan 2011)	9 Euro	Funded from sub-national (rayon and city) budgets, covered by equalisation transfer based on the number of persons who provide care
– Care allowance to pensioners who are not eligible to receive pension and to disabled pensioners	15-50% of subsistence minimum for persons who lost ability to work (UAH 750 from 1 Jan 2011)	10-34 Euro	Fully funded from the Central Budget via earmarked transfer to local budgets
– Additional fixed-amount care allowance to disabled and lonely pensioners	50 UAH	5 Euro	
– Attendance allowance to caregivers of mentally disabled (any age, Group I and II disability)	10% of subsistence level for active age persons per each disabled person under care (UAH 941 from 1 Jan 2011)	9 Euro	
– Quasi-allowances via payment of wages to specifically created posts in territorial centers		n/a	Territorial centres are allowed to create special posts for social workers to provide care for eligible categories of people in need of care, including elderly. Their wages are treated as de facto allowances to care givers. They are funded from respective local budgets, covered by equalisation formula based on the number of registered clients.

**Based on subsistence minimums as of 1 January 2011 and official exchange rate of Ukrainian hryvny to Euro as of 3 March 2011*

The negligible size of cash-for-care schemes nullifies its impact on development of informal care or volunteering. It is notable from the above table that monthly amounts of care allowances vary in the range of 5-34 Euro. In fact, the relatively higher monthly allowances are only available to the mentally disabled elderly and elderly not eligible to receive pensions, while the majority of population of older age can receive a maximum of 5 Euro a month (which is 10% of subsistence minimum and minimum wage). At this level, cash allowances do not represent a tangible financial incentive or factor which could have any implications for the development of informal LTC or engagement of volunteers.

The individual types of funding, specifically for LTC benefits, are summarised in the table below.

By direct reimbursement by national social security or health insurance funds	No
By general intergovernmental transfers [such as block grants]	Yes: equalisation block grant covers expenditures on – Allowance to physical persons who provide social services to elderly, disabled or other persons requiring external care – Quasi-allowances via payment of wages to specifically created posts in territorial centers
By earmarked intergovernmental transfers	Yes: earmarked subvention from the State (central) budget to local budgets covers – Care allowance to pensioners who are not eligible to receive pension and to disabled pensioners – Additional fixed-amount care allowance to disabled and lonely pensioners – Attendance allowance to caregivers of mentally disabled (any age)
By consumer charges / co-payments	Not for benefits, only for services: Social service providers (organisations – including elderly homes and territorial centres - and individuals) can provide LTC to the elderly funded through consumer charges (Cabinet of Ministers of Ukraine 2004)
By local taxation	Although, theoretically, local taxation could contribute to the overall amounts of funds available to local government to fund LTC benefits, the actual size of local taxes is negligible. The new Tax Code approved in 2010 assumes introduction of Property taxation from 2012, which might increase importance of local taxation.
Through a combination of sources	Yes, as described above

Do intergovernmental transfers provide any compensation for differences in levels of local revenue bases, age group composition or local indicators of socio-economic deprivation?

The way cost differentials across regions and socio-economic variation are treated by the formula is summarised below:

Type of differences	Compensated or not?
Differences in levels of local revenue bases	To some extent: Equalisation transfer formula compensates local budgets for the difference between relative fiscal capacity of a delegated revenue basket and relative expenditure needs on a set of delegated spending programmes. Relative fiscal capacity of each local budget is defined based on the historical (3 year) trends in collections of a set of delegated revenues, the bulk of which is PIT (Personal Income Tax). This approach is a proxy to a compensation for differences in local revenue bases, since the formula includes actual historical collections, not revenue bases for the delegated taxes such as PIT.
Differences in age group composition	To some extent. Age structure affects due amounts of equalisation transfers for each budget through relative expenditure needs for healthcare and education: – Transfer formula adjusts local relative expenditure needs for healthcare of each oblast/rayon/city based on the gender-age structure of their population: the formula contains a coefficient (Kzi2) defined based on MOH assessment of relative differences in costs of healthcare provision by age groups and gender. The formula also allows flexibility in the extent to which age-gender structure should be taken into account: every year, the Kzi2 is adjusted by another coefficient, lambda, whose level could vary (for 2010, it is equal to 0.5). – Transfer formula defines relative expenditure needs for education based on the sizes of relevant age groups of children.
Differences in local indicators of socio-economic deprivation	To some extent. Neither equalisation transfers nor earmarked subventions for provision of social assistance benefits take into account socio-economic differences or deprivation levels across the regions. However, Ukraine's regional development policies assume regular monitoring and identification of deprived territories (based on legally defined criteria), which should, in theory, lead to central financing of joint anti-deprivation programmes for such regions (Verkhovna Rada of Ukraine 2005). Anti-deprivation programmes may contain transfers for capital investment or business development.

How much discretion do local authorities have over the types, standards and levels of services and benefits they provide?

	Types	Levels	Standards
Overall menu of LTC services	In theory, national legislative framework assumes significant flexibility for local authorities to choose types and levels of needed services, including a possibility to introduce innovative and alternative social services. However, in practice (as was described earlier), local authorities face a range of strong administrative, financial and political incentives to maintain existing set of services and their input structure. Moreover, these incentives stimulate local authorities to expand the level of residential provision which directly affects the size of available equalisation resources available from the central budget.		National standards of social service provision are in development by the MoLSP. Some of the input-based standards (such as amounts of food which should be available to each resident in an elderly home) are defined by national legislation.
Attendance/Care Allowances	Types and levels of LTC benefits are strictly defined by the national legislation. In theory, local authorities can introduce local programmes of social assistance but this is rarely affordable given the negligible level of marginal revenue autonomy at the local level.		N/A

What, if any, arrangements have been established for distinguishing between the roles/functions of commissioning and providing long term social care benefits/services?

At the moment, most expenditures on social service provision are administered via sub-national administrations based on the existing network of service-providers. In essence, this represents input(provider)-oriented allocation of funds for social services. This arrangement is fundamentally different from an alternative financing principle, when the state acts as a service purchaser representing best interest of the vulnerable client, assessing the client's needs, and commissioning required services on competitive basis. Proper division of roles/functions of commissioning and providing of social services in Ukraine is obstructed by the following factors:

- Fragmented and conflicting allocation of responsibility for social service provision across tiers of government and across line ministries;
- Marginal revenue autonomy at the local level, which makes it difficult for local authorities to diversify service menu;
- Financial, administrative and legal incentives which stimulate allocation of funds to specific providers, mostly residential.

2. Roles of Non-governmental providers

General note on barriers to non-state provision of social service in Ukraine

Ukraine's government as well as independent observers agree that the country's current system of social services is strongly skewed towards residential services by large state (or quasi-state) providers. This imbalance and the domination of state providers in the social service markets was accepted as weakness, inefficiency and target for reforms in all conceptual documents such as LSS.

The roots of this bias is deeply institutional and complex. This complexity and the comprehensive scope of needed reforms is one reason why tangible progress was not achieved in the matter since the problem was first legally accepted in 2003. It was also stated by earlier studies that the balance of service provision, with an optimal mixture of residential, day care and community based services will never develop until these barriers are removed (Joshua 2006) The barriers which make it practically impossible for the non-state providers to expand their presence are listed below and discussed in detail in respective sections of this questionnaire:

- Lack of institutional arrangements to implement purchaser-provider models of service financing, which contributes to slow changes in currently dysfunctional tender procedures, as described earlier.
- Weaknesses in Public Procurement legislation, which contributes to continued dominance of existing state providers;
- Financial, administrative and political incentives for local governments to allocate money to residential care, as described earlier;
- Multiple privileges (including financial) to big quasi-state NGOs who traditionally provide some of the social services (although their activities are concentrated in services for disabled);
- Dysfunctional licensing systems and legal requirements for non-state participation in service provision;
- Financial barriers (taxation, budgeting procedures, accounting regulations);
- Expectation of large hidden demand for alternative services, which means that liberalisation of the market will not lead to immediate savings, despite improved efficiency, and might actually require extra fiscal space.

Are non-governmental organisations permitted by law to provide social care? If so, what types of social care are provided and how widely spread is their range?

Ukraine's legislation permits non-governmental organisations to provide social services, including LTC, but:

- this legislation is fragmented and conflicting;
- despite legal permission, non-governmental providers face a range of strong institutional barriers to access public contracts for social provision, described below. As a result, their actual activity is **narrow in scope and negligible in size**. Moreover, no public statistics is available either on the range of existing non-state providers or the size of their activities.

Participation of non-governmental organisations in social service provision is guided, apart from the basic Law on Social Services, by at least three other laws: the Law on Associations of Citizens, the Law on Charity and Charitable Organisations, and the Law on Liberty of Conscience and Religious Organisations. These laws were approved

at different times of Ukraine's independent history, and they are based on divergent approaches to regulation of NGO activities (e.g. in terms of various mandates on the expenditure structure of NGOs). (Facilitating Reform of Social Services in Ukraine Project (DFID) 2007). The legislation also assumes complex and demanding registration procedure for NGOs (with burdensome double registration by central justice bodies and local authorities), which increases compliance costs.

Are these services funded by long term care service users [i.e., out-of pocket expenses] or by national or local budgets?

Since the role of non-state providers in LTC is negligible, there is no public statistics on the structure of their budgets. Based on existing legislation, both types of funding for services is possible.

- Allocation of grants to NGO providers from local budgets is possible if respective local council designs and approves a special local programme for this purpose and allocates funds from the local budget. Although cases of such co-operation were registered in some regions, they were normally linked to international project activities and not always sustained after such projects ended.
- The central budget (MoLSP) does not fund any non-state provision of services for the elderly.
- In principle, as discussed earlier, Ukraine's legislation permits social service providers (state and non-state) to charge users for a list of services defined by central legislation (Cabinet of Ministers of Ukraine 2004). Respectively, most providers resort to user-charges in their work. Statistics on exact shares of co-financing is not publicly available, and no surveys to analyse out-of-pocket and informal contributions was conducted specifically for LTC (although OOP were shown to be very significant in Healthcare and Education).

Is public funding subject to contracts with service providers? Are such contracts secured by a competitive tendering process? Are they limited in duration?

Ukraine's public procurement legislation suffers from numerous weaknesses despite on-going declarations of reform. The latest approved Public Procurement Law (approved in June 2010) improved some of the procedures, but remained problematic. In June 2010 the VR approved a new Law of Ukraine "On State Procurement" (Verkhovna Rada of Ukraine 2010). This law was approved after a considerable debate, including active participation of international development actors led by World Bank and the EU, given that several prior versions of the procurement legislation have not complied with the recommendations from the international community based on the Directives and international standards in the field of procurement regulation, as well as on experience of European countries. Our in-depth analysis of the approved law argued that while the new Law was significantly improved in comparison with the version voted in February to the dismay of international observers (by removing some of the biases in favour of domestic providers, improving definitions, requirements to confidentiality, and implementing some of the EC/WB recommendations towards complaints procedure and Appeal Agency), it remained highly problematic since it continued to discredit small procurement, kept many procedures cumbersome and lacked clarity of definitions.

Public funding is subject to service provision under a prescribed competitive process, but respective regulations are problematic for social services and do not lead to transparent competition. Recent legal changes have improved many aspects of public procurement with implications to social services. The definition of "public funds" subject to contracting out became sufficiently broad, the list of items that cannot be procured under national procurement law was limited, and provisions for the possibility of coordinated procurement both at central, regional and local levels were clearly established. However, for the purposes of effective procurement of social services, the following problems remain: the definitions and qualification criteria are still vague; complaint review mechanism lacks clarity and is not in line with international best practice; independence of Appeals Agency is not sufficient, and many procedures remain too burdensome and complex. Moreover, it should be also noted that the Law does not amend the Law on Civic Associations, therefore a majority of the existing problems faced by NGOs as social services providers will remain unsolved. The requirement on bid security in amount of 1% (for works) and up to 5% (for goods and services) which can be introduced by a procuring entity under Article 24 of the PPL (though corresponds it to the EU directives), might be problematic to some NGOs providing social services, due to the lack of necessary funds for securing the bids.

Is there a static or growing role for non-government sector providers in the provision of long term social care?

For the reasons described above, the role of non-governmental sector providers in the LTC is statically marginal.

Are there tax incentives for encouraging NGOs to become engaged in the provision of long term social care?

There are no such tax incentives.

What processes for licensing, inspection, quality assurance etc are used to monitor and ensure the quality of services provided by state, for-profit and not-for-profit enterprises?

Lack of standards for social service provision and dysfunctional licensing procedures (which are, at the moment, entirely non-existent) were noted by the Government and independent observers as a significant barrier to liberalisation of the market and to wider access of non-state providers.

- **Standards.** While the Ministry of Labour and Social Services continues to work on development of standards, they remain uncertain.
- **Licensing.**
  - **Temporary existence:** Licensing requirements of social service providers and procedures for control over compliance with the licensing requirements existed in Ukraine over a short period 2008-2009.

- **Introduction:** Since 2003 (and until 2009), Ukraine's legislation required licensing for social service provision (under the Law on Social Services and the Law on Licensing of Certain Activities). However, exact procedures for licensing did not exist until 2008. Notably, the requirement was discriminative in favour of state providers, since licensing was required only for non-governmental organisations.

  The procedures for licensing were introduced in 2008 (by the joint initiative of the Ministry of Labour and Social Policy and Ukraine's State Committee for Regulatory Policy and Entrepreneurship (Ukraine's State Committee for Regulatory Policy and Enterpreneurship; Ministry of Labour and Social Policy 2008)). Despite the discriminative formulation in the basic law, the Procedures were not limited to a specific type of providers. They contained a detailed description of the licensing system approved throughout previous years. Under the new Procedures, licences were issued by the MOLSP or oblast administrations, who were also responsible for compliance control jointly with the State Committee for Regulatory Policy and Entrepreneurship. The procedures required planned annual and off-plan regular inspections, described rules and limits for such inspections, cases leading to annulations of licences and complains mechanisms.

- **Cancellation: Step 1.** In 2009, a cross-cutting law approved under an initiative to simplify doing business in Ukraine has removed a requirement for any licensing from the Law on Social Services (Verkhovna Rada of Ukraine 2009). The change was presented as a restoration of discrimination against non-state providers.

- **Cancellation: Step 2.** In 2010, the Licensing procedures were cancelled (Ukraine's State Committee for Regulatory Policy and Enterpreneurship; Ministry of Labour and Social Policy of Ukraine 2010). Amendments to the comprehensive Law of Ukraine "On licensing of certain types of activities" in the same year removed social services from the list of licensed activities.

3. Role of families, neighbours and individual volunteers

What types of financial or practical support are given by national or local government to family members, neighbours or other individual volunteers who care for elderly – including those with physical and mental health disabilities?

- As described earlier, individuals who provide care to the elderly are eligible to receive monthly financial allowance in a size of 10% of subsistence minimum of working age persons [currently 941 UAH, to be increased to 1004 by end of 2011] (in case if the care provider is a pensioner, 10% of subsistence minimum for people who lost working ability [currently 764 UAH, to be increased to 800 UAH by end of 2011]) (Verkhovna Rada of Ukraine 2010) (in average, this makes attendance allowance equal to about 7 Euro. (More detail in Box 1 on page 34).

- Providers of care to mentally disabled are eligible to receive a separate type of allowance, also in the size of 10% of the subsistence minimum of active age persons.

How wide-spread is the financial and practical support that is available?

Data on the amounts and number of recipients of such financial support are not publically available, which makes it impossible to analyse its scope and distribution.

Part 3. Key Policy Questions

Parts 1 and 2 are intended to provide a factual background. Observers are now asked to express a qualitative judgment on the way the divisions of responsibility they have outlined work in practice.

1. Does the overall provision of long-term social care benefits address demographic changes and changing demands/needs?

Despite wide-spread recognition of the fiscal, social and political challenges emerging as a result of ageing population in Ukraine, the country's system of social service provision and healthcare remain institutionally incapable to register the implications and to address them. Both systems, and their LTC-related components and linkages, maintain basic features inherited from the Soviet period and have not experienced tangible structural reforms. The key barriers which define the inability of LTC to address demographic change are summarised below:

- Absence of multi-year strategic budgeting, which affects reliability and meaningfulness of sector-level allocations. Although Ukraine's government committed itself to introduction of medium-term expenditure framework, the conceptual approach reminds multi-year forecasting rather than responsible negotiations between stakeholders over hard budget ceilings for individual programmes and sector-wide policies. Respectively, sector-wide expenditure forecasts do not entail long-term analysis of demand for services and the underlying demographic trends (Facilitating Reforms in Social Services in Ukraine Project (DFID) 2007); instead, they are based on input-based line-item positional bargaining.
- The system of LTC service provision, as a part of wider social service and healthcare system, suffers from a range of weaknesses which make it strongly biased to inefficient residential care.
- Healthcare sector experiences an institutional and fiscal crisis, which led to growth in mortality rates and population decline which is unprecedented across European countries. Observers agree that Ukraine's health sector is not prepared to address the changing morbidity structure and growing impact of non-contagious diseases. Weak capacity for public health and prevention results in a situation when a growing share of mortality is represented by deaths that could be avoided, and especially by avoidable risk factors such as lack of compliance with prescription drugs for cardio-vascular diseases or alcohol abuse.
- Poor alignment of financial, administrative and political responsibilities for LTC programmes makes it nearly impossible to expect any tier of government to invest into improved efficiency and diversification of service provision.

The key "progressive" measure to address health and social care reform in the last decade was the incomplete budget reform of 2000-2001, which aimed to create fiscal rules for delegating a sufficient amount of autonomy to sub-national governments to enable them to search for more cost-efficient solutions to local social problems including social care and public health. However, because of the incomplete nature of these reforms (discussed in detail earlier in this report), the actual opportunities for flexible management of resources at sub-national level have never materialised.

Inefficient spending policies in core social security sectors (including health care) have come to the fore after the economic recession of 2008, as Ukraine's budget revenues shrank and the country started to accumulate growing (explicit and quasi) fiscal deficits and public debt. International development organisations, especially IMF, whose policy leverages in earlier more affluent years was variable and less palpable, found themselves engaged in the debate on the content of reformso in Ukraine's public finance with renewed intensity. In particular, in 2008, in reaction to the crisis-related fiscal tightening, Ukraine requested a renewal of financial co-operation with the IMF, which opened intensive negotiations over the content of the economic reform package which would be supported by the potential loan. The size of the requested funding in these recent years has been considerably higher than any previous lending operation of the IMF in the country: agreement approved in November 2008 equalled about USD 16.4 billion, and the re-negotiated agreement in July 2010 equalled about USD 15.15 billion, compared to much smaller amounts in earlier years. Throughout negotiations over both of these agreements, with two consecutive governments over 2008-2010, IMF has communicated a strong vision for the needed reform package, which focused on sustainability of macro-fiscal policies, reforms in the gas sector and the banking system.

In particular, recent negotiations with the IMF focused on the growing sizes of Ukraine's fiscal deficit, including the extreme fiscal stress experienced by Ukraine's Pension System caused by the inability of the current pay-as-you-go system to ensure sustainable financing of growing fiscal expenditures. Another aspect of spending policies at the center of this debate was the unaffordability of further increases of social payments (via increases of minimum wages and subsistence minimum) above inflation. However, exact features of possible sector-level reforms which might help the budget to address current inefficiencies and to achieve savings and improve public services without creating additional macro-fiscal risks, have not yet become central to the policy agenda.

2. Does LTC service provision distinguish between the care needs of those aged between 65-79 and those aged 80 plus?

- No, there is no such distinction.
- NB: Because of the ageing profile in Ukraine, the increase of population size in the age group 80plus between 2010 and 2030 will be palpable (+184 thousand) but not as substantial as in the group 65-79 (+1 124 thousand).

3. **Are there disparities in access to service provision in different kinds of territorial unit?**

- There are considerable disparities in access to service across territorial units because the current mechanism for funding LTC (equalisation formula) is based on the number of clients registered in the already existing facilities rather than objective demographic indicators. A detailed description of this problem is provided in earlier sections.

4. **Does local government discretion over types and standards of LTC (including benefits) provide a useful instrument for local flexibility and adaptation to local need, and create platforms for innovation?**

- Local discretion over types and standards of LTC is marginal and therefore has little impact on the efficiency of services or prospects for innovation. The reasons and outcomes of this problem are described in detail in earlier sections.

5. **Alternatively does the current system of funding and standards lead to disparities in levels of service or reinforce opportunities for local prejudice and discrimination?**

- As was just mentioned, the funding mechanism is the primary reason for considerable disparities in access to service across territorial units. However, the funding mechanism (or other elements of the legal and institutional frameworks) does not reinforce opportunities or create any specific biases for local prejudice or discrimination.

6. **Do divisions of responsibility or funding resources lead to distortions of priorities and bias towards types of provision which are more costly or inappropriate to individual needs?**

- As discussed in detail in the previous test, the current funding mechanism which allocated resources based on existing infrastructure is a very strong incentive to provide LTC in existing state-owned residential facilities, which are currently dominating the market.

7. Are social care, social benefits and medical services sufficiently "joined up" to provide a comprehensive assessment of what types of long-term care or financial support clients most need, and to give clients information on the range of support available to them?

- Existing links between social care services, benefits and medical services are primarily guided by the objective of avoiding duplication in coverage of the same categories of population by multiple support instruments. E.g. executive authorities have to ensure that the person who receives care allowance provided to citizens not eligible to receive pensions does not at the same time resides in the elderly home (in which case the allowance is not provided) (Verkhovna Rada of Ukraine 2004). In a similar example, healthcare facilities have to support LTC organisations (elderly homes and territorial centres) in checking eligibility of applicants for care (in terms of their need for external support). However, the three sectors are not joined up in terms of:
  - strategic linkages between the three areas (in terms of policy alignment to take into account long-term changes in demand for services)
  - sub-national policy coordination to construct a balance of service provision with an optimal mixture of residential, home-based and community-based care based on the needs of local population;
  - local gate-keeping to inform social service commissioning, which is also absent.

8. What are the strengths, gaps and omissions in the legislative framework for long term social care?

- Overall legislative framework is based on the Constitutional tradition with a significant menu of declared rights without realistic sources of funding; supported with obsolete structure of vertical sector regulation with rigid spending norms detached from budgeting sources. This tradition makes it impossible to fund all promises in full and leads to constant de jure violation of legislation. The bottom-line of this approach is a highly legalistic nature of the policy environment, which is biased towards approval of statues rather than strategic coordination of conflicting interests and responsible agreements over hard budget constraints (financial, institutional and political).
- Lack of policy co-ordination behind the legislative process results in excessive fragmentation of the legislation (and, ultimately, institutional fragmentation, as well as numerous conflicts, gaps and duplication of responsibilities). Detailed examples of these inconsistencies were mentioned and analysed throughout the factual parts of this questionnaire.

- Overall system of allocation of public funds for LTC suffers from lack of strategic coordination between sectors and tiers of government, as was described earlier. Some of the resulting specific gaps, omissions and overlaps are listed below.
  - Because of the intrinsic input-based philosophy of resource allocation, current spending on LTC is linked to the existing (inefficient) infrastructure for service provision, which leaves a significant hidden demand for additional, unavailable and more

9. Are there significant gaps, omissions or overlaps in budgetary flows for long term care provided from public funds?

client-oriented services unsatisfied. This uncovered need for support is likely to grow as the population ages in the next decades.

- A particular gap is lack of public support to non-state provision of services and to individuals for self-care and, especially, self-control of age-specific diseases whose prevalence is growing. As was mentioned earlier, the current system of LTC is heavily dominated by state-owned residential providers of care. Moreover, the size of financial benefits for LTC (care and attendance allowance) is negligible and insufficient to stimulate stronger participation of individuals and families in taking care of themselves or their elderly.
- Excessive size of quasi-LTC provided via medical facilities is highly cost-inefficient, but also represents an overlap with financing of residential and home-based LTC.

Annex 1. Territorial Centres for Social Services: Background Information

History

- Ukraine's Territorial Centres for Social Services to Pensioners and Lonely Disabled Citizens ("Територіальні центри соціального обслуговування пенсіонерів і самітніх непрацездатних громадян") were created in 1995. They evolved from reorganised units of local administrations responsible for homecare to respective vulnerable categories of population (based on a two-year pilot in Mykolaivska oblast of Ukraine).
- During 1995-2009, Territorial Centres effectively functioned as units of local administrations. They were headed by deputy heads of departments for social protection of local administration.
- In 2009-2010, Territorial Centres went through a reform which increased their autonomy and decreased the degree of automatic financial support they received from the budget. The Centres were re-organised into publicly owned organisations, whose creation, structure, management (director) and budget became a responsibility of the local self-government. The element of the 2009-2010 reform with the biggest financial implications was the decision to discontinue publicly funded services to disabled children and pensioners who have relatives, financial means or reverse mortgage insurance agreements for provision of LTC (previously, this category of clients was receiving services in response to transferring 5% of their pension to the Territorial Centres). From now on, such clients would have to receive services paid by user charges against a defined price lists. This change resulted in palpable protests in the left-wing media (Karpachova 2010) (Socialist Party of Ukraine 2010), resulting in minor concessions (Sumska Oblast State Administration 2010) such as permission to local governments to provide exemptions from user-charges to elderly with families who cannot access their relatives for significant reasons, increased ceiling of minimal income for means-testing, etc. However, the overall approach survived to this day.

Remit and Functions

Territorial centres are responsible for complex assessment and provision of social services to people in difficult life situations and requiring external help. People eligible to receive services from territorial centres include elderly and disabled in need of constant care and low-income unemployed. The range of services provided by territorial centres is listed in the table below, broken down by types of structural units responsible for these functions.

Units of the Territorial Centre	**Minimum amount of eligible clients needed to establish the unit**	**Type of services provided**
Home care unit («Відділення соціальної допомоги вдома»)	At least 80 eligible clients	- Cooking, food delivery and feeding; - Shopping (books; medicines); - Help in asking for medical help; - Cleaning (house and clothing); - Applying for social benefits; - Reading press; - Gardening on small areas; - Applying for residential care; - Acquiring equipment for rehabilitation;

		- Organisation of utility services; - Help in acquiring job or working at home; - Legal support.
Social and Medical Services Unit («Відділення соціально-медичних послуг»)	At least 50 eligible clients to be served each day or in case of availability of 25 beds to serve elderly and disabled	Services to prevent medical complications and generally improve health: - Consultations on preventive measures to improve health; - Psychological counselling; - Provision of information to help resolve a difficult life situation.
Residential and Respite Care Unit («Стаціонарне відділення для постійного або тимчасового проживання»)	At least 10 but maximum 50 eligible clients[1] who need constant external care.	- Provision of accommodation, clothing, footwear, linen, basic dwelling supplies, and tableware. - Four healthy meals a day, according to medical conditions and in line with respective norms for residential care providers; - Constant medical care; - Hearing devices, glasses, prosthetic and orthopaedic appliances, prescribed medications; - Utilities (heating; water supply etc).
Individual in-kind and Cash Support Unit («Відділення організації надання адресної натуральної та грошової допомоги»)	At least 500 eligible clients, based on verification of dwelling conditions, needs, and income.	- Free provision of clothing, footwear and other essentials; - Medications; - Meals.
Social Adaptation Unit («Відділення соціально-побутової адаптації»)	At least 30 eligible clients (who have a need for social reintegration and improved daily living skills).	- Assistance with daily living with a view to improve skills; - Individual teaching programmes to improve daily living skills - Psychological counselling; - Provision of information to help resolve a difficult life situation.

[1] The upper ceiling becomes effective from 1 January 2015

On top of the services provided by individual units, Territorial Centres can create additional posts within their structure for social workers for provision of homecare. Based on anecdotic evidence, these posts often essentially represent quasi cash-for-care allowances to members of the families or other care *providers.*

Financing

- The bulk of financing for Territorial Centres is provided from sub-national (rayon and city) budgets, covered by equalisation transfer based on number of clients registered (in residential/respite care departments). On top of these funds, Territorial Centres can receive charity contributions and user charges (described below).
- In 2009, national legislation has introduced user charges for services of Territorial Centres to elderly and disabled who have relatives or whose income is above means-testing thresholds. Earlier, these categories of clients were served in response to a transfer of 5% of their pensions.
- The local government which decides to create/maintain a Territorial Centre approves the ceiling on a number of employees of this Centre, but – at the same time – the number of employees which has to be hired and the level of salaries is defined by central regulations established by the Ministry of Labour and Social Policy.
- Unlike elderly and disabled staying in residential homes (internats), people staying in residential units of the Territorial Centres receive full amounts of their pensions.

Administration

- Territorial Centres are created by Local Governments, which have to also approve its structure and budget. However, as described above, the number of staff and their salaries are defined by central legislation, and the structure of a Territorial Centre for approval of the Local Government is designed and proposed by the Department of Social Protection of the local state administration, in coordination with the Ministry of Labour and Social Protection.
- Territorial Centres are supervised by the Ministry of Labour and Social Protection, and are also accountable to the local administrations.
- Territorial Centres are headed by directors appointed by the Local Government (whose candidacy is proposed by the Department of Social Protection of the local state administration, in coordination with the Ministry of Labour and Social Protection).

Advantages, disadvantages and key issues

- Territorial Centres are the only providers of publicly-funded non-residential care, which is their core current relative advantage. However, because of the wider incentives in the system, they have also tilted towards residential care, opening and expanding units for residential and respite care.
- There are no specific disadvantages of Territorial Centres as such, but many weaknesses in their work are explained with strong disadvantages present in the wider system. The key problem is that the wider institutional framework assumes a single type of non-residential care provision (by the territorial centres), given the absence of opportunities for competitive social commissioning described in the core text of this report. As a result of this non-competitive framework, Territorial Centres are themselves non-competitive, are not motivated to improve and innovate, or search for more cost-efficient types of care.
- Financial and institutional incentives for residential provision of services and for provision of services of specified types (such as transfer formula based on the number of registered clients) is a strong negative factor in organisation of Territorial Centres and their efficiency.

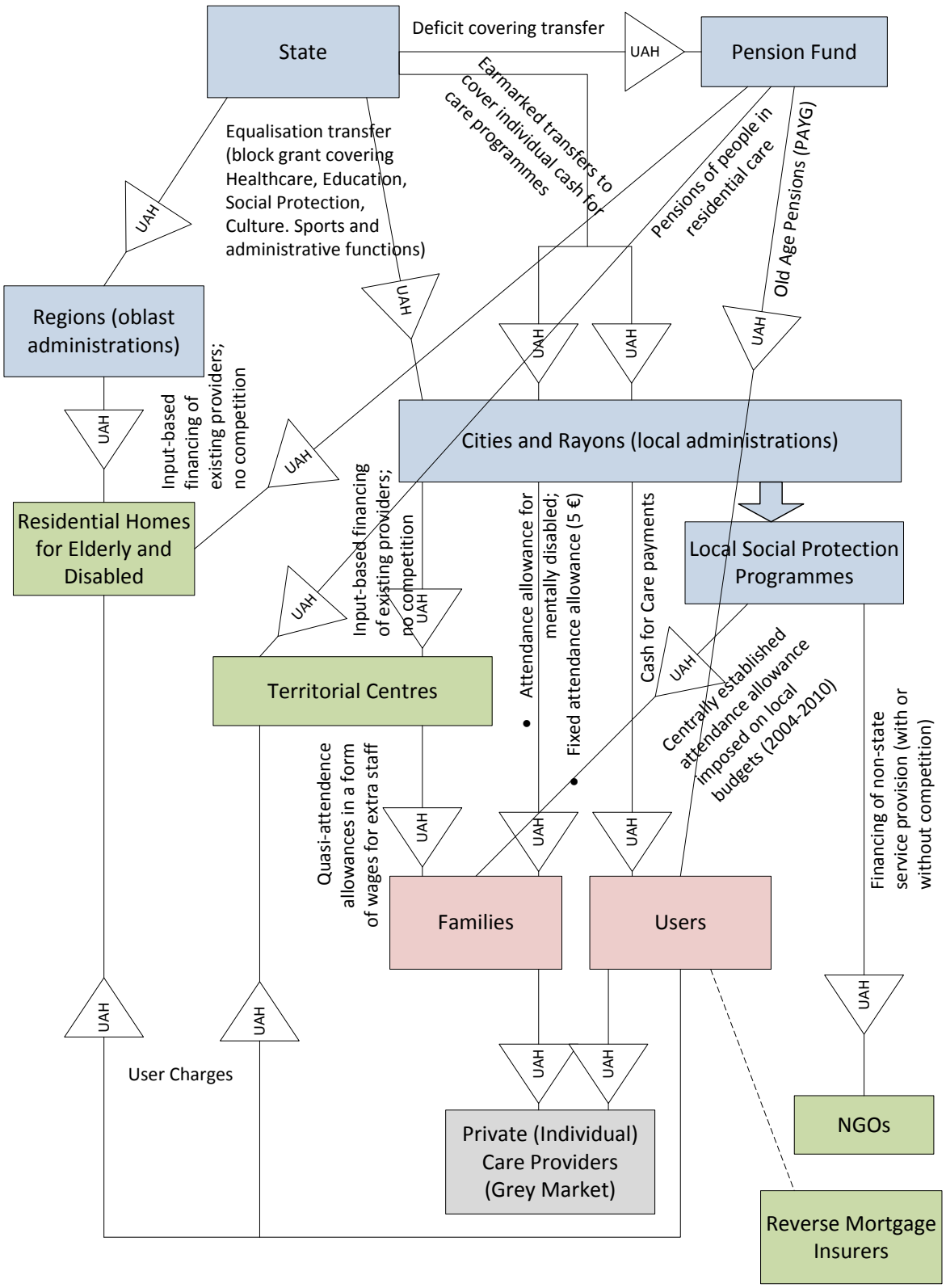
Annex 2. SWOT analysis of policy environment for stronger participation of commercial actors in LTC provision

Strengths	*Weaknesses*
▪ Relatively low cost labour; ▪ Low quality of public LTC services (which can make commercial alternatives more attractive to consumers); ▪ Weak licensing procedures (which is a problem for consumers but makes it easier for providers to enter the market).	▪ Lack of qualified social workers.
Opportunities	*Threats*
▪ Ageing population with a growing demand for LTC (especially given the deteriorating state of health which creates additional needs for support); ▪ Pure "Blue Ocean" situation: opportunities to generate new demand in an uncontested market place, given the low level of development of LTC services market; ▪ Cultural inhibition against submitting elderly to residential care, which stimulates demand for home-based services.	▪ Extremely low level of LTC benefits which make it difficult for the elderly to pay for any additional care; Lack of prospects for increased levels of cash-for-care programmes given the fiscal difficulties after the crisis and extreme deficits in other sectors including Pensions and Energy Sector. ▪ Systemic barriers against private LTC insurance: A major tax loophole has fundamental implications for profitability structure of insurance companies. Insurance of non-existent risks for the sake of tax optimisation is unbeatably more profitable compared to any other legitimate type of insurance. ▪ Systemic barriers against service commissioning at local level: weak alignment of responsibilities between authorities; lack of sub-national regulatory and fiscal autonomy; weak public procurement legislation. ▪ Taxation policy which makes it costly to start and run small businesses. ▪ Weak licensing and standards, which opens opportunities for fraudulent competitors in a service with highly asymmetric information. ▪ Weak systems of public health which decrease longevity and create barriers for further growth of elderly population size and demand for LTC; ▪ Dysfunctional licensing systems and legal requirements for non-state participation in service provision (which create uncertainty and lack of transparency). ▪ Relatively weak priority of LTC on the agenda of both the Government and international lending organisations, whose attention is focused on acute macro-fiscal risks.

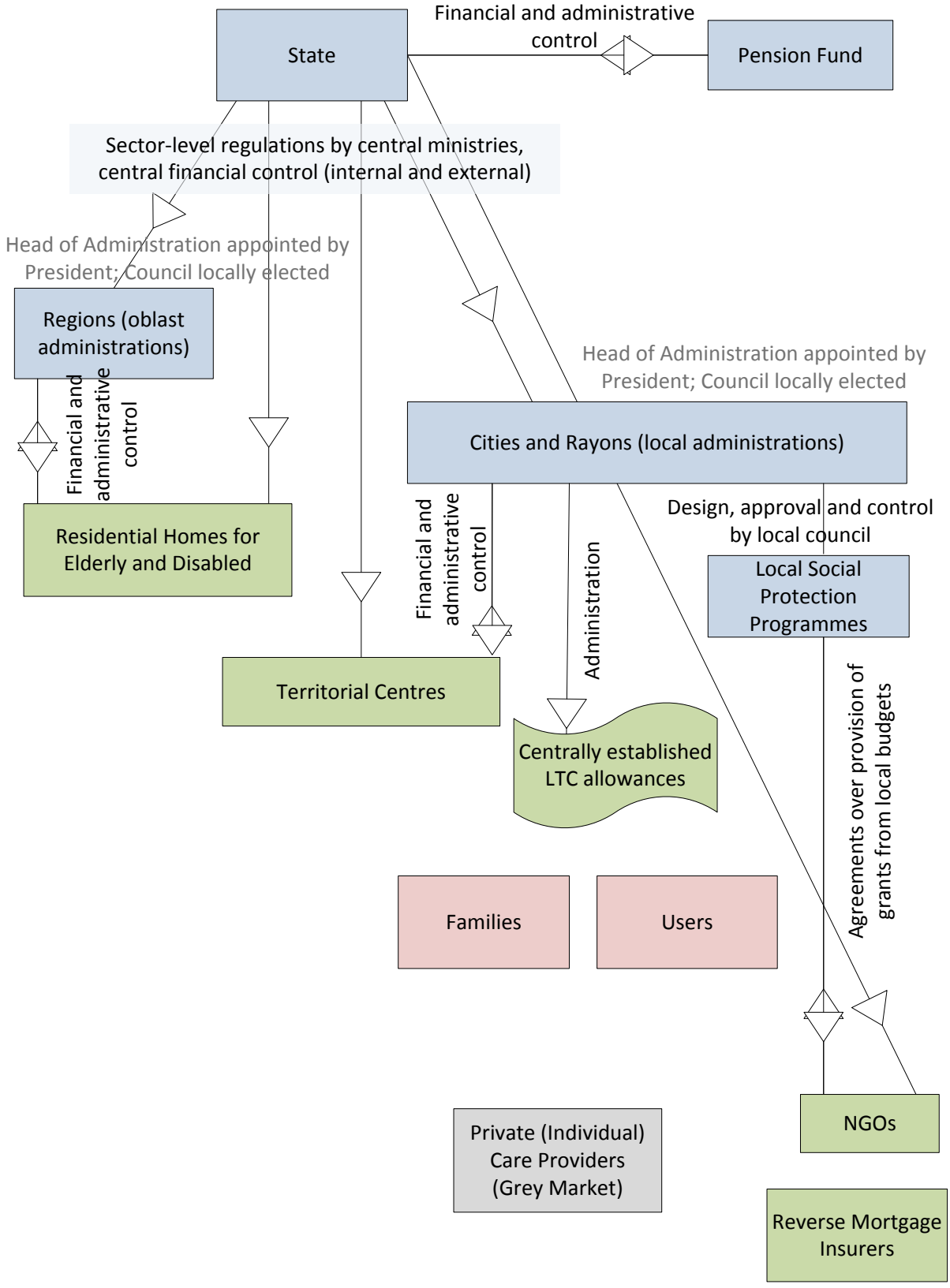
Annex 3. SWOT analysis of policy environment for stronger participation of non-for profit actors in LTC provision

Strengths	*Weaknesses*
▪ Pronounced profile of typical LTC needs (given the depth of poverty among the elderly, its gender bias and concentration in rural areas) – which makes it relatively easy to target support well. ▪ Relatively low cost labour.	▪ Lack of cultural tradition for civic association and organised / collective charity. ▪ Lack of qualified social workers. ▪ Lack of skills for organisational management, and strategic planning within the country's non-for-profit sector. ▪ Emerging non-for-profit sector is concentrated in urban areas, while elderly in Ukraine in biggest need of support usually reside in isolated rural areas.
Opportunities	*Threats*
▪ Ageing population with a growing demand for LTC (especially given the deteriorating state of health which creates additional needs for support); ▪ Cultural inhibition against submitting elderly to residential care, which stimulates demand for home-based services. ▪ Large hidden demand for alternative services (given the current domination of residential care). ▪ Some opportunities for external funding from international development organisations and charities; ▪	▪ Systemic barriers against service commissioning at local level: weak alignment of responsibilities between authorities; lack of sub-national regulatory and fiscal autonomy; weak public procurement legislation. ▪ Financial incentives in the regulatory system which stimulate allocation of public resources into residential provision of LTC and to support existing types of care rather the diversifying provision (e.g. problems in the intergovernmental transfer formula; allocation of responsibilities across authorities based on types of providers rather than care outputs; input-based budgeting etc); ▪ Multiple privileges (including financial) to big quasi-state NGOs who traditionally provide some of the social services (although their activities are concentrated in services for disabled); ▪ Dysfunctional licensing systems and legal requirements for non-state participation in service provision (which create uncertainty and lack of transparency); ▪ Financial barriers (taxation, budgeting procedures, accounting regulations); ▪ Conflicting and fragmented legislation. ▪ Relatively weak priority of LTC on the agenda of both the Government and international lending organisations, whose attention is focused on acute macro-fiscal risks.

Annex 4. Diagram of financial flows in LTC system in Ukraine (top-down perspective)



Annex 5. Diagram of governance arrangements in LTC system in Ukraine



References

Cabinet of Ministers of Ukraine. “Directive "On Approval of Measures to Implement EU-Ukraine Action Plan in 2008".” 06 August 2008.

—. “Instruction "On Approval of a Social Services Reform Concept".” 13 April 2007.

—. “Instruction "On Approval of Action Plan for 2008-2012 to Implement Ukraine's Social Service Reform Concept".” 30 July 2008.

—. “Resolution "On approval of daily norms of food provision in boarding houses, education and rehabilitation facilities supervised by the Ministyr of Labour and Social Protection".” http://zakon1.rada.gov.ua/cgi-bin/laws/main.cgi?nreg=324-2002-%EF, 13 March 2002.

—. “Resolution "On approval of the procedures for allocation and payment of a compensation to physical persons who provide social services".” http://zakon1.rada.gov.ua/cgi-bin/laws/main.cgi?nreg=558-2004-%EF, 29 April 2004.

—. “Resolution "On Approval of the Programme for Social Protection of Veterans".” http://zakon1.rada.gov.ua/cgi-bin/laws/main.cgi?nreg=42-2005-%EF, 15 January 2005.

—. “Resolution "On Approval of the State Programme for Prevention and Therapy of Cardiovascular and Vascular-Cerebral Diseases for 2006-2010".” http://zakon.rada.gov.ua/cgi-bin/laws/main.cgi?nreg=761-2006-%EF, 31 May 2006.

—. “Resolution "On Approval of the State Targeted Programme 'Diabetes' for 2009-2013".” http://zakon.rada.gov.ua/cgi-bin/laws/main.cgi?nreg=877-2009-%EF, 19 August 2009.

—. “Resolution "On Approval of the Strategy for Demographic Development fo 2015".” 24 June 2006.

—. “Resolution "On Certain Aspects of Activities of Territorial Centers for Social Services".” 29 December 2009.

—. “Resolution "On procedures for provision of social services funded by user-charges and on approval of their list".” http://zakon.rada.gov.ua/cgi-bin/laws/main.cgi?nreg=12-2004-%EF, 14 January 2004.

Chaykovska, V. “Geriatric Support to Population: Challenges and Prospects.” *Biblioteka Semeinogo Vracha (http://family-doctor.com.ua/)*, 09 October 2010.

European Union. “European Neighbourhood Partnership Instrument (Ukraine): National Indicative Programme (2011-2013).”

EU-Ukraine Cooperation Council. “EU-Ukraine Association Agenda, to prepare and facilitate the implementation of the Association Agreement.” 23 November 2009.

Facilitating Reform of Social Services in Ukraine Project (DFID). “Non-Government Organisations in the Market of Social Services: Institutional, Legal, Financial and Tax Aspects.” 2007.

Facilitating Reforms in Social Services in Ukraine Project (DFID). “Demography, Social Statistics and Financial Trends: Background to the Future Demand and Need for Social Services (Proposed Evidence–Based Framework).” http://fisco-id.com/?module=an&action=preview&id=6, 2007.

FISCO id. “Child-Related Social Security Spending in Ukraine: Overview of Related Programmes and Reform Priorities (Social Insurance, Social Assistance, Social Services, Health Care).” UNICEF Ukraine, 2010.

Inter-Parliamentary Assembly of the CIS. “Edlerly Charter.” *Resolution No 11-15*, 15 June 1998.

Joint Committee at Senior Official's Level of the EU-Ukraine Association Agenda. “EU-Ukraine Association Agenda Priorities for 2010.” 26 January 2010.

Joshua, L., Dzhygyr, Y. *Assessment of Public Expenditure Management: Developing a Technical Framework for the Financial Reform of Social Services.* 2006.

Karpachova, O. “What is the Price for Kindness?” *Oleksandriyshkyi Tyzhden'*, 16 April 2010.

Kotomkina, O. “Is there a hunt for appartments of lonely pensioners?” *H.UA*, 24 December 2006.

Krentovska, O.P. “Global Social Policy and International Co-Operation on Ageing.” *Academic Papers Collecion*, 2009.

Ministry of Health of Ukraine. “Decision of the Board of the Ministry of Health "On development of hospice and palliative care".” 29 April 2010.

—. “Order "On approval of measurse to develop palliative care in Ukraine during 2009-2010".” 26 June 2009.

Ministry of Healthcare of Ukraine. “Order "On the procedures for regular vaccinations in Ukraine, control over the quality and circulation of medical immunobiological products".” http://zakon1.rada.gov.ua/cgi-bin/laws/main.cgi?nreg=z0665-06&p=1296322767150318, 03 February 2006.

Ministry of Labour and Social Policy of Ukraine. “Order "On Approval of Guidelines for Boarding Houses for Elderly, Disabled and Children".” http://zakon1.rada.gov.ua/cgi-bin/laws/main.cgi?nreg=z0066-02, 29 December 2001.

Mykolaiv Emergency Care Hospital. “Description of the Therapeutic Ward.” 2011.

President of Ukraine. “Decree "On the Programme 'The Health of Elderly People'".” http://zakon1.rada.gov.ua/cgi-bin/laws/main.cgi?nreg=1347/97, 10 December 1997.

—. “Degree "On State Complex Programme for Social and Medical Care of War Veterans to 2005".” http://zakon1.rada.gov.ua/cgi-bin/laws/main.cgi?nreg=442/2002, 08 May 2002.

Socialist Party of Ukraine. “Socialists ask authorities to align the new regulation on territorial centres with the Constitution.” 27 March 2010.

Solomianka Newspaper. “For the Autumn to be Gold.” April 2008.

Sumska Oblast State Administration. “Organisation of the work of the Territorial Centres for Social Services in terms of the Changes in the Legislation.” 06 May 2010.

The Vienna Institute for International Economic Studies (wiiw). “Social protection and social inclusion in Belarus, Moldova and Ukraine - Synthesis Report.” *Final Report.* Vienna, June 2010.

Ukraine's State Committee for Regulatory Policy and Enterpreneurship; Ministry of Labour and Social Policy of Ukraine. “Order "On cancellation of the Order of the Ukraine's State Committee for Regulatory Policy and Enterpreneurship and Ministry of Labour and Social Policy of Ukraine No 141/519 dated 11.11.2008".” http://zakon1.rada.gov.ua/cgi-bin/laws/main.cgi?nreg=z0567-10, 07 June 2010.

Ukraine's State Committee for Regulatory Policy and Enterpreneurship; Ministry of Labour and Social Policy. “Order "On approval of licensing requirements for professional activities in social service provision and of Procedures for control over compliance with these requirements".” http://zakon1.rada.gov.ua/cgi-bin/laws/main.cgi?nreg=z1178-08, 11 November 2008.

Verkhovna Rada of Ukraine. “Civil Code of Ukraine.” http://zakon1.rada.gov.ua/cgi-bin/laws/main.cgi?nreg=435-15&p=1295864269557930, 16 January 2003.

—. “Law of Ukraine "On Amending certain laws of Ukraine to simplify doing business in Ukraine".” http://zakon1.rada.gov.ua/cgi-bin/laws/main.cgi?nreg=1759-17, 15 December 2009.

—. “Law of Ukraine "On approval of the National Programme for Fighiting Oncologic Diseases to 2016".” 23 December 2009.

—. “Law of Ukraine "On Basic Principles of Social Protection of Labour Veterans and Other Elderly Citizens in Ukraine".” *Law of Ukraine.* http://zakon1.rada.gov.ua/cgi-bin/laws/main.cgi?nreg=3721-12, 16 December 1993.

—. “Law of Ukraine "On ensuring sanitary and epidemic wellbeing of population".” http://zakon1.rada.gov.ua/cgi-bin/laws/main.cgi?nreg=4004-12&p=1296396290054157, 24 February 1994.

—. “Law of Ukraine "On protection of population against infectious diseases".” http://zakon1.rada.gov.ua/cgi-bin/laws/main.cgi?nreg=1645-14&p=1296396290054157, 06 April 2000.

—. “Law of Ukraine "On Social Housing".” http://zakon1.rada.gov.ua/cgi-bin/laws/main.cgi?nreg=3334-15, 12 January 2006.

—. “Law of Ukraine "On Social Services".” *Law of Ukraine.* 12 June 2003.

—. “Law of Ukraine "On State Budget of Ukraine for 2011".” http://zakon1.rada.gov.ua/cgi-bin/laws/main.cgi?nreg=2857-17, 23 December 2010.

—. “Law of Ukraine "On state social support to persons who are not eligible to receive pensions and to disabled".” http://zakon1.rada.gov.ua/cgi-bin/laws/main.cgi?nreg=1727-15, 18 May 2004.

—. “Law of Ukraine "On stimulating regional development".” http://zakon.rada.gov.ua/cgi-bin/laws/main.cgi?nreg=2850-15, 08 September 2005.

—. “Law of Ukraine "On the Status of War Veterans and on Guarantees of Their Social Protection".” *Law of Ukraine.* 22 October 1993.

—. “The Law of Ukraine "On State Procurement".” *Law of Ukraine.* 1 August 2010.

World Bank. *An Avoidable Tragedy: Combating Ukraine’s Health Crisis. Lessons from Europe.* K.:VERSO-04, 2009.

World Bank. “From Red to Gray: the "Third Transition" of Aging Populations in Eastern Europe and Former Soviet Union.” 2007.

World Bank. “Ukraine; Improving Intergovernmental Relations and Public Health and Education Expenditure Policy: Selected Issues.” World Bank Report, February 2008.

World Bank. *What Underlines Ukraine's Mortality Crisis?* К.: VERSO-04 – 2010, 2010, 56.