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Current news

PAID MEDICAL SERVICES IN MUNICIPAL HEALTHCARE FACILITIES: LEGISLATIVE REQUIREMENTS AND PRACTICAL SOLUTIONS

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Almost all healthcare services delivered by public and municipal healthcare institutions are, in practice, paid services, as the state functions as the primary purchaser and reimburses providers in accordance with the Program of State Guarantees for Medical Care of the Population.
The provision of services under this program constitutes the core function of these institutions. Nevertheless, the Program of Medical Guarantees (PMG) does not fully cover the operational costs of healthcare facilities, including expenditures necessary to provide healthcare workers with at least the minimum wage stipulated by labor legislation.
The purpose of this work is to convey to doctors and managers of state and communal non-commercial health care institutions that in modern conditions it is quite possible and appropriate to establish such a tool for additional financing of a medical institution as the provision of paid medical services to the population, as well as to offer some practical recommendations for the introduction of paid medical services.
In fact, all services for medical care of the population in state and communal health care institutions are paid. The customer of these services is the state, which pays the executor for the provision of these services under the Program of State Guarantees of Medical Services to the Population (the provision of medical services under the Program of Medical Guarantees is the main activity of state and communal health care institutions). Unfortunately, the medical guarantee program does not cover all the costs of a medical institution to provide medical workers with even the minimum wage, which is determined by law.
New Resolution of the CMU No. 781 of July 5, 2024 "Some issues of providing medical services to the population for a fee from legal entities and individuals" significantly expands the opportunities of state and communal health care institutions to obtain sources of additional funding, without in any way limiting the medical institution in determining the list of paid services that will be provided in it, giving the medical institution the right to independently set prices for these services.
Conclusions. Absolutely all services for medical care of the population in state and communal health care institutions may be paid under certain circumstances (unless otherwise specified by law). The health care institution independently determines the list of paid services, sets their prices and can use these additional funds to meet its own needs. The introduction of the provision of paid services in state and communal non-commercial health care institutions is a very real and expedient process.

Keywords: paid medical services, communal non-commercial health care institution.

Introduction

The right of a healthcare institution to provide medical services at the expense of legal entities and individuals in Ukraine is guaranteed by law. In particular, Article 18 of the Law of Ukraine "Fundamentals of the Legislation of Ukraine on Healthcare" states that state and municipal healthcare institutions "may provide medical services that are not covered by the program of state guarantees for medical care of the population, as well as in other cases, the list of which is approved by the Cabinet of Ministers of Ukraine, for a fee from legal entities and individuals. The fee for such medical services is established by healthcare institutions independently..." [1].

The purpose of the work - to convey to doctors and heads of state and municipal non-profit healthcare institutions that in modern conditions it is quite possible and advisable to establish such a tool for additional financing of a medical institution as the provision of paid medical services to the population, as well as to offer some practical recommendations for the introduction of paid medical services.

In July 2024, Resolution of the Cabinet of Ministers of Ukraine No. 781 (entered into force on January 1, 2025) "Some issues of providing medical services to the population for a fee from legal entities and individuals" was adopted, which actually repealed Resolution of the Cabinet of Ministers of Ukraine No. 1138 of September 17, 1996 "On approval of the list of paid services provided in state and municipal healthcare institutions and higher medical educational institutions" [2, 3].

The scope of services paid by the state and free of charge for patients is determined in the Medical Guarantees Program. On December 24, 2024, the Cabinet of Ministers of Ukraine adopted Resolution No. 1503 "Procedure for the Implementation of the Program of State Guarantees for Medical Care for the Population in 2025", which contains the so-called comparison table, i.e. a certain classifier of medical interventions (medical procedures, surgical operations) that belong to the Medical Guarantees Program, i.e. are paid for from the state budget. The comparison table is approved by Order of the Ministry of Health of Ukraine No. 773 [4, 5].

In addition to national regulatory documents that regulate the provision of paid medical services by state and municipal healthcare institutions, the medical institution itself must have local regulatory documents, including in order to protect itself in the event of certain legal problems that may arise in the process of medical activities. These are documents such as the charter of a medical institution, regulations on paid services, an order of the head of the medical institution on the implementation of this regulation, an order of the head on the implementation of tariffs for paid services, and an agreement on the provision of paid medical services.

The charter of a medical institution must provide for the provision of paid medical services by the enterprise, since the charter is the basic document under which any legal entity, including a medical institution, operates. Most charters provide, in at least one phrase, that any institution, even a non-profit one, has the right to carry out certain economic activities to meet its economic needs. The only difference between non-profit institutions and commercial ones is that they do not transfer profits from their activities to their founders, but use them for their own needs, to improve the material and technical base, to provide employment for employees, to pay competitive wages, and to cover any expenses for their main activities.

Whether a provision on paid services is a mandatory or desirable local document depends on how detailed the charter is about what exactly the institution does and how exactly it provides paid medical services. If these points are set out in the charter in a rather general manner, it is recommended to make a provision on paid services, which would partially duplicate the Resolution of the Cabinet of Ministers of Ukraine No. 781 and which would state which paid services, under what conditions, are provided by the institution, and which would contain a list of these paid medical services (this list may not contain all paid services provided in the medical institution).

If the institution has a Regulation on paid services, then there must be a person who implements it. The easiest way to do this is by order of the manager, because there is no need to convene a general meeting of the enterprise's staff or summon the founders of the institution. Such an order in the future, if the list of paid services is expanded or narrowed, simplifies the procedure for changing it.

The institution must have an Order of the Head on the introduction of tariffs for paid services. This document is public, since Resolution No. 781 clearly states that a medical institution must publicly announce what paid services it provides and at what tariffs.

Is it possible to implement a contract for the provision of paid services in the form of a public contract, or is it necessary to conclude a contract for the provision of paid services with each patient? Current legislation does not require the conclusion of a written contract with each individual patient. The easiest way to save resources is to post a public contract on the provision of paid services on the institution's website, noting that by paying for a particular paid service at the institution, the patient joins the public contract and agrees to its terms. A fairly large number of points can be included in a public contract that can reduce many risks for the enterprise. The contract should also note that the consumer is informed about the possibility of receiving the service he needs under the Medical Guarantee Program.

A healthcare institution has the right to set prices for paid medical services independently. A single procedure for setting prices and tariffs for medical services has not been approved at the state level. Any pricing methodology that takes into account general calculation standards can be used.

The price of a medical service must be calculated and must be logical, because by starting to provide paid medical services, a non-profit medical institution enters a competitive commercial market. This provides for the possibility of filing a complaint with the Antimonopoly Committee against such a medical institution about unreasonable prices. If the Antimonopoly Committee is not shown what justifies the price of a medical service, it may unilaterally cancel the price as not being competitive and justified.

It should also be remembered that a medical institution must spend its profits on updating its material and technical base, on employee salaries. But the institution also reports on these funds: it sets a plan for them, and then reports on the implementation or non-implementation of this plan. Therefore, it is necessary to act within the framework of economic feasibility and understanding what the demand for certain medical services will be and how the profits from them can be spent for the benefit of the medical institution itself.

All services provided by a state or municipal non-profit healthcare institution are paid, but some of them are provided under the Medical Guarantees Program, and some are paid for by citizens. Therefore, state and municipal non-profit enterprises replenish their income from various sources: at the expense of funds from individuals, funds from legal entities (for example, for preventive medical examinations of employees, which are paid for by employers) and funds from the Medical Guarantees Program. The institution has a team of doctors to whom it must fulfill certain obligations regarding the minimum wage, etc. Any changes to the duration of a doctor's working hours must be agreed with him in accordance with labor legislation. If a doctor implements a medical guarantee program within his working hours, the remaining time may be allocated to providing paid medical services. Unfortunately, the Medical Guarantee Program does not cover all the costs of a medical institution to ensure even the minimum salary for medical workers, which is determined by law.

Resolution of the Cabinet of Ministers No. 781 of July 5, 2024 “Some issues of providing medical services to the population for a fee from legal entities and individuals” was approved in accordance with Part 10 of Article 18 of the Law of Ukraine “Fundamentals of the Legislation of Ukraine on Healthcare”. The document defines the basic requirements for entities that provide medical services for a fee, including licensing, service quality standards, and the procedure for interacting with patients.

The document also creates equal conditions for all medical entities operating in the field of paid services.

The resolution significantly expands the possibilities of medical institutions to obtain additional sources of financing. All services provided by municipal and state non-profit enterprises must compete properly, that is, have equal conditions with commercial medical institutions. The resolution in no way restricts healthcare institutions in determining the list of paid medical services to be provided.

The resolution defines the list of cases of providing paid medical services (not the list of paid services themselves), cancels the list of paid services in resolution No. 1138 (i.e., absolutely all medical services may be paid under certain circumstances), gives healthcare institutions the right to independently set prices for these services (based on the conditions of the local medical services market, the solvency of the local population, competitors' prices for similar

services, etc.), defines the obligation to document the provision of paid services (in the same way as is done in commercial healthcare institutions, i.e. an appropriate contractual basis, a clearly defined price, confirmation of the fact of the provision of the service) and determines the transition to cashless payment.

The list of cases in which state and municipal healthcare institutions may provide medical services to the population for a fee from legal entities and individuals is divided into two groups:

1) cases when legal entities and individuals pay in full for the services provided;

2) cases when legal entities and individuals pay for additional services (when the patient receives certain services under the medical guarantee program, and pays for additional services he needs).

Full payment for services is made in the following cases:

- when the service is provided without a doctor's referral, except in cases where a referral is not required by law (referral to a gynecologist, psychiatrist, dentist, etc.);

- provision of medical services to the population under contracts with legal entities;

- provision of medical services to the population in healthcare institutions falling under the jurisdiction of the State Administration of Affairs and state bodies included in the security and defense sector, to patients who do not belong to the attached contingent;

- provision of medical services to the population that are not covered by the Program of State Guarantees of Medical Services to the Population (when the service is not included in the Program of Medical Guarantees or the medical institution is unable to provide such a service within a certain time, but the patient wishes to receive it urgently).

The service cannot be provided for a fee (provided only under the medical guarantee program) in the following cases:

- when the patient has a signed declaration with a family doctor, therapist or pediatrician and the service is provided at the primary health care level;

- when the patient has an electronic referral for a service included in the Medical Guarantees Program from a family or treating physician;

- when the patient applies for a service included in the Medical Guarantees Program and does not require a mandatory electronic referral;

- when the patient is in an emergency and requires emergency medical care.

Payment for additional services is made in the following cases:

- when the service is provided at the patient's place of residence or stay of his choice, provided that there are no indications for its provision;

- when independently choosing a treating physician when providing specialized medical care on a scheduled basis in a hospital setting;

- when the patient is in a ward with an increased level of comfort and service by the patient's own choice.

The clause on the independent choice of a treating physician during planned inpatient treatment opens up a fairly broad field for the head of a healthcare facility when this facility has doctors who are widely popular among patients.

There are the following features of the provision of paid services from the point of view of general rules:

- contractual obligations of the patient-hospital are similar to the obligations of the client-contractor (conflict situations are possible regarding the quality of the service provided, because the patient considers a paid medical service not as the medical care he needs, but as a service that he orders at his own expense and requires a certain quality of it - timeliness, lack of queues, comfort of the office, communication with the doctor, etc.);

- obligations must be documented (this is a contract between a legal entity - a medical institution, and an individual - a patient). In judicial practice, a legal entity is considered the party with more rights and opportunities, therefore, the recording of obligations (recording the calculation, recording the provision of the service, the scope of the provision of

services, the presence of additional questions about the service) must be well established so that there are no questions to the healthcare institution later;

- clear price fixing (the patient must understand how much what he orders costs);

- similar restrictions on entrepreneurship, in particular regarding advertising and competition (reasonableness of prices, information about services, which is actually equated to advertising, justification of why a certain service cannot be provided free of charge);

- liability for non-provision of services or their poor quality.

Taking into account the possible risks arising from the provision of paid medical services, general recommendations for healthcare institutions can be formulated:

- transparency of information (list of paid and free services, their cost and terms of provision, emphasizing that receiving a service under the Medical Guarantees Program or receiving a paid service is the patient's choice);

- publication and updating of information (on the official website of the institution and on information stands);

- public offer (availability on the website). Not mandatory according to the resolution, but can help in resolving disputes. A public offer is a contract offered to a potential client on certain conditions (timeliness of attending the ordered services; conditions and procedure for returning paid funds to the client; resolution of conflict situations; understanding by the client that receiving a service for a fee is his choice, etc.);

- cashless payment (mandatory condition, with entry of relevant data into the Electronic Health Care System).

Is it possible to charge a fee for services from a patient with an existing electronic referral if there is no place in the queue for the selected date? Yes. The referral is valid for a year. The need to provide a service according to the referral is regulated by Order of the Ministry of Health No. 586, the term is 30 days. If the date does not suit the patient, a paid service can be provided. If the facility is unable to provide this service within 30 days, the facility must notify the patient, and the patient decides whether to wait for the opportunity to receive the service under the Medical Guarantees Program (MGP), look for another facility where the service will be provided, or receive this service at their own expense.

Is it possible to run two separate queues (MGP and paid services) during the same period of time with the same doctor? It is possible, but it is recommended to divide the doctor's working day into two separate schedules: first MGP, and then paid services, or vice versa. This will simplify the provision of the minimum level of services under the MGP, simplify communication between doctors and patients and between patients, and when checking the level of service provision under the MGP, simplify reporting on the implementation of the provision of services under the Medical Guarantees Program.

May a municipal non-profit enterprise be a contractor and provide services under a contract with an individual entrepreneur? No, according to the restrictions established in Resolution No. 781, municipal non-profit enterprises may provide services under a contract exclusively with legal entities. This is discrimination against individual entrepreneurs, and most likely this provision will be corrected. The more appeals there are on this issue from both individual entrepreneurs and medical institutions, the sooner this restriction will be corrected.

What primary care services may be paid for? Primary care services (family doctor, pediatrician, therapist) may be paid for only in the absence of a declaration, if it is impossible to conclude a declaration with this doctor, or if the patient wishes to receive the services of a specific doctor. At the primary level, services related to the specialized level (ultrasound, laboratory tests, etc.) may be subject to payment.

Is it possible to set tariffs for paid services at the level of the National Health Service tariffs? If so, what documents should be used to properly formalize this at the enterprise and where can I get the approved National Health Service tariffs? It is possible to do so. Tariffs for paid services are approved by order of the head of the healthcare institution, and it must specify how they are calculated, their cost, and all this must be made public. The tariffs of the National Health Service of Ukraine are set out in the Medical Guarantees Program.

How to organize the provision of paid dental services to children, if the SMP for 2025 provides for the provision of planned dental care to children free of charge, but the established tariff of UAH 134.68 does not allow for the provision

of high-quality dental care? The only way out is not to work under medical service packages. Then the institution does not have medical service packages, but it has a license, there are specialists, so by providing paid services, the institution does not violate anything.

Is it possible to be hospitalized in a hospital on a paid basis and how? This is possible when the patient does not have a referral, the patient is not in an emergency, when there are no indications for this service at the patient's place of stay, or this service is not included in the MGP.

What is the procedure for conducting medical examinations if the hospital provides this as a paid service? How to enter it into the Electronic Health Care System and is it necessary to enter it at all? Conducting medical examinations is the provision of assistance in the direction of "Prevention". The MGP defines cases when prevention is carried out under the terms of the MGP once a year (once a year - free of charge). In all other cases, prevention is carried out either by the primary link under the terms of the declaration, or at the patient's expense, if the patient seeks specialized care. Therefore, if a patient applies for a preventive examination that is not paid for by a legal entity, it is necessary to check whether he had an episode of prevention with this diagnosis during the current year. If so, the service will be paid.

Can patient meals be transferred to the category of paid services? It depends on the medical services package. If it is a “Surgery in a single day” package, then it does not include patient meals, so this service can be provided for a fee. But with inpatient treatment, meals are included in the package and should be provided free of charge. If we talk about improved nutrition as a paid service, then there is currently no standard for defining what improved nutrition is. Some additional elements of nutrition may be paid for, but the basic nutrition package is paid for from budget funds.

May an emergency medical care hospital establish paid services? Any municipal non-profit institution has the right to provide paid services, but not in the event of a patient's emergency. If such a hospital works with scheduled patients and if this is not prohibited by the institution's charter, then it has the right to provide paid medical services.

Is it legal to index tariffs to the inflation index instead of their annual recalculation? Institutions have the right to index the cost of paid services taking into account the inflation index when calculating. However, all changes in tariffs for paid services must be published on the institution's website and on the stand so that they are up-to-date at the time of the patient's request. After all, according to the Law "On Consumer Protection", the patient has the right to receive paid medical services at the price that is published. The institution independently regulates the frequency of recalculation of tariffs for paid services provided there.

What percentage of the cost of a paid service should go to the doctor's salary? This issue is not regulated by state regulatory documents, but can be regulated by the institution's internal documents. Conditionally, the institution can charge the doctor even 90% of the salary.

Currently, most healthcare facilities do not have enough funds to fully cover doctors' salaries under the Medical Guarantee Program, provided that the minimum wage requirements are met. Is it possible to transfer doctors to 0.5 salaries and cover the remaining 0.5 salaries through paid services? Is this legal? The issue of transferring doctors to 0.5 of a full salary is a matter of labor law alone; it is a significant change in working conditions, and it can only happen in agreement with the employee. There can be no unilateral decision by the manager here. If the manager sees that the introduction of paid services, changing the doctor's internal work schedule without transferring to 0.5 rates will ensure the necessary wage levels, then there will simply be no need to activate the entire procedure under the Labor Code to change tariff rates, staffing levels, etc. If paid services cannot cover the costs of the minimum wage, then it is necessary to decide how to fulfill the requirements of regulatory documents and ensure at least a break-even point for the enterprise.

Conclusions:

1. Under certain circumstances (unless otherwise specified by law), absolutely all medical services provided to the population in state and municipal healthcare institutions may be subject to payment.
2. The healthcare institution independently determines the list of paid services, sets prices for them, and may use these additional funds to meet its own needs.

3. The introduction of paid services in state and municipal non-profit healthcare institutions is a completely real and appropriate process.

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