WHO IS RESPONSIBLE FOR OUR HEALTH? CHANGING CONCEPTS OF STATE AND THE INDIVIDUAL IN POST-SOVIET UKRAINE

Maryna Bazylevych
State University of New York at Albany

In this article I examine contestations in the transforming health care system of Ukraine, which have gained momentum in the past few years of destabilized political process in the country.[1] The dynamics of the concept of *responsibility* are central to this discussion and will guide the article. In the midst of political debates, the current state administration has sought to move the country towards European integration. The Ukrainian Ministry of Health is promoting reforms that emulate the Western European model of health care ideology, delivery and financing. These attempts at transformations aim to align the Ukrainian health care system with Western standards and thus assist the country's efforts to gain EU membership. The route pursued here is one of restructuring the crisis-ridden centralized Soviet health care model that is operating in Ukraine today and implementing more market-driven mechanisms. Among the most significant proposed policies are the implementation of national health insurance, a new focus on primary health care institutions as opposed to the current trend of (over-) spatalization, and the legalization of a fee-for-service system in contrast to the current dominance of informal exchanges (Polishchuk 2005). Although these ideas may sound promising on paper, very little has been done by way of officially adopting the new policies and initiating their implementation.

Perhaps the most prominent health care discourse that has captured public attention is the shift of responsibility for one's health away from the state and onto the individual. Analysis of the debates that surround Ukrainian health care can help us map the dynamics of post-socialist scripts on the roles of the state and the individual. This article will explore the ways in which the national health care policies contribute to spatalization of the state (Ferguson and Gupta 2002) by focusing on some of the discourses engaged by the current government and their interaction with people working in the biomedical sector.

Methods and Research Setting

The article draws on ethnographic fieldwork research I conducted in central and Western Ukraine during 2006 – 2008. I use data from key participants' interviews, life histories and focus groups. My broader research project focuses on the transformations in the Ukrainian health care system, changing meanings of medical professionalism and morality, and their interactions with gender categories. For the purposes of this paper, I scrutinize the national policies and trends in health care, as they are understood by the most immediately engaged parties, such as health care administrators and physicians. This population group is centrally located in the debates surrounding the shifting roles of the state and the individual in the Ukrainian health care system. Through the eyes of these insiders of the health care system, I will track local understandings of the unfolding socioeconomic, political and institutional transformations and the meanings attached to them to unpack the concepts of *rights* and *responsibilities*.

The participants for this study were recruited from different positions and institutions in the health care system, including health care administrators (head physicians, municipal authorities), established physicians in state-sponsored clinics and some private facilities, and primary providers, including pediatricians. I focused on a broader range of variation among health care professionals to capture a variety of voices, including the older generation of providers trained in the Soviet Union and younger physicians who made their professional choice after Ukrainian independence (i.e. post-1991). The data were collected in the capital city of Kyiv (pop. 2.8 million), as well as the central Ukrainian city of Vinnytsia (pop. 350,400) to compare center-periphery dynamics in the medical profession.

Today, Ukraine continues to use the hierarchical and centralized Soviet health care model mandated by the Ministry of Health. The Constitution of Ukraine appoints legal responsibility for ensuring free and universally accessible health care to the state:

> The State creates conditions for effective medical service accessible to all citizens. State and communal health protection institutions provide medical care free of charge; the existing network of such institutions shall not be reduced (Constitution of Ukraine 1996. Article 49. Official English translation).

The Ukrainian health care system has inherited systemic problems, which have been magnified in the post-socialist years of general economic and political crisis (Ponomarenko 1999). Currently, only about 4% of the Ukrainian GDP is spent annually on health care (Bezrukov 2003), compared to the 8% recommended by the World Health Organization. Ukraine currently experiences a mortality crisis with average life expectancy 73 years for females and 67 years for males, which is on average 11.76 years less than in Western European countries. Ukraine's population has fallen by five million since independence, with fertility rates one of the lowest in Europe. Deaths from cardiovascular diseases have increased by 40%, and communicable diseases are also on the rise (Lekhan et al. 2004, WHO in Ukraine statistics).

The country's socioeconomic crisis has created an environment in which health problems flourish. In the context of skyrocketing prices on pharmaceuticals, medical supplies, equipment, energy and utility costs, "free" and "accessible" health care is essentially substituted by the informal fee-for-service system. The financial burden falls first and foremost on the patients. The lowest-income layer contributes a disproportionately large portion of their income towards their health care (Ponomarenko 1999).

The informal payments for medical services are ubiquitous, but because of their shadowy nature, they are not well researched. Ex-Minister of Health Dr. Mykola Polishchuk and the Ukrainian National Academy of Medical Sciences (2005) estimate that over 50% of all health care financing originates from unofficial and quasi-formal payments. Patients may incur any of the following informal costs: purchase of medications and supplies; payments to the physician or the surgery team; payments to nurses or sanitary workers; and miscellaneous fees to speed up access to scarce resources and services (Thompson and Witter 2000:172). It is hard to over-emphasize the discontent of the local population. The health care administrators, physicians and patients alike screamed from the pages of newspapers, interview tapes, and television screens that health care was not accessible to all, did not always offer high quality services, and lacked advanced technology, medications and supplies.

I now turn to a discussion of the proposed direction of health care reforms and changing understandings of the individual and state rights and responsibilities that accompany them. I then explore how these discourses are re-negotiated by the insiders of the health care system on the ground. Analysis of competing narratives about the roles of individuals and the state illuminate the process of spatalization and provide context for understanding the difficult reform process in post-socialist health care.

Post-socialist Politics of Health Care

Although people in Ukraine are disillusioned by inconsistent and prolonged health care reforms, most long for changes, be it a national health care insurance or other reforms. Public opinion polls indicate that in 2004 as many as 75% of the population expressed dissatisfaction with the work of the health care system (Polishchuk 2005). Perhaps, just as many would express dissatisfaction with the reform process if they were polled about it. Drafts of laws that address reforms in health care have gone through four readings in the course of the past five years, and are still being debated. The two-faced nature of the current health care system frustrates most physicians and patients, who want to make the rules of the game clear: "I believe that a person must clearly know what he or she will receive truly free of charge …and what he or she will have to pay for" (Interview with Halyna, 2007).

Another respondent agrees,

> The first problem that we need to solve is figuring out what "free" health care really looks like. Medicine for which nobody pays…Here is the root of the problem! They [the state] want everything to be all right without anyone paying for health care. In addition, they want to have all the supplies and medications to spare, high salary for the physicians, and keeping everybody satisfied… All of this on the background of free health care! (Interview with Sergiy, 2007).

President V. Yushchenko's administration developed a "road-map" of health care development for the next ten years (Surzhik 2006). The general direction of the reforms is towards decentralization of the system, bringing in private capital from the general population and employers, implementing open market principles in the health care system, and generally aligning Ukrainian medical care with the European Union standards. According to the Ukrainian Ministry of Health (2005), the reform packet prioritizes structural reorganization of health care with a principal focus on primary health care providers (family physicians); a switch from centralized health care delivery and management to contract-based health care; increased health care financing; the harmonization of state promises with the financial abilities of the health care system; the implementation of a quality control system; conducting more active policy making in human resources; and better regulation of the pharmaceutical sector.

The allocation of responsibility for one's health is prominent in discussion of health care reforms. People are about to be officially asked to pay for something that has been framed as the fundamental "human right" for a period of almost a century. It will dramatically change the idea of the state and its roles. Although informal payments have been in circulation for a long time, their illegal nature still allows for a space in the minds of people that health care must be free, and they blame their physicians and the bureaucracy for this discrepancy with the ideal. Now, people are being asked to part with this image and to move from universally free care to only a minimum health care provision (Sheiman 2000). Even the most ardent supporters of health care reforms insist on at least the basic medical help being free and accessible for the population: "Medical services need to be fee-based, and medical help needs to be free! … We need to have a guaranteed minimum of health care provision" (Interview with Lev, 2007)

Political unrest permeates Ukrainian society. Because health care is sponsored by the state, it is especially influenced by sways in political power. In the past five years, at least four Ministers of Health tried their hand at running the biomedical field. None of them made much headway (Bobrov 2006). Respondents were confident that "fish starts rotting from the head," and that political fighting of different lobbying groups and attempts to gain control over the million-dollar funds were at the root of the problem. As one informant who has worked in the municipal health care administration for over ten years stated:

> The question is: who will control the prospective national insurance funds? It may be the governmental structures … or private parties… It is clear that we are talking about billions of dollars… As of today, I believe it has to be the governmental structure that would control the insurance funds, because there is no honest private capital at this point of accumulation of wealth in Ukraine. Here we currently have Fordism… "Don't ask me where I got my first million!" The attitude to money is, to say the least, unscrupulous, and we cannot give the new capitalists access to another source of money at this point (Interview with Leonid, 2007).

Other respondents were even harsher in arguing that a fight for power and money is to blame for the ineffective attempts of the reforms. A young physician in the beginning of his medical career pointed out:

> I see no light in the end of this tunnel. It is deadly silent here [about the reforms]. The fight for power is ongoing. The Cabinet of Ministers – President President – Cabinet of Ministers… It makes me sick to my stomach…If you had asked me two years ago, when Yushchenko and the Orange Revolution [happened], I would have told you – Oh! Now we are talking! Now everything will finally move from the dead point. Now we will get things going (Rus. "сейчас прогреем и поедем")![2] Aha…See, there is no light anywhere… Anywhere… Everything is falling down. Destruction, disarray, disorder… And nobody to rescue what remains… (Interview with Oleg, 2007).

Health care is a fruitful field for political parties to use in their programs as good "PR," yet none of the political forces in Ukraine today offers a realistic and clear-cut health care policy plan. The statements are mostly demagogical (Skrypnyk 2006). No matter what

reforms will eventually take root in Ukraine, they are bound to meet some degree of social resistance, because their direction is towards shifting the responsibility for health onto the individuals and away from the state. None of the political parties are interested in unpopular statements, and withdrawal of free health care provided by the state is not popular, because a large portion of the population is impoverished and relies on at least a minimum of state-sponsored resources. In addition, hardly any work is being done on promoting the health care system reforms among the population. Instead, the suggestions to implement health insurance are often understood by the public as an attempt to get access to their hard-earned money. What the population sees is less health care for more money.

Thus, political parties see meddling in health care programs as political suicide (Andrusiv 2006, commentary). Additionally, there is resistance to reform on the part of those officials who have found a lucrative niche, and those who are afraid of losing their positions in a new health care system. Some medical workers (mostly medical doctors) may also resist the proposed reforms, for they have already established their clientele and receive regular informal income at the cost of the state, which provides free room and board for patients, free utilities, and labor of the supporting staff (Interview with Vsevolod, 2006). I argue that these processes could be understood through an examination of the changing concepts of state and individual and their social roles.

Changing Concepts of State and Individual: Theoretical Considerations

There are competing public discourses in Ukraine and other post-socialist states on the role of the individual in improving his or her own health status. Some of the more salient tendencies can be loosely divided into those that emphasize the responsibility of the individual in managing her or his health, and those that bestow the responsibility on the state and critique its failure to fulfill its Constitutional promises.

Discourses emanating from the current "EU hopeful" Ukrainian state administration emphasize the responsibility of the individual and urge Ukrainians to protect their health through the following material and non-material actions: healthier lifestyle (exercising, cutting down on alcohol and tobacco, eating healthy); seeking out health insurance opportunities; and making more sensible use of the existing health care resources. Most of the interviewed health care providers emphasized this approach at least to a degree. Current scholarship that focuses on health care reforms in post-socialist societies (Apanasenko 2006, Musiy 2006, Pyrig 2006, Polishchuk 2005, Barr et al. 1996, Cockerham 1999) also promotes this discourse on individual responsibility. "State dependency" (Cockerham 1999) theory offers some of the most critical arguments within this discourse. It explains unhealthy behaviors on the part of large number of Ukrainians as rooted in their Soviet past, when their health care choices were made for them by the authoritative state. "State dependency" theory claims that by inertia, many Ukrainians do not attempt to provide for their health independently and do not follow a healthy lifestyle because they expect to have state support when they need it.

Contrary to Cockerham's state dependency theory (1999), Apanasenko (2007) argues that this attitude towards health is not so much about dependence on the state, but rather about (mal) adjustment to new values when the established expectations are clashing with new realities. According to him, less than 1% of the Ukrainian population is currently in the "safe health zone," while twenty years ago at least 20% of the Ukrainian population fell under this category. State dependency alone, therefore, cannot account for continuing deterioration of the public health indicators. Still, this personal responsibility-focused approach does not account for structural obstacles to leading a healthful life. Such theories emphasizing healthier lifestyles ignore larger social structures that may be responsible for poor health indicators, such as the informal commercialization of health care and problems of access to it by the newly formed social classes (Baer 2003).

Public discourses that ascribe responsibility for the nation's health to the state focus on the Constitutional promises and the state's failure to meet them. People are all too aware that more often than not they will be asked to pay for their medications, supplies, and consultations. Conflicts with health care professionals flourish, and the medical workers simply cannot deliver the promises of the state, while approximately 19% of the population is below the poverty line. My interviewees jokingly quoted a famous Soviet joke: "порятунок потопаючих – справа рук самих потопаючих"

(Rescue of the drowning victims is the responsibility of the drowning victims). Ex-Minister of Health Polishchuk (2005) argued that the level and quality of health care services accounts only for 10-15% of the population's health indicators, while lifestyle, income, environment, education and genetic factors contribute 85-90%. Some of my interviewees immediately identified this statement as an attempt of the state agencies to avoid responsibility (interview with Halyna, 2007). No wonder that a popular Ukrainian joke re-named the Ministry of Health into "a Ministry without Health" (Ukr. Міністерство Без Охорони Здоров'я) or "Ministry of Burying Alive" (Ukr. Міністерство ЗдравоПохування) (Podolyan 2006).

The clash of these salient discourses demonstrates the current complex renegotiation of state and individual roles in health care. Administrators, providers and users of the health care system are searching for new ways to spatialize the Ukrainian state. I argue that health care polemics in Ukraine can at least in part be explained by the conflict between the ways in which the state wishes to project its roles and the ways in which the individuals imagine the state. Granted, the state is not a solid unified body, but rather a collection of competing agendas and influences. I borrow the concept of state spatialization from Ferguson and Gupta (2002), who argue that states are not merely bureaucratic entities, but they also function to produce symbolic and culturally determined images in order to be represented in a particular desired way. A series of "metaphors" are offered to the population as a toolkit, with which one could conceptualize the state: "Through specific sets of metaphors and practices, states represent themselves as reified entities with particular spatial properties…By doing so, they help to secure their legitimacy, to naturalize their authority, and to represent themselves as superior to, and encompassing of, other institutions and centers of power" (Ferguson and Gupta 2002:982).

Everyday practices make such metaphors routine and easily recognizable. Thus, states are constructed and use sets of images and practices to confirm their authority and legitimacy. Free access to health care has been formulated as a fundamental right of the Ukrainians, and it has become a part of routine expectations of the state role. Free health care is a powerful image that has an important role in securing legitimacy and authority of the state. Inefficient health care transformations concern not only reformulation of the health care structure and financing, but also ideology, or the metaphors in which the state is imagined. The players involved in discussions about health care reforms are struggling to piece together a new image of the state that would be socially acceptable, effective and improved compared to the current inefficient system. There is no single image in which the state is spatialized; it is rather a dynamic, negotiated set of images and practices. This process is especially bold and profound in the current sociopolitical and historical context in Ukraine.

Rethinking the Ideology of Health Care

Morality and Responsibility through Physicians' Eyes

How are these dynamics negotiated on the ground, by physicians working within these new discourses on rights and responsibilities in the context of changing social relations? In what ways do physicians navigate the tangled health care system and how do they understand their current roles and responsibilities? Local mass media often accuses Ukrainian physicians of low professionalism, immorality, and bribe taking (Barr et al. 1996). Despite the complicated and conflicted relationships with the patients, I found that many Ukrainian physicians managed to strike a relatively comfortable living according to local economic standards. Although official wages of Ukrainian physicians are not high, they often represent a fraction of their unofficial income, such as patients' informal payments, second jobs in private clinics and pharmaceutical companies. These informal and semi-formal earnings often constitute the bulk of physicians' actual incomes (Kornai 2001). Because it is a state job, the medical profession also has the advantage of being one of the few stable professions in the extremely unstable post-socialist world. It is therefore reasonable to suggest that the Ukrainian biomedical profession may be more prestigious and lucrative than the current scholarship shows (Navarro 1977, Reskin and Roos 1990), even though the newly accrued prestige may be achieved through somewhat questionable routes. Responsibility and formulations of morality are being re-constructed, and are especially illuminating in the case of physicians due to their precarious role as middle-men and middle-women between the state and the patients.

Michele Rivkin-Fish (2005) discusses these new income venues and the consequent renegotiation of doctor-patient relationships. She argues that Soviet physicians utilized the ideology of medicalization to assert their authority and to broaden their limited socioeconomic status. Acquaintance relations and informal exchanges served to facilitate work and were based on an ideology of moral obligation rather than personal enrichment. With post-socialist changes, physicians are rethinking the meaning of professionalism, and now accept monetary payments in lieu of other forms of gratitude. A term used to indicate informal payment is "лівак" (Ukr.) meaning "left," unofficial, unaccounted for. Sufficient income was repeatedly mentioned as a crucial aspect of physicians' professional dignity. When prompted to discuss the motivation behind his work, one young physician who has not been able yet to find a lucrative employment niche commented, "How can we talk about prestige, higher purpose of medicine, doctors' call to help people?! Decent level of income is my main motivation at this point. There could be no other under the circumstances!" (Interview with Sergiy, 2007).

This informant quickly and accurately identified the idealized discourse of the enlightened and dignified medical profession and ridiculed it. He felt that presenting an ideal picture of the medical profession was a slap in the face to young specialists who are struggling to make ends meet. Sufficient or "decent" income was repeatedly equated with respect and a sign of professional achievement rather than a sign of corruption of lack of morale. The concept of what it means to be a good doctor now constitutes a changed set of values, and includes "decent" income as one of the major expectations. This illustrates physicians' engagement with broader social phenomena, such as the formation of a new social contract between doctors and patients, and a renegotiation of their rights and responsibilities in the context of reorganization of social classes and marketizations. In my larger project, I demonstrate that these changes in biomedical morality are influences by competing discourses that carry both socialist and new post-socialist rationalities that inform material and non-material aspects of the medical work. In this article, I would like to emphasize the shift in understanding the rights and obligations on the part of both physicians and patients, understandings that are circumscribed by new social relations unleashed by the open market and poorly regulated capitalism in Ukraine.

Rights versus Obligations

Despite the seeming status quo of the Ukrainian health care system where the Constitution froze it in a socialist limbo, a multitude of changes has long been under way. The Ukrainian biomedical field is reorienting itself towards a different set of values, along with the rest of the post-socialist society. The ways in which biomedicine is practiced are transforming, and the former focus on citizens' obligations is now changing towards a closer look at the individual rights. Soviet medical students were trained to work with each patient with a degree of freedom in making their professional decisions. An ideal physician was imagined as responsible and enlightened, and the work as a creative process. "Medicine is an art. No two patients are the same" (Interview with Lev, 2007). In contrast, the Western-style medicine towards which Ukraine is striving, focuses on democratic principles: attending to the *rights* of the patients. This type of medical work follows standardized protocols, or "standards of care." These are the algorithms of diagnostic procedures, treatments, and medication schedules.

The root of the difference is in the means of reaching the final goal: Soviet physicians were encouraged to save or improve the health of the patient in whatever ways they deemed the best or possible, while Western physicians have had to maneuver within the frames of medical protocols (Interview with Lev, 2007). Currently, such standards of care are being introduced in Ukraine, but they are not strictly enforced. My informants considered the protocols unrealistic given the economic situation. The protocols require a certain level of technology and specific medication schedules among other things, which are far from accessible to the majority of clinics and patients. Hospital administrations do not control whether the protocols are followed (especially if the treatment results are acceptable), and the current standards of care carry only a declarative value.

Many respondents felt that the most appropriate way to approach the patient was to work within his or her financial abilities, and design the treatment course in a way that would not bankrupt the patient's support network. Yet, it is a high order to fill – since the health care

facility and the particular physician can be held responsible for not following the protocols in case of outside investigation. The uncertainty in health care makes it difficult for the physicians and patients to navigate the system. The current ambiguity of the use of medical protocols in Ukraine illustrates a new type of "bioethics" (Muller 1994) in this post-socialist setting, a bioethics that has been formulated in terms of "medical morality" (Fox and Swazey 1984). The Ukrainian health care system is not financially or ideologically prepared for the Westernized focus on individual rights. These are still being actively negotiated and experimented with. Meanwhile, physicians are attempting to reconcile their own ambitions, material limitations, new professional regulations, and the overarching ideas of what is right and wrong.

Generating (and Generations of) Moralities

The changing locus of responsibility in matters of health care is especially clearly illuminated by the intergenerational differences within the biomedical field. Though with many exceptions, in general, older physicians trained in the Soviet Union had a more critical assessment of the current developments in the field compared to the younger generation of doctors graduating in post-socialist Ukraine. However, this division is quite rough with plenty of older respondents actively involved in the new earning strategies, and younger respondents unable to conform and longing for the predictable order of the Soviet times. Many older physicians were convinced that the Ukrainian health care was staying afloat only thanks to the efforts of the older generation. An older respondent with many years of medical work under his belt quoted Voltaire to jokingly characterize some of the younger doctors' work ethics: "Physician must entertain the patient while Nature is curing him" (Interview with Vsevolod, 2007). It is also younger physicians who often take second and third jobs to supplement their incomes, which are sometimes unrelated to medicine (IT technologies, sales, etc.), since, unlike their older counterparts, they are still working on establishing their reputation and loyal clientele. This routine does not aid their professional growth and undermines the patients' trust, since patients may suspect their doctors as being negligent and collaborating with the pharmaceutical companies rather than genuinely attending to their health.

Ukrainian medical publications and respondents' narratives accuse the mass media of nonobjective portrayal of medical workers. They feel like scapegoats of the system trapped between the patient and the state and unable to satisfy the expectations of either one:

> …Everyday … one can hear a massive amount of unreasonable charges against physicians, complaints about their incompetence, inattentiveness, carelessness, corruption, and other big and small deadly sins… At the same time, we hardly get to hear about the miserable situation in health care facilities, lack of equipment, horrendous conditions of work, life and income of the medical workers… (Musiy 2006).

Younger respondents emphasized the lack of incentive to pursue improvement of their professional qualifications. This young physician without established clientele who works in the military sector was sarcastic about his professional future:

> Doctors receive the same salary as janitors, so how can he enjoy life? What good will come of taking the qualification exams (Ukr. "здавати категорію")? Five or ten hryvnia[3] bonus to the salary (laughs)? Then again, if you take the qualification improvement course (Ukr. "курси"), at your own expense, you will get another five hryvnias (continues to laugh) (Interview with Sergiy, 2007).

Morality quandaries were often framed in relation to "decency" and "order." Older, and especially already retired physicians, understood the informal payments as bribery, i.e. indecent disorderly behavior. In contrast, practicing medical doctors considered the informal payments as an important marker of their professional success and respect.

The attitudes of physicians towards the activities of their hospital managers were ambiguous. Hospital administrators are in position to make especially good money via unofficial sources, such as regular fees from subordinate administrators (pyramidal "tribute" schemes at their workplaces were reported by many informants); payments for hiring new

employees; or a portion of revenue from the hospital store, pharmacy, cafeteria, etc. While some respondents commented that they would have done the same, others frowned upon the ways in which administrators managed their workplaces. Popular press and professional medical publications call some of the more unscrupulous head physicians "feudal warlords" who hire and fire their employees at will (Musiy 2006). In contrast to the evaluation of work of the head physicians, head accountants, administration and other health care officials, nearly all informants viewed the work of their more established practicing physicians-colleagues as "moral." They argued that despite the popular rumors, there were more patients who did not tip the doctor than those who did. This is especially relevant for younger physicians who have not yet established their clientele, or for physicians in urgent care who have only brief contact with each patient. That is why, the respondents argue:

> Physicians are trying their best to work their way to the patient in order to "milk" at least a couple of hryvnias out of him or her, because they have got to live on something! … Because everybody takes this money, because the physician needs a place to live, needs to provide for the family, needs everything like other people do, needs to live… This money is not for luxury, not for chic! (Interview with Sergiy, 2007).

My informants specifically tried to rebuff rumors that the patients will not be helped if they do not pay extra. This female physician who has worked in the emergency hospital for all of her decade-long career, emphasized:

> If the emergency brigade delivers a patient with a stroke, a physician will hustle and provide the necessary treatment regardless of the money. How can we wait for the money? This is our job. No matter what, a physician … does his or her work… We take care of the homeless… We, Maryna, provide free health care to two categories of patients: the homeless and the government [employees]! Yes, yes, the hospital will provide them with free medications! (laughs) Yet, what kinds of medications do we have? The most primitive ones, but they do not care, they get hospitalized and treated. In order not to spend 200 – 500 hryvnias, they will agree to be treated with the lowest quality of drugs, just so that they do not have to pay! (Ukr. "на халяву") (Interview with Halyna, 2007).

Although the informal economy could presumably improve the experiences of individual patients, it draws upon the resources of the population without making positive infrastructural changes (Thompson and Witter 2000: 186). Informal payments are ever-present, yet not official (Grodeland et al. 1998). We witness shifting ideas about the contract between medical workers, patients and the state.

The health care sector remains a state-sponsored project in post-socialist Ukraine, yet despite this association, the participants of the system often work on the assumption that the state as such has already retreated from this space. The problems of the health care are left untackeled, while the providers and their administrators scramble to continue to make income and do meaningful work. Elizabeth Dunn (2008) discusses similar processes in Georgia: via her analysis of the canned food industry and its current retreat into domestic sphere, Dunn shows how some "social spaces remain uncolonized, unpenetrated and largely abandoned" in post-socialist contexts. Though initially these "stateless spaces" are created by withdrawal of the Soviet regime, they subsequently continue to grow and expand by the disregard of the new state. The rules by which the Ukrainian health care system is called to operate have shown to be incompatible with current structural and infrastructural arrangements. Continuing imposition of these rules in an effort to push a certain image of the state creates double standards and backfires.

Conclusions

This article has addressed transformations in Ukrainian health care and the debates surrounding them. As the population decreases and its health indicators are dramatically worsening, the health care system is under special scrutiny. The Ukrainian pursuit of EU membership informs the restructuring of the health care sector. Currently, Ukraine continues

to rely on the Soviet model of health care delivery, which is centralized and hierarchical. However, state planning of health care delivery is in sharp contrast to the market economy in other sectors of the Ukrainian economy.

The ideology of health care is changing, and the roles of the physician, the state, and the patient are currently being re-negotiated. This process is complicated by the incongruence between the Ukrainian law and everyday practices in medical facilities. According to the Constitution, health care must be free and accessible to all; however, medical facilities are unable to provide such care and increasingly rely on the informal economy. Multiple moral codes are currently operating in the Ukrainian health care system, where the ideas of right and wrong and state-citizen obligations and responsibilities are now being re-negotiated. This feeds conflicts between physicians, patients, and the state. What was once considered immoral comes to be not only socially acceptable, but formative in the construction of new ideas of professional success. This conflict is especially prominent when examining the differing views on morality held by different generations of those participating in the health care field.

The health care reform "road-map" prioritizes decentralization of the system, introducing private capital from population and employers, implementing the principles of the open market within the health care system, and in general aligning the Ukrainian medical care with European Union standards. However, there has been no headway in the actual designing and implementing of the reforms. Health care could be a fruitful field for winning the voters' loyalty, yet none of the political forces in Ukraine today offers a clear-cut health policy plan. No matter what reforms will eventually take place in Ukraine, they are bound to meet some degree of resistance, because the direction of the reforms is towards shifting the responsibility for health onto individuals and away from the state. The political parties are wary of such unpopular statements. Significantly, health care reforms are being stalled by the political deadlocks between different lobbying groups that are trying to gain control over the million-dollar medical industry.

This paper has argued that health care polemics in Ukraine can at least in part be explained by conflicts between the ways in which the state wishes to project its role and the ways in which citizens imagine it. Using Ferguson and Gupta's (2002) theory of state spatialization, I have argued that in the Ukrainian society where free health care is formulated as one of the basic rights, radical reforms could be a major blow to legitimacy and authority of the state, for we are dealing not only with the reformulation of the health care structure and financing, but also ideology - the metaphors in which the state is imagined. Spatialization of the state is a dynamic process, and competing public discourses that emphasize varying degrees of individual and state responsibility inform health care transformations. These processes point to the changing ideas about the roles of the state and the individual in Ukraine.

Endnotes

[1]This article is based on data collected during dissertation fieldwork research in central Ukraine in 2007- 2008, and was supported with a Wenner-Gren Foundation Dissertation Fieldwork Grant, a National Science Foundation Doctoral Dissertation Improvement Grant, a Benevolent Award and a University of Albany Dissertation Fellowship Award. Parts of this paper were presented at the 2007 Association for the Study of Nationalities Convention ("Nation, Community, and the State") at Columbia University.

[2] Both Ukrainian and Russian are spoken in Ukraine. Some words are included with their corresponding translations to indicate the terms and concepts that do not have clear parallels in the English language, but are important for understanding the context (such as cultural idioms or occupational slang words). I designate Ukrainian and Russian words/phrases by the indicators "Ukr." and "Rus."

[3] The hryvnia (UAH) is the Ukrainian currency. In May 2009 the official currency exchange rate is currently 1 USD to 7.7 UAH, according to the National Bank of Ukraine. However, the exchange rate is not stable and fluctuates. In the last few years it went from 1 USD to 4.5 UAH to 5.5 UAH, 7 UAH, 10 UAH and now back to around 8 UAH.

References

Andrusiv, M. 2006 "My Ego Teriaem," ili Nekotoryie Razmyshlenia po Povodu "Natsionalnogo Plana Deistviy v Interesah Zdorovia Naroda Ukrainy." Mezhdunarodnyi obshchestvenno-politicheskiy ezhenedelnik Zerkalo

Nedeli. 8 (587). Electronic document, http://www.zerkalo-nedeli.com/nn/show/587/52730/ Accessed in March 2006.

Apanasenko, G. 2007 Pochemy Vymiraiut Vostochnyie Slaviane? Zerkalo Nedeli 1 (630). Electronic document, http://www.zerkalonedeli.com/ie/show/630/55548/, accessed in Jan. 2007.

Baer, Hans A. 2003 The Work of Andrew Weil and Deepak Chopra – Two Holistic Health/New Age Gurus: A Critique of the Holistic Health/New Age Movements. Medical Anthropology Quarterly 17(2):233-250.

Barr, D., and M. Field. 1996 The Current State of Health Care in the Former Soviet Union: Implications for Health Care Policy and Reforms. American Journal of Public Health 86:307-312.

Bezrukov, V. 2003 Long-Term Care in Developing Countries. Ten Case-Studies. World Health Organization. Geneva and JDC-Brookdale Institute - the WHO Collaborating Centre for Health and Long-Term Care Policy and Research. Edited by Brodsky, J., J. Habib and M. Hirschfeld.

Bobrov, O. 2006 Reformofrenia. Zerkalo Nedeli 35(614). Electronic document, http://www.zerkalo-nedeli.com/nn/show/614/54478/ , accessed in Sept. 2006.

Cockerham, W. 1999 Health and Social Change in Russia and Eastern Europe. New York: Routledge.

Constitution of Ukraine. 1996 Chapter II: Human and Citizens' Rights, Freedoms and Duties. Article 49. Electronic Document, http://www.rada.gov.ua/const/conengl.htm#r2, accessed on May6th, 2009. Official English translation.

Ferguson J. and A. Gupta. 2002 Spatializing States: Towards an Ethnography of Neoliberal Governmentality. American Ethnologist 29(4):981- 1002.

Fox, R. and J. Swazey. 1984 Medical Morality is Not Bioethics: Medical Ethics in China and the United States. Perspectives in Biology and Medicine 27:336-360.

Grodeland, A., Koshechkina T., and W. Miller. 1998 "Foolish to Give and Yet More Foolish not to Take"- In-Depth Interviews with Post-Communist Citizens on their Everyday Use of Bribes and Contacts. Europe Asia Studies 50(4):651 – 657.

Kornai, Janos. 2001 Welfare, Choice and Solidarity in Transition: reforming Health Sector in Eastern Europe. Cambridge University Press.

Lekhan V, Rudiy V, Nolte E. 2004 Health care systems in transition: Ukraine. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

Muller, Jessica H. 1994 Anthropology, Bioethics, and Medicine: A Provocative Trilogy. Medical Anthropology Quarterly 8(4):448-467.

Musiy, O. 2006 Analiz Stanu Zahystu Prav ta Interesiv Medychnyh Pratsivnykiv v Ukraiyni. Electronic document. http://experts.in.ua/analytics/document18666.shtml, accessed in Dec. 2006.

National Bank of Ukraine. http://www.bank.gov.ua/ENGL/default.htm. Electronic resource. Accessed on May 6th, 2009.

Navarro, Vicente. 1977 Social Security and Medicine in the USSR: A Marxist Critique. Lexington, MA: Lexington.

Podolyan, L. 2006 Sistema bez Zdravoohraneniia. Zerkalo Nedeli 43 (622). Electronic document, http://www.zerkalo-nedeli.com/nn/show/622/55027/. Accessed in Nov. 2006.

_____. 2006 Gamma-Tsentr Postroiat v Feofanii. S Zolotoi Tablichkoi. Zerkalo Nedeli 48 (627). Electronic document, http://www.zerkalonedeli.com/nn/show/627/55367/, accessed in Dec. 2006.

Polishchuk, M. 2005. Vyklyky Transformatsiyi Systemy. Report of the Minister of Health of Ukraine.

Ponomarenko, V. Ed. 1999 Okhorona Zdorov'ia v Ukraiyni: Problemy ta Perspektyvy. (Health Care in Ukraine: Challenges and Future Developments). Ternopil. Ukrmedknyga.

Pyrig, L. 2006 Likari – Ukrayintsi Svitu – Yednaimosia! Speech of the President of the International Federation of the Ukrainian Medical Organizations.

Reskin, Barbara and Patricia Roos. 1990. Job Queues, Gender Queues: Explaining Women's Inroads into Male Occupations. Philadelphia: Temple University Press.

Rivkin-Fish, Michelle. 2005. Women's Health in Post-Soviet Russia: The Politics of Intervention. (New Anthropologies of Europe). Indiana University Press.

Sheiman, I. M. 2000. Vozmozhnyie Strategii Reformirovaniia Gosudarstvennyh Obiazatel'stv v Zdravoohranenii (Possible Strategies of Changes in State Responsibilities in Public Health). Economics of Public Health 5:45-60.

Skrypnyk, O. 2006. Patsient ili Izbiratel? Zerkalo Nedeli 9(588). Electronic document, http://www.zerkalo-nedeli.com/nn/show/588/52810/, accessed in March 2006.

_____. 2006 Gamma-Nozh v Zerkale Nashego Mentaliteta. Zerkalo Nedeli 49 (628). Electronic document, http://www.zerkalo-nedeli.com/nn/show/628/55408/, Accessed in Dec. 2006.

Surzhik, L. 2006. Podaite Bogatomu na Strahovku! Zerkalo Nedeli 43 (622). Electronic document, http://www.zerkalo-nedeli.com/nn/show/622/55026/, accessed in Nov. 2006.

2006 Eto Sladkoie Slovo – Medstrahovanie. Zerkalo nedeli 48 (627). Electronic Document, http://www.zerkalo-nedeli.com/nn/show/627/55354/, accessed in Dec. 2006.

Thompson, R. and S. Witter. 2000. Informal Payments in Transitional Economies: Implications for Health Sector Reform. International Journal of Health Planning and Management 15:169-187.

The World Bank. Ukraine Poverty Assessment: Poverty and Inequality in the Growing Economy. Electronic document, http://go.worldbank.org/HULJZ3A1S1. Accessed on March 3rd, 2007.

World Health Organization. Countries. Ukraine. Electronic document. http://www.euro.who.int/Ukraine/20080123_1 Accessed on May 6th, 2009.