Health-care reform
Taking first hard steps

English summary of the report

Introduction

Ukraine's healthcare is currently in a dire need of reform. On average Ukrainians live 10-12 years less than EU citizens and have an infant mortality rate that is 2.5 times higher than in the Union. At the same time, the rate of premature deaths surpasses three-fold the same indicator for EU countries. Two years ago President Viktor Yanukovych introduced a program for reforming healthcare services in 2010-2014 based on recommendations from Ukrainian and international experts. Last year the Ukrainian parliament approved a law to test the healthcare reform in four pilot regions - Vinnytsa, Dnipropetrovsk, Donetsk, and Kyiv city.

In 2011-2012 the reform plan for the pilot regions has placed a high priority on primary care by re-organizing such facilities, upgrading their equipment, and retraining general practitioners, pediatricians and other medical specialists into family practitioners. All medical institutions will have to be categorized into primary and secondary levels, implying a reorganization of some. The share of funding for primary care in the pilot regions is expected to increase dramatically. Primary care clinics will also sign agreements with local administrations on providing healthcare services and receive their funding based on the output and structure of medical care.

Implementation of the reform

In the first year of the reform the pilot regions have for the most part finished re-organizing primary care centers, which are predominantly based on the existing facilities. However, these centers are underequipped and do not employ enough family practitioners. Now only 18-20 percent of doctors in primary care are family practitioners. Moreover, around 30 percent of doctor positions in primary care are vacant.

The rush to open underequipped and understaffed primary care facilities has in some cases created an organizational chaos in their operations and resulted in unacceptably long lines, more referrals to specialists (who are now located in geographically remote hospitals), and intermixing of child and adult patients, which frustrated parents. Because family practitioners are trained through a six-month course, part of the public does not believe this short-time training can improve their competence. A newly introduced method of payment has tied the compensation to family practitioners to output and quality of care. But so far the proposed quality indicators do not work and family practitioners have to take a large number of patients to ensure a decent salary. This practice may negatively affect the quality of services and in the end decrease doctors' motivation to join the specialty.

Some medical institutions in the pilot regions have undergone reorganization with the medical staff dismissed and hospital beds reduced. Although these unpopular steps are necessary to reform, in some cases they end up reducing access to healthcare for rural inhabitants. With bad roads and lack of public transportation, reaching secondary level hospitals is difficult, and specialists in some fields are 20-30 or, in some instances, even 60-70 kilometres away. Furthermore, there are often cases when after shutting down a rural hospital a newly opened primary care clinic in that area lacks necessary equipment and

family practitioners, and an emergency care facility to transport patients to a remote district or regional hospital has not yet been opened. Thus, neither a primary care clinic nor an emergency care unit serves as a good alternative to the closed hospital. The present situation of demolishing the "old" without establishing the “new” carries health risks for the population and has generated a wave of protests.

The reform was expected to be financed through internal budgetary resources of the healthcare system, in other words by reallocating the funds that would become available as a result of the reorganization (closure) of hospitals and decrease in the number of beds and staff. However, the plan proved to be unrealistic. In 2012 additional funds were transferred from the state budget to equip primary care clinics in the pilot regions with medical vehicles for family doctors, medications, etc. Although the share of funding for primary healthcare in the pilot areas grew from 5-7 to 35 percent, the redistribution of funds has led to underfunding secondary and tertiary levels of care and may produce a non-transparent and unjustified process of closing secondary level hospitals, dismissing their employees, and increasing overall public unease about the reform. At the same time, the primary care centers have signed agreements with local administrations on providing medical care. But since the agreements define ‘medical care’ in very vague terms, the centers are financed in accordance with the previously prescribed standards and available funding ceilings.

Key Issues

The reform is widely criticized by civil society organizations and physicians, partly due to the lack of awareness about its purpose and the lack of transparency when it comes to the difficult issue of closing hospitals. But most criticism centers on the fact that at this stage the reform has created many inconveniences and risks without showing any noticeable improvements in healthcare quality. Three key issues are crucial for the continuation and eventual success of the reform.

1) Reform management and consensus

Having a proper administration of the reform at the central and local levels and involving doctors’ associations and the general public would contribute to finding a consensus on the issue. Currently, there is a lack of coordination among three central bodies administering the reform – the Committee for Reforms, the Ministry of Healthcare and the Committee on Healthcare in the parliament. The Ministry of Healthcare is too slow in preparing normative documents and regulations. In some cases the quality of such materials is quite low. The local governments in the pilot regions complain that they lack flexibility and resources to conduct the reform. The flaws in administration can create risks and problems in implementation. The public discontent can easily lead to abandoning the reform altogether, as many political actors are quick to suggest. To continue the change, civil society organizations and doctors need to be involved in the process and engaged in developing a consensus on its content.

2) Human resources

Creating incentives and providing high quality training for family practitioners should be a priority. Only high-skilled family doctors would be able to demonstrate advantages of primary care and ease the public skepticism. Here the existing associations of family practitioners and other professional organizations can play a constructive role. The opportunities to involve international experts and donors in re-training schemes should also be considered.

3) Funding

The envisaged reform is too large-scale and requires additional funding. Insufficient financing would otherwise place healthcare provision for many people at risk. Funding is a particular problem given Ukraine's slow economic recovery after the global financial crisis since 2008. The reform should be financed with new budgetary allocations, the healthcare resources available as a result of the gradual and well justified reorganization of inefficient hospitals (including those for members of parliament) and additional non-budgetary resources. Given the current fiscal circumstances, it is also critical to define priorities for allocating the scarce healthcare funds.

Conclusion

The first year of implementing the reform has shown that it is a huge organizational and financial challenge, which has encountered protests from the public, doctors, local authorities, and other interest groups. Although the first steps have been taken in the right direction, they are also too hasty and insufficient to improve the quality of care. Instead, the changes have created risks and inconveniences, which need to be addressed.

The current reform is going to be a long and difficult undertaking that is likely to show any significant positive results only in five-ten years. However, if it is abandoned, as some civic groups demand, the healthcare system in Ukraine will face further deterioration. Public organizations, such as associations of health professionals, unions, patient organizations, should not try to stop the reform, but require a better implementation and public oversight.

• The public should demand that new primary care facilities be equipped and staffed prior to the closure of rural hospitals in remote areas. Furthermore, local administrations should invest into maintenance and construction of roads and offer additional public transport to reach district-level hospitals. Regular visits of medical specialists to provide specialized care to rural inhabitants should be organized.

•Civic groups and associations should urge the government to improve the quality of training courses for family practitioners, their work conditions and methods of payment.

• Civic groups should monitor whether outpatient clinics are fully equipped, how long is the waiting time, and whether the number of referrals is reduced. This information should then be communicated to the management of primary care clinics and the official bodies that implement the reform to improve their work.

•Civic groups should control how a decrease in hospital funding impacts healthcare services at the secondary level, in particular whether it leads to: a) shortages of beds for inpatient treatment; b)inadequate and poor conditions for patients; c) long lines and waiting times to see a specialist or to be admitted into the hospital; d) an increase in informal payments for medical services; e) an increase in the cost of medications.

• Civic groups should request that all preferential medical services for members of parliament and other officials be discontinued and specialized hospitals of this kind be re-organized and made available to all.

The public should try to improve the implementation of the reform, by ensuring a public oversight and promoting the key innovations, without which the current transformation will not bring the desired results.