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REFORMING THE UKRAINIAN HEALTH SYSTEM AT A TIME OF CRISIS

By: Valeria Lekhan, Dorit Nitzan Kaluski, Elke Jakubowski and Erica Richardson

Summary: Ukraine has retained the extensive Semashko model health care system it inherited on gaining independence from the Soviet Union in 1991 and it is largely unreformed. A large proportion of total health expenditure is paid out of pocket (42.8% in 2013) and households face inadequate protection from impoverishing and catastrophic health care costs. These weaknesses have been exacerbated by the strain of caring for conflict-affected populations since 2014. The government faces the challenge of implementing fundamental reform in the health care system to rebuild universal health coverage against a background of resource constraints and ongoing conflict.

Keywords: *Universal Health Coverage, Health System Reform, Internally Displaced Persons, Ukraine*

Introduction

Ukraine gained independence from the Soviet Union in 1991 and successive governments have struggled to overcome funding shortfalls and modernise the health care system to meet the population's health needs. The system retains many of the core features of the Semashko model health system, with an extensive infrastructure and a strong bias in the system towards inpatient care. This has meant that most resources are spent on running costs for health infrastructure rather than on patient care, and primary care has remained weak.[1] However, the main strength of the Semashko system – universal health coverage – has been lost and health care in Ukraine is now inaccessible to many. Overall, access to health care has improved across the former Soviet Union since the turmoil of the 1990s, but in Ukraine it has worsened.[2]

Chronic underfunding has allowed the gap to widen between the Constitutional promise of universal coverage and the reality of what is provided for free at the point of use. Formal salaries for health workers are extremely low and this, with the absence of sustainable health financing, has resulted in a plethora of formal, quasi-formal and informal payments in the system. A large proportion of total health expenditure is paid out of pocket (42.8% in 2013) and households face inadequate protection from impoverishing and catastrophic health care costs, particularly if they have chronic conditions. Most out of

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pocket payments are to cover outpatient pharmaceutical costs, which is why people with chronic conditions are so severely affected.

> 5 million people are affected by the humanitarian crisis in Eastern Ukraine

Successive Ukrainian governments have struggled to raise sufficient revenues to cover the full cost of the extensive social spending commitments guaranteed by the Constitution. Rapid marketisation and hyperinflation following independence from the Soviet Union in 1991 caused severe socioeconomic hardship and, while there was some stabilisation in the economy from 2000 and even growth from 2003–2004 and 2006–2007, the global economic downturn has hit the Ukrainian economy hard and the country has not recovered. By the end of 2012, Ukraine was back in recession due to a poor harvest and lower than expected demand for steel which is a key Ukrainian export. The conflict in the east of Ukraine has also had a negative impact on the economy. Early in 2015, the Ukrainian government approached the International Monetary Fund (IMF) for an emergency loan to prop up the beleaguered economy. The IMF agreed, but with certain conditions, including a requirement for Ukraine to reform government services. Due to the crisis, the government has made cuts across the government budget, including to funding for the health system.

Overview of the system

The Ukrainian health system is tax-funded from national and regional budgets, and voluntary health insurance plays a very minor role in health care financing. There has been considerable decentralisation in the system since independence; however, in most other respects, the system remains largely unreformed. Allocations and payments are made according to strict line-item budgeting procedures as under the Semashko system. This means payments are related to the capacity and staffing levels of individual facilities (inputs) rather than to the volume or quality of services provided (outputs).

The bulk of government expenditure (52% in 2012) pays for inpatient medical services, with only a relatively small proportion going to outpatient services and public health. Ukraine has an extensive health care infrastructure despite a rapid reduction in the number of beds in 1995–1998 in response to a severe fiscal crisis. Reductions in the number of hospitals were achieved largely by closing rural facilities rather than rationalisation of provision in urban areas. Ukraine has also retained a large number of facilities in parallel health systems. The number of acute care hospital beds in Ukraine is high by international standards but despite this, operating indicators show that utilisation remains quite high and, once admitted, patients on average stay for ten days. The high utilisation and long length of stay highlight the inefficiency of financing hospitals based on their capacity. Research has shown that almost a third (32.9%) of hospitalisations in Ukraine are unnecessary.[1] Consequently, operating indicators remain high despite the development of day care and other schemes that could potentially substitute inpatient care.

Traditionally, primary health care in Ukraine has been provided within an integrated system by therapeutic specialists – district internists and paediatricians employed by state polyclinics. In 2000, the transition to a new model of primary care based on the principles of family medicine began. Family doctors/general practitioners (GPs) now make up more than half (57.2%) of all primary care physicians; they work at family medicine polyclinics or in appropriate polyclinic departments. Some movement towards reforming the health system started in 2010, but lacked overall strategic planning and implementation.

Recent changes

While no fundamental reforms of health system financing have yet taken place, various changes have been initiated and sometimes realised since independence; the most recent package of reforms were introduced from 2010. Three phases of the reforms were to be implemented through a World Bank funded project in a few selected regions (oblasts) over a four-year period (2010–2014). They started with changes to health financing mechanisms which sought to reduce fragmentation in funding flows, prioritise primary care and strengthen emergency services. Phase two was to pilot the programme in four regions (Donetsk, Dnipropetrovsk, Vinnitsya regions and Kyiv city), where provider payment systems would be based on outputs rather than inputs, i.e. the volume of services provided rather than capacity criteria such as bed numbers or staffing levels. In phase three, the pilot regions were then due to deepen the reforms, and the successes would be rolled out nationwide, but these plans were not fully implemented, and so did not impact on the health system and did not result in fundamental reform. The political and humanitarian situation from late 2013 has made it even harder to continue. By 2014, these reform projects were abandoned.

Useful lessons have emerged from this most recent reform effort, particularly around the importance of communication strategies to explain why such changes were being made.[1] Strengthening primary and emergency care, rationalising hospitals and transforming the model of health care financing are ambitious aims in health care reform, and ones which often face strong resistance from patients and existing power structures. Fundamental issues re-emerged, such as numerous institutional barriers which have hampered reform efforts in the past, including constitutional blocks on reducing the number of state-owned health facilities. However, in this instance, conflict and political instability have proven the greatest barrier to reform implementation. More recently, governments in Ukraine have necessarily concentrated on more pressing humanitarian concerns.

Conflict and health care

Health services were therefore overstretched even prior to the current crisis in Ukraine, but conflict has increased humanitarian and health-related needs. A severe lack of vaccines, medicines, and medical supplies in the conflict affected territories and the inability to provide services for many of the internally displaced persons (IDPs), their absorbing communities, the wounded and those who reside in fighting zones represent additional burdens. Consequently, WHO, UNICEF, the Red Cross and other health partners are working together to fill the gaps. About 5 million people are directly affected by the humanitarian crisis in Eastern Ukraine. More than 1.2 million IDPs have been registered, of whom about 15% are children and about 60% pensioners. Since mid-April 2014, more than 6,200 people have been killed and more than 15,500 people have been wounded. The conflict is also likely to have increased the mental health needs of the affected population.

It is estimated that 77 out of 350 and 26 out of 250 health care facilities (eg. polyclinics, outpatient departments and hospitals) have been damaged or destroyed in Donetsk and Luhansk regions, respectively. Many clinics and hospitals are closed or only partially operational due to shortages of medicines, medical supplies and personnel. Many have run out of basic supplies such as antibiotics, intravenous fluids, gloves and disinfection tools. Around 1.4 million people require health assistance and primary health care centres and hospitals are struggling to treat the war wounded. Some of the health staff have not been paid, and some have become IDPs; 30–70% of health workers have fled the conflict affected areas or been killed.

WHO has been filling gaps in provision with a network of Mobile Emergency Primary Health Care Units (MEPUs) and Emergency Primary Health Care Posts (EPPs). However, the cities of Donetsk and Luhansk, which have been foci in the conflict, hosted the tertiary level specialised medical services for their respective regional populations. Due to travel and other restrictions on the movement of people around the two regions, patients who require specialist services cannot access these hospitals.

Communicable disease control

Communicable diseases are reportedly on the rise in the conflict affected areas, due to economic isolation, deteriorating water and sanitation conditions, and limited access to adequate health services. Ukraine already has the lowest immunisation coverage in Europe – in 2012 only 79.2% of children were inoculated against measles, and only 73.5% of infants were immunised against polio.[3] This was an improvement on previous years (in 2010 just 56.1% were immunised against measles, 57.3% against polio) but was still way below the level required to ensure herd immunity. However, as a result of multiple factors, such as lack of funds, poor forecasting and planning and a general weak national medicines management system, no vaccines have been procured for Ukraine's immunisation programme since the end of 2014. The fact that millions of children have not been fully immunised makes the risk of severe outbreaks of vaccine-preventable diseases extremely high.

A complicating factor in this is that public health services in Ukraine have recently undergone substantial changes. In 2014, the Government abolished the State Sanitary and Epidemiological Services (SES), which was part of the original Semashko model health system and which was there to maintain some basic population health surveillance and health protection functions. The central and regional SES network had a number of problems. These included overcapacity in some areas of health protection and inspection which was determined by a complex institutional network of labs and inefficient, out-dated and duplicated infrastructures; the provision of services to private entities; and a high level of under-recorded for-profit activities. Nevertheless, despite the shortcomings of the SES system, it served as the baseline system enabling the delivery of some essential public health operations in Ukraine, including the monitoring of immunisation programmes. The abolition of the SES has left the country without the ability to provide essential public health functions that are so needed, especially in times of crisis.

The government requested WHO to provide support in the assessment of essential public health operations to restore their delivery, and which are centred on surveillance, monitoring and emergency response, and health protection. These services need to be restored also in view of deteriorating access to essential medical services, including medicines and vaccines supply and an increasing prevalence and risk of communicable diseases outbreaks and the weak early warning system.

Conclusion

The Ukrainian Ministry of Health, together with WHO and the donor community, are aware that, paradoxically, the crisis may provide a window of opportunity to steer Ukraine into modernising its health system, in all its functions. For example, there is new impetus for transforming and strengthening disease prevention services to tackle non-communicable diseases alongside other public health functions. The draft Health Strategy for 2015–2020 is one of the documents where this impetus for change is presented.[4] The document also highlights the fragmentation of financial pooling, the inadequate protection of the population from catastrophic health care costs, the strong bias in the system towards inpatient services, the need to rationalise hospital stock, and the need to strengthen primary care and public health services. The Strategy, if adequately planned, could turn into a reform programme which would hopefully bring Ukraine back to the path of universal health coverage. This undertaking is ambitious and will require sustained government commitment with technical and financial support from the international community. It is important to avoid further reductions in state health expenditure, which accounted for a modest 4.2% of GDP in 2013.[5] Improving efficiency, quality and access to health services that are people-centred is a great challenge, even more so at a time of financial, political and humanitarian crisis.