Belarus: developments in primary care

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In order to maintain the provision and access to health care services following independence, Belarus has pursued a policy of incremental health care reform. Consequently the Belarusian health care system bears many of the same features as the Soviet Semashko system which the republic inherited in August 1991. However, the primary care sector in Belarus is one area of the system which has seen more change in the last decade. In common with health systems across Europe, primary care services have been expanded in response to rising health care costs and the need to develop better ways of caring for people with long term conditions. Evidence from around the world suggests that primary care services are more technically efficient than hospital in-patient services and health systems that have a greater primary care orientation have better aggregate health outcomes as well as better access and equity.

Shifting the focus from secondary to primary care involves a broad package of measures, such as enhancing the prestige of primary health care, shifting resources away from secondary to primary care and strengthening the gatekeeper role of primary health care practitioners. However, reforms designed to increase the primary care orientation of established health care systems can be very challenging to implement in practice as their success is contextually dependent.

Primary care reforms in Belarus

Primary care in Belarus has been in transition since the late 1990s as the country has experimented with different models of organising services. The successful piloting of per capita resource allocation in Vitebsk oblast (region) led to the nationwide roll out of new financing mechanisms for primary health care from 2000 and the implementation of per capita financing for services from 2004. Reforms in health care financing have aimed to improve efficiency in the system by moving away from input-based financing mechanisms to reduce excess capacity in the hospital sector thereby releasing extra resources for primary care services. The Concept on the Development of Health Care in the Republic of Belarus 2003–2007 was envisaged as a document which would guide the health care system to a new model in which primary care would become the main priority and resources would be allocated to it accordingly. The aim was to improve the technical efficiency of the health system as a whole and reverse worrying demographic trends in the country related to the rapid ageing of the population and the burden of premature mortality. As a result there has been significant investment in order to improve both the quality and accessibility of primary care services in rural areas, namely a significant expansion in the number of primary care facilities and capital investment to improve the state of repair of 113 rural health care facilities. This capital investment has been accompanied by a significant investment in the retraining of primary care doctors working in rural areas as general practitioners.

Organisation of primary care services

As a result of these reforms, there is now a dual primary health care system in Belarus: a system of general practitioners in rural areas and on the outskirts of some cities and the maintenance of the traditional Semashko polyclinic system in urban areas. All primary care facilities are state owned and financed and controlled by Regional Health Care Departments. In remote rural areas primary care services are provided.
Future primary care reform challenges centre on attracting and retaining the best staff; raising prestige; and improving the gatekeeping function of doctors working in primary care. There are ongoing problems in rural areas in attracting and retaining health care personnel. The shortage of primary care doctors in Belarus, despite extremely high rates of physicians per capita nationally, is one of the most acute problems in the health care system. In many respects, the introduction of general practice to rural regions was a response to the realities of the situation – primary health care doctors in understaffed practices were working alone treating both adults and children, irrespective of their training as either paediatricians or internists treating adults.

One measure to address this shortage has been the reintroduction of compulsory placements in primary care settings for all new graduate doctors from 2007. Salaries for doctors working in primary care have also been boosted by 40%, but working conditions are still very challenging. The main expansion in primary care in Belarus has been in the workload of primary care doctors, particularly the need to fulfil a large number of routine annual check-ups, that in many cases has to be conducted by four to five narrow specialists (ENT, neurologist, surgeon, ophthalmologist). These check-ups involve extensive paper work and cover large segments of the population (e.g. all school children twice a year, chronically ill patients, women of reproductive age). Primary care doctors also are responsible for carrying out annual fluorography screening for tuberculosis, opportunistic screening (particularly for cancers) and all sick leave authorisations. All these practices contribute to the extremely high number of out-patient contacts in Belarus, which increased to 13.6 per person per year in 2007.5

There has been little success thus far in raising the prestige of primary health care in order to attract more young doctors. Indeed, compulsory placements in primary care could serve to reinforce the idea that working in primary care is not something to be embraced as an active career choice. The low prestige of general practice and primary care services is also one reason why the traditional polyclinic system with community specialists has been maintained in the cities. However the polyclinics in the big cities are also understaffed and face the constant drain of primary care doctors to the specialist and hospital sectors, and in many cases out of the medical profession.

Patients prefer the traditional polyclinics and would rather consult a specialist than an internist or general practitioner [6]. Patients prefer to self-refer to specialists when they are ill, as is their constitutional right, and the weak gate keeping role of primary care doctors mean that there is a considerable over-utilisation of inpatient care. The fact that such rights are enshrined in the constitution makes it especially challenging to change the status quo in urban areas; in rural areas, it is only the geographical distance from specialist services which reinforces the gate keeping role of primary care doctors. Nevertheless, the ongoing development of a new two-year national health strategy provides the Belarusian government with a good opportunity to define a clear vision for the future of primary care in Belarus.

References