Outpatient care in Russia: problems, current activities and outcomes

Igor Sheiman, professor of HSE

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The major problems of outpatient care in Russia:

1) Underfunding
2) Excessive specialization of primary health care
3) Acute shortage of district service physicians (district therapists, district pediatricians and GPs)
4) Inadequate qualification and competencies of district service physicians
5) Low level of service integration: within polyclinics and between polyclinics and hospitals

Excessive specialization of primary health care

- Started in 1970-s and is still underway. Specialists – 65-70% of polyclinics physicians
- District physicians (PHC) – only 11% of all Russian physicians – two times lower than in EC countries (France is around 45%)
- Special type of outpatient specialists (not involved in provision of inpatient care)
- District therapists and pediatricians turned into actors dealing with a very limited set of diseases (Denisov, 2007), their organizational and coordination functions have been lost
- Traditional system of patients referrals (gatekeeping) is undermined
- PCH composition debate: the concept of “extended primary care”, that is involvement of a number of specialists (Boerma, 2008) . In Russia – an extreme version of extended primary care when PHC and outpatient care are practically the same.
- Does it strengthen PHC?

Shortage of district service physicians

- Our estimate of the shortage: district therapists – 33%, pediatricians – 10%
- The average 2600 residents per district therapist (3000-3500 in some regions), while the MoH target is 1700
- GPs are marginal – only 13% of total district physicians, while in Central and Eastern European (CEE) countries - 90-100%

The major reason: the government has lost control of the structure of health labor:

- only 20% of medical schools have the subject “General practice” in postgraduate education. In Europe – 100%
- only 3% of graduates have postgraduate education in general practice, while in France – 48% (Lember et al, 2015)
- *None of federal health strategies over the last decades set the objectives of strengthening district health service and a shift to a GP model*

Inadequate qualification and competencies of district service physicians

- Short education and upgrading qualification only once in 5 years
- Inadequate instruments of qualification verification.
- As the result, limited curative functions of district physicians.
- HSE survey based on European PC Monitor methodology (Sheiman, Shevski, 2017):

-only 70% of primary visits are tackled by DPs themselves without referrals (very optimistic estimate), while in Europe – 85-95% (Kringos et al, 2015)

-only 5 of 9 diseases are treated by DPs, while in CEE countries - 9

Current government activities to strengthen outpatient care

1. strengthening outpatient care infrastructure,
2. service restructuring,
3. organizational changes in polyclinics,
4. IT development,
5. general practice development,
6. new payment methods,
7. new policy of health workers remuneration,
8. professional development policy.

Service restructuring (Moscow model)

- **Merging polyclinics**

- 450 adult polyclinics were consolidated into 46 outpatient centers with catchment area 250-300 thousand residents each
- Three levels of outpatient care: a) district services + some specialists (eg cardiologists), b) other polyclinics' specialists, c) specialists of hospitals
- The major objective is to concentrate the "rare" resources (expensive diagnostic devices and some specialists) and make them more accessible

Positive outcomes:

- KT, MRT, USI tests became much more accessible
- waiting time for visits to some specialists is much shorter
- administrative cost is lower

Problems:

- patients travel time is longer
- primary level is extended to many specialists (opthalmologists, ENT, urologists, etc) because of district physicians overburden and their limited qualification
- third level (hospital specialists) is not linked to the previous ones

Service restructuring-2 (the model in other regions)

Strengthening multi-level service delivery – establishing inter-rayon specialty centers serving the residents of a few neighboring areas

-the way to concentrate specialty outpatient care

-the way to enhance accessibility of specialty care for the rural population

Long-term project: data on the results is unavailable yet

Organizational changes in polyclinics (Moscow model)

- Special unit for home visits (to decrease the burden of DPs)
- Nurse posts for routine services
- IT for medical records, visits appointment, drug prescription, communication between physicians, etc
- Piloting management of multi-morbidity cases
- Centralized physicians activity monitoring (EMIAS program): identification of low access areas, re-distribution of resources
- Patients are allowed to see any DPs. ‘Physicians on duty”.
- Care to chronic cases is delegated from DPs to specialists. Direct access to cardiologists, neurologists, urologists, etc.

Pro: specialization may result in higher “productivity”. Physicians tend to have more time for patients.

Contra:

- Principle of the regular doctor is undermined
- More specialists are needed
- Nurses are less involved in curative activity

New health labor policy

- New educational standards
- Shift to post graduate education for 2-5 years
- Shift to continuous qualification upgrading
- Choice of the organization for qualification upgrading
- Activating GP training, but without clear vision of primary care organization
- Accreditation of physicians with the approval of a set of curative activities. The first step is in 2017 г.: graduates will have a “preliminary accreditation” for the work in the capacity of district therapist or district pediatrician

Outcomes of outpatient care

- Special focus on prevention – large-scale program of “dispanserization”
- According to the MoH, in 2014 r. The number of revealed diseases increased by 7,5 times. First and second level cancer - 60-80% of their total number.
- Some positive outcomes of health education programs.
- But the problems of “dispanserization” program:

- The principle of dynamic surveillance is not followed: the lack of follow up care of the revealed cases
- The programs of chronic disease management are very limited
- District physicians are overburdened
- Cost effectiveness of some screenings is questioned by experts
- Total morbidity increases faster than primary morbidity, which is the indication of the “chronization” of some revealed cases

Some additional indicators of outpatient care outcomes

- Impact on the rate of hospital admissions and volume of inpatient care
- Impact on the rate of emergency care utilization
- Patients satisfaction level

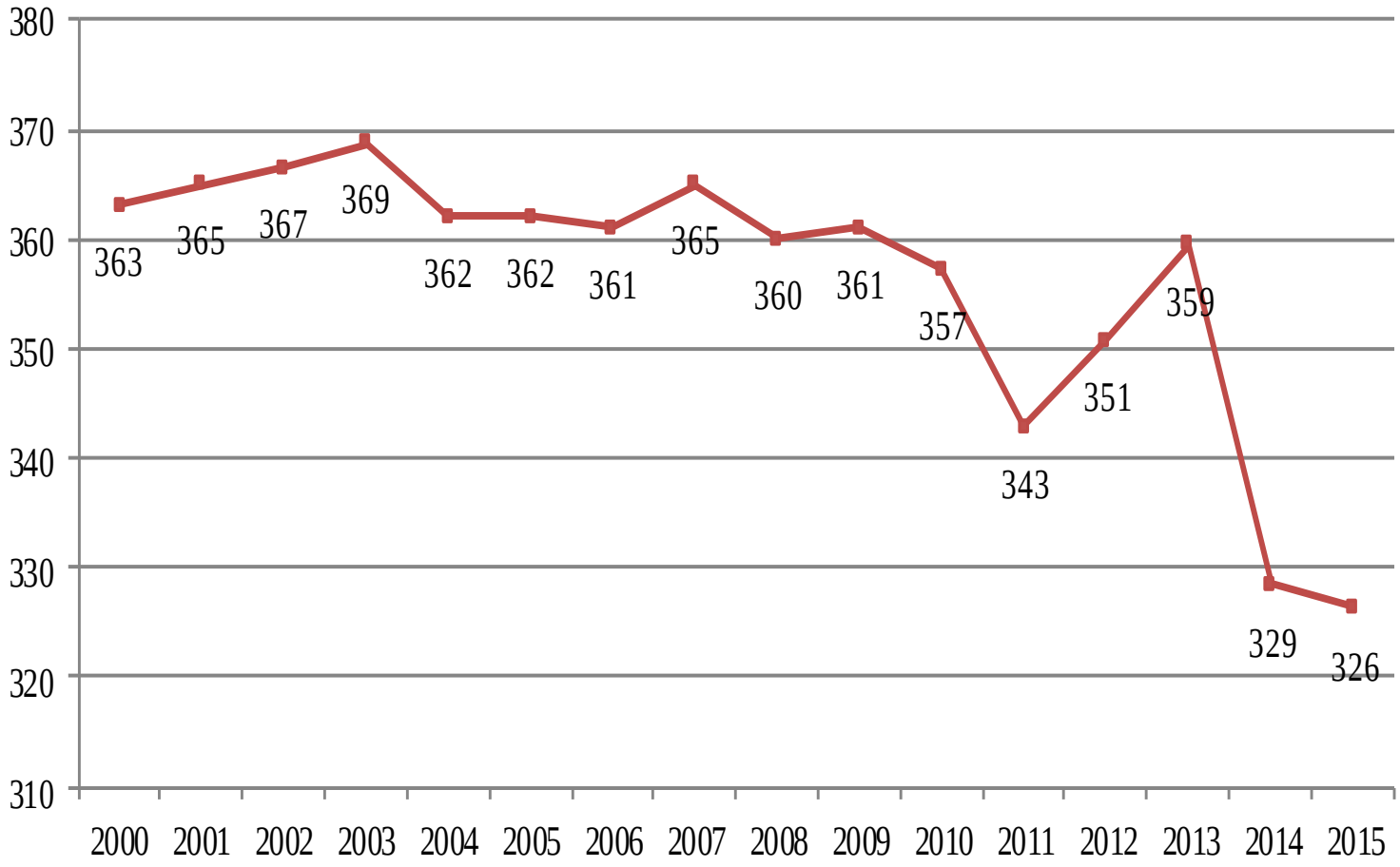
Number of bed days per capita

Comparison of inpatient care utilization in Russia and CEE countries in 2013 (or the latest year)

	Number of total hospital admissions per 100 residents*	Number of total bed-days per one resident**
	17.14	1.18
Estonia	17.53	1.33
Slovenia	18.41	1.27
Latvia	18.55	1.54
Romania	19.80	1.46
Slovakia	19.99	1.46
Hungary	20.35	1.93
Czech Republic	20.94	1.96
Russia	**21.80**	**2.61**
Belarus	33.1	3.34

*In hospitals of all types.**Admission rate is multiplied by the average length of stay
Sources: MoH, 2017; WHO, 2016

Emergency care visits rate per 1000 population of Russia in 2000-2015



In 2015 - total **605, including**
326 in emergency care stations,
279 in emergency service of polyclinics

Impact on emergency care utilization

Comparison with EU countries:

- OECD (2016) provides data on the “proportion of residents who visited an emergency department because primary care was not available”**: average for Europe – 23% with the variance 8-30% across countries**

-In Russia -60%

- Thus, inpatient and emergency care utilization is substantially higher in Russia than in Europe, which is the indication of outpatient care weaknesses (particularly, primary care)

Patient satisfaction

The Levada Center survey (2016):
-44% respondents are dissatisfied with “too short visit”
-63% - with «inadequate qualification of polyclinics physicians»

Degree of satisfaction with district physicians are even lower:
-Roszdravnadzor survey (2010): only 14% respondents are happy with their DPs

Similar estimates for European countries:
-80-90% of population are happy with their GPs (Kringos et al, 2015).

Concluding remarks

- **Outpatient care is originally designed well:**

-the focus on prevention

-patient list

-multi-level delivery of care with the expected role of district physicians as gatekeepers

-teamwork in polyclinics should strengthen PHC

- **But positive characteristics are not realized well:**

-revealing diseases is not followed by their adequate treatment

-*specialists in polyclinics substitute rather than supplement primary care physicians* with the resulting marginal role of the latter

-the acute shortage of district physicians, their limited curative and coordinating functions weaken dynamic surveillance and sole responsibility for patients served

-referral system is undermined

-teamwork, coordination and continuity of care do not work well in polyclinics (despite the expectations)