# 6 Professionalism of the health workforce in Ukraine

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## Introduction

Professionalism is closely related to access and quality of care (Passi *et al.*, 2010). The concept of professionalism in the medical field is constructed from a variety of characteristics, for example, excellence, respect of others, altruism, duty, accountability, and honour or integrity (Chisholm *et al.*, 2006), as well as clinical competence (Veloski *et al.*, 2005). Recent trends have been moving from the individual to the institutional dimensions: professionalism should be inculcated within medical schools with complete integration of a culture of professionalism' (Passi *et al.*, 2010, p. 20). Indeed, a deeper look into the culture and context contributes to the interpretation of 'professionalism' in a society as 'certain elements that characterize the nature of medical practice are key to providing a contextual understanding of medical professionalism', underlined by Swick (2000, p. 613). In particular, institutions, social expectations and the nature of their transition frame the behaviour and responsibility of healthcare service providers within any one country or context.

Professionalism as an important characteristic of healthcare providers is often expected and valued by consumers. Lack of professionalism, for example, is recognised as the fourth most problematic area of the Romanian healthcare system, while corruption, lack of interest of medical staff and lack of modern medical equipment are the top three on the list (Fărcăşanu, 2010). These challenges of the system of healthcare service provision are relevant for most countries in the Eastern European region, however, their degree differs (Rechel and McKee, 2009; Pavlova *et al.*, 2012).

A rise in 'self-help' coping strategies has been noticed in Ukraine during sociopolitical changes (Williams and Onoschenko, 2013; Polese, 2014) as a response to the distrust and scepticism toward public institutions and to insufficient funding with inadequate allocative efficiency (Polese and Stepurko, 2016). Moreover, Ukraine shows high rates of corruption, low rates of political stability and a very moderate level of economic development and health expenditure.[1] The burden of healthcare service financing has shifted to patients and their families: about 18 per cent have to borrow money or sell assets and about 60 per cent of Ukrainian respondents report on forgoing healthcare

services (Tambor *et al.*, 2014). However, despite having widespread quasi-formal and informal patient payments, high private expenditure is not recognised as problematic by key stakeholders in Ukraine (Gryga *et al.*, 2010; Stepurko *et al.*, 2013). By and large, a mixture of practices conducted under 'multiple moralities' (Wanner, 2005, p. 530) and the extensive use of networks (Ledeneva, 1998) are intertwined in the healthcare system and other public services provision.

Furthermore, health outcomes in Ukraine remain poor: life expectancy at birth increased by only one year between 1970 and 2010, and is currently 71 years (66 for men and 76 for women), which is approximately six years lower than the WHO European region average (WHO, 2013). Ukraine has not shown significant progress in the strengthening of primary healthcare (General Practitioner practices), the reduction of hospital capacity (9.0 hospital beds per 1,000 population in Ukraine in contrast to 6.5 in Poland, 6.2 in Moldova and 6.1 in Romania; WHO, 2013), the improvement of quality and equity in healthcare provision, or improvements in cost-effectiveness. Primary healthcare delivery has remained essentially the way it was, with a large network of underperforming urban and rural polyclinics, women's consultation clinics, poorly equipped rural physicians' ambulatories, polyclinic units in urban hospitals and outpatient departments in rural hospitals. In fact, primary care physicians are consulted only for minor complaints, and patients have obtained care from a specialist without any formal referral for decades. The lack of an effective referral system and the absence of clear 'care pathways' and post-discharge care protocols contribute to costly (and avoidable) admissions and readmissions for mostly non-communicable diseases.

In contrast to other countries in Eastern Europe, Ukraine has not switched from the system of central planning and declared free-of-charge healthcare to a decentralised system with a health insurance fund (Danyliv *et al.*, 2012; Lekhan *et al.*, 2015). This suggests that the Ukrainian healthcare system has a low potential for change and effective decision-making. Moreover, the country has experienced numerous appointments of Ministers of Health during the last decade (about ten appointments with an average length of stay of 1–1.5 years), which partly explains the uneven character of healthcare sector development.

Taking into account the specific context of the Ukrainian healthcare system, we question how professionalism within it is constructed. We particularly aim to identify both good and challenging practices as well as administrative approaches for assuring healthcare professionalism at Ukrainian public facilities.

## Methodology

In this chapter, we study the topic of professionalism of the Ukrainian health workforce and aspects of the environment that ensure the enhancement of professionalism, using an ethnographic approach and qualitative data collected through the 'Governance in healthcare in Ukraine' research project (Belli, Dzygyr and Maynzyuk, 2015). This study was initiated by the World Bank and

implemented in cooperation with analytical and sociological organisations. The wider frame of the study aimed to compare the legislative framework with *de facto* practices that exist in healthcare facilities and healthcare governance at the local level. The explorative–descriptive research approach allows us to include a special look in this chapter at medical professionalism and the obstacles related to its enhancement.

Empirical data for this project was collected through structured interviews conducted with several groups of respondents:

- healthcare providers (82 respondents): medical doctors, nurses, chief nurses;
- administrators of healthcare facilities (25 respondents): heads of facility departments and chief doctors, as well as deputies of chief doctors;
- regional policy-makers (11 respondents): *oblast* and *rayon* (both are administrative areas of Ukraine) heads or representatives of healthcare departments.

The scope of the empirical study covered five regions of Ukraine, with Central Ukraine represented by Kyiv, the capital (where the research instrument was pretested), Vinnitsa and Poltava regions, Western Ukraine represented by Lviv region and Eastern Ukraine represented by Luhansk region. The regions were selected for the study based on (a) the availability of reliable contact points (to assure data quality and reliability in terms of potentially sensitive topic) and also (b) representation of regions of different cultural and geographical areas of Ukraine and of regional peculiarities of healthcare system provision (for example, status of pilot *oblast* in healthcare reform launched in 2010). Snowball and convenience sampling methods were applied for each region, its facilities and medical staff, as well as the administrative body's selection of representatives. The most important condition for recruiting the respondent was more than two-years' working experience in the position.

The research instrument was developed by the team of the researchers and included three major sections on: (a) human resources, (b) planning, budgeting and financing, and (c) medical information. A mixture of open- and closed-ended questions were presented in the questionnaire, since both stories about personal work experience and quantitative estimations of the spread of practices were important. The instrument was pretested with an empirical data collection in the summer and autumn of 2012. Face-to-face interviews based on the questionnaire developed with specific parts for each group of respondents were considered the most appropriate data collection mode, as they allowed for the study of respondents' individual unique experiences and attitudes, as well as aspects of the quality of governance perceived and its procedures. Furthermore, questions on non-transparent and corruptible (or bribing) practices were included in the research agenda as additional means to ensure data validity under the topic sensitivity. As is shown in Box 6.1, we paid special attention to sensitive questions of the questionnaire by asking questions on both personal

**Box 6.1 Example of the sensitive questions asked in the study**

(*Type A question*) Please describe the usual practices followed in the hiring of medical staff, according to your experience – doctors, nurses (are there any differences?)

(*Type B question*) In your experience, which of the following criteria are more important when medical doctors/nurses/other staff are appointed? Show card. Ask respondent to rank answers (1 – most important), add answers to the table.

- Knowledge, skills and capacity
- Performance in previous relevant employment
- Education
- Years of experience
- Loyalty to hospital management (no criticism)
- Political affiliations
- Connections (factors of interpersonal nature – being friends, old colleagues; family ties; being recommended by such people)
- Other. Specify: _____

(*Type C question*) There is a wide-spread public belief nowadays that it's impossible for a doctor to get a job without using some private connections to an employer or authorities, or paying money. Do you know of any case that contradicts this view (among your colleagues or doctors you know)?

(*Type D question*) What would you estimate to be the share of people whom you know who get a job mostly because of their merits (knowledge, experience and other professional qualities) and not because of any other factors?

experience and perceived experience of others, as well as questions of similar content but of different connotations and changed wording (Tourangeau and Smith, 1996).

Face-to-face interviews were mostly conducted at the facility where the respondent worked, though a minority of respondents agreed to meet for an interview in a public place. The duration of an interview with medical personnel was about one hour and about two hours with administrators. Each interview was audio recorded with the respondent's approval. A small cash compensation was provided for virtually all medical staff and facility administrators who were respondents to provide the motivation to accept the survey

invitation. Payment was given at the end of the conversation. A direct cash payment as stimulus to public servants, for example, representatives of health departments, was not used due to national anti-corruption policies. Confidentiality was guaranteed to all respondents. The individuals participated in the study on a voluntary basis. Two researchers (co-authors of the paper) analysed the data qualitatively and independently from each other without using computer software as a triangulation at the stage of qualitative data interpretation.

## Results

The results of the study suggest the presence of problematic aspects of the environment from which healthcare professionalism originates. Here, we describe practices and perceptions reported by healthcare providers and administrators in several fields related to professionalism: the improvement of clinical and service qualification of providers, appointments and the job appraisal system.

### *Postgraduate medical education*

Specialised state medical courses are basic obligatory and regular (every five years) education for physicians during their career. These courses are essential for promotion to higher medical categories. The certificate regarding state postgraduate education is issued to medical doctors who pass computer-assisted tests and who collect enough points during a certain period of time (a so-called 'cumulative point system'). In our study, physicians underlined the challenges related to the transparency of state attestation that has been partially overcome by the introduction of computer-assisted exams, which minimise the personal influence of the examiner. Most of the respondents consider the state courses a formality with minor impact on real knowledge and skills, although the courses are seen as a possibility to extend one's professional network via communication with colleagues from other regions. The participation in these courses is not very valued by facility administration (chief doctors' comments) since the curricula of the courses are rather theoretical and not relevant to the practice.

We notice positive experience of medical doctors (respondents) concerning educational events which are organised in healthcare facilities. Such seminars, lectures and workshops are mostly initiated by the administration of the facility – by the chief nurse, the head of department or the chief doctor. It is important to note that these training sessions are usually implemented with the support of other institutions, for example, international organisations, projects and pharmaceutical companies. In-facility short-term and irregular training sessions are considered by physicians as a more effective way of getting relevant knowledge compared to the previous form of professional postgraduate education. Although the share of answers is virtually the same between the two types of training, the comments about internal training are more positive and less

formal. However, some physicians dispute the high quality of both of these training sessions and state courses and argue that the design of educational activities does not always tackle the need for updated knowledge and skills for narrow specialities:

> Those who graduated 20 years ago can be happy with this kind of course as well as with each conference. But for those who graduated two years ago and who constantly read medical literature, these events are not so attractive because of the lack of new information – I constantly hear repetitive information here.
>
> (Lugansk city, physician, in-patient facility)

In terms of improving the skills and knowledge of medical personnel, 'external' education – that is, outside the state system of postgraduate education and in-facility events – is more positively perceived by the majority of the respondents. Indeed, such 'master-classes' and conferences are perceived as real professional development. However, these workshops and conferences which they perceive as worth attending are paid for by medical doctors personally out of their own pockets. Other sources to fund participation in external events come from the pharmaceutical industry. In rare cases, the expenses are shared with a public healthcare facility (for example, the participation fee is paid by the employee, while travel costs and *per diems* are covered by the facility).

Some physicians also report hiding their participation in additional educational activities from the administration: they ask for days off work or holidays without mentioning the real purpose. Although the motives for avoiding mentioning education as a purpose of leave are rarely discussed, several answers provide clear indications of the unwillingness of facility administration to manage gaps in service provision when the doctors are engaged in activities outside the facility. Meanwhile, physicians participating in this study find 'private' (non-government) external training as the only possibility to get the relevant, modern and essential knowledge to update their professional skills. A few physicians admit that the best effect on professional growth is participation in international educational events (outside of the country), but this option is a rather expensive one and the use of the English language at these events creates a barrier. However, such valuable activities for medical practice often have very little impact on the formal side of promotion: 'private' training does not carry any points for state attestation and, therefore, does not contribute to achieving higher categorisation and, consequently, has little impact on the formal salary of a physician.

Thus, the process of the professional development of physicians is constructed mostly at the initiative of the doctor, who invests substantial personal financial capital (which is, however, often earned via informal patient payments), and is rarely initiated by the administration of the healthcare facility.

***Job appointments at healthcare facilities***

Access to information concerning vacancies can be characterised as a 'trade secret', as such information is quite often seen as a resource of the administration. Indeed, a large share of health workers suggest that a major bottle-neck in the field of employment is the lack of open and accessible information on available vacancies:

> In our facility we do not have vacant job positions, but from time to time new staff appears [. . .] nobody informs others how they have got that position but I am sure they are employed with a reason behind it [. . .] My son had to move to Zhytomyr because we could not find any vacant position in Lviv as here the competition among physicians is extremely high.
>
> (Lviv city, physician, in-patient facility)

Furthermore, instead of creating a good platform for engaging the best staff at the facility and, therefore, stimulating a competitive atmosphere at the point of entry, chief doctors or other representatives of the administration of some healthcare facilities are actively involved in maintaining the old-style system of appointments. The study shows that job positions are mostly 'offered' by the chief doctor to some preselected medical doctors in cities. There is no formal procedure to register and appraise the candidate's application, and selection is mostly done by the chief doctor and head of department without any standard criteria:

> To be honest, there are two pathways for appointment: an official way – a nice one, and an unofficial one that works in 50% of cases. A medical student after graduation is practically nobody and nobody wants to take him into a vacant position. Such students can just work in the emergency room of the facility or as an outpatient service provider in a rural area. It is the only possible job position for those who do not use 'gratitude' [. . .] But everything else is achieved because of 'gratitude' or friendship. If a person has a higher professional level, he has more options for appointment [. . .] Still, here we have a person at the facility with a minor knowledge about prescriptions and treatment, as well as about medical information keeping, but somehow she has a fairly high position. Although, when we ask her a question, she cannot adequately respond and always sends us to get consultation from other colleagues.
>
> (Kyiv city, physician, outpatient facility)

Indeed, recently graduated medical doctors and nurses point to *napravlennia* (referral) to a facility as a means of securing a job after graduation. Such referrals are taken at the *oblast* or *rayon* health department. We identified several respondents who shared their experiences about the formal procedure of

referral, which can also be supplemented by informal practices in order to avoid referral to rural area. Those who work in *rayon* hospitals indicate that they are able to get a referral without either problems or informal agreements, in contrast to healthcare staff, who have a more prestigious place of work, for example, in cities or at in-patient departments.

Among physicians and nurses, those who work in cities have wider limits in the healthcare human resource market, as they show better familiarity with opportunities for changing job positions than do physicians from *rayon* facilities. The latter perceive the question about the experience of applying for a job position only within the context of '*rozpodil*' ('assignment' – obligatory referral to a certain healthcare facility as directed by the state):

> I have no idea about hiring procedures. I got this job about 30 years ago when I graduated from the university and I received a referral. I think the same procedure is applied now. Young physicians who work at our facility say they have come here due to referral.
>
> (Vinnitsa region, physician, in-patient facility)

The respondents consider knowledge, skills (according to 22 out of 41 physicians and 3 out of 16 nurses) and education (according to 12 out of 41 physicians and 7 out of 16 nurses) as the most important criteria for appointment, while personal connections are the main source for information about vacant positions (according to 38 out of 71 respondents from the physician–nurse subgroup). Such inconsistency in the respondents' answers can be explained by chief doctors' and department heads' interest in hiring staff with good knowledge and skills because it will lead to higher performance indicators for the department as well as the satisfaction of patients and low complaint rates. However, candidates for vacant positions are often chosen from the personal network of the administration in line with the need to have loyal employees. It may not exclude an informal payment to a chief doctor for the opportunity to be hired:

> The chief doctor selects really qualified staff, but such conditions are created for having applicants from a narrow circle, so a stranger cannot appear in the list for interview with the chief. Or it should be a kind of benefit to the administration. Qualities are important, but there should still be some connection. The chief doctor will take only the best of those whom he knows, it is not a thoughtless decision.
>
> (Vinnitsa city, physician, in-patient facility)

Overall, these major problems in attaining a position – lack of information and lack of transparent criteria – are noticed by physicians and nurses. The opinions of employees are quite different when they are asked to estimate the ease of searching and getting an appropriate position: some report quite easy pathways to reach the final appointment, while others note that they needed several years to get the position they have now. Possibly, the specialisation of the physician

contributes to the huge variation in the answers: several of the respondents who are dentists, for example, do not recall problematic issues, since the private sector is quite developed in that field, while cardiologists and endocrinologists have a long path to travel to reach their desired position.

All groups of respondents agree that there is a much easier path for job appointment for nurses compared to physicians, due to nurses' lower responsibility and lower access to informal income sources. These and other factors, for example, working conditions, make the position and profession unattractive.

However, there is variation in the formal regulations in the regions. In Vinnitsa city, for example, relatively recent regulations for the hiring of physicians have been introduced: transparency of medical doctors' appointments has been considered as the goal of this intervention. In particular, information about the vacancy is published in the newspaper and on a web page, the list of documents for the job application are collected at the city health department, and then, a committee of professors and chief doctors (about 15 committee members) interviews each applicant. Chief doctors and administration representatives find this 'open competition' to be a fair and transparent procedure; however, virtually all physicians who work in Vinnitsa's city healthcare facilities and interviewed for this study mention 'open competition' with great scepticism, since the procedure has inherited earlier practices which include bribery and/or social connections.

> A web-page of the *miskarda* [city council] offers application forms, and then we wait for the competition. We present a CV, diploma, its supplement, the certificate of internship. I personally paid the chief doctor, but personal connections and communicable skills are also important. Social connections play an essential role in our city – without such connections it is impossible to live. All arrangements involve personal connections and agreements. I have a family where all members are physicians and we do not know anyone who applied for a job without a personal connection, but in the Soviet Union it was not so deep-rooted.
>
> (Vinnitsa city, physician, in-patient facility)

In short, the overall system of job appointments remains uncertain, with an absence of clear and transparent rules and procedures, and there is a prevalent use of informal practices. Professionalism in each specific case of appointment may have a different level of importance, depending on the type of position and the administrator's human resource typical practices.

### *Job appraisal system*

The lack of a systematic approach in professionalism enhancement is also noticeable in performance appraisal procedures at the facility level. Generally, the majority of chief doctors interviewed in our study were able to describe key principles of the appraisal system at their organisation in detail. In most

cases, the appraisal system in health facilities represented the combination of formal and informal approaches. In some of the departments, the performance indicators are chosen and collected, and summarised at the facility level. The representatives of the facility administration, as well as doctors and nurses, assume that these scores are used to stimulate the performance of the department. In particular, one chief doctor of a city in-patient facility mentioned that when he gets an offer to host any kind of equipment, those who perform better have a greater probability of getting it, though such situations occur rarely. The formal appraisal methods are mandatory for all facilities in the country, whereas informal appraisal procedures can be established in a variety of ways, including single penalty measures with no rewards for good performance.

> Appraisal, it is a rare practice. If you work well, everybody just keeps silent. But if you start making mistakes [*kosyachyt*], then the punishments will surely reach you and it varies from 'come to my office' to losing a bonus for the month and even for the year. There are doctors who – for whatever reasons – have been prohibited from signing sick leaves. So they treat patients, and then they show them to another physician who has the right to issue the sick leave.
>
> (Kyiv city, physician, outpatient facility)

The following tools are mentioned particularly concerning the informal part of job appraisal: informal conversations with the department head or with the chief doctor; night shifts as a sanction; prohibition to issue sick leave, and so on. Overall, the performance assessment is mostly associated with punishment rather than with rewarding for good performance. In other words, 'a carrot and stick' motivation principle is used, but the carrot is too small to be attractive, while the stick is often used. Moreover, informal methods to punish personnel are also reflected in formal calculations of bonuses (overall salary) and less often in possibilities to participate in training (as has been mentioned above, the administration is rarely informed by physicians about their additional education).

It is interesting, however, that facility administration is very limited in available ('fully legal') tools to stimulate or to sanction the performance of their employees and, therefore, we observed a huge variation in human resource decisions. In particular, we identified a case of the use of state attestation as a sanction tool for the physician in response to a patient complaint.

> One physician had a conflict with the patient. We assumed that the doctor violated ethics and did not show relevant qualifications, so we sent him for recertification in the area. And if his category is not confirmed, he will lose a part of his wage. They [the state attestation committee] understand that if we send someone for recertification without a good recommendation then there are reasons. We cannot reduce his salary directly [. . .]. Rewards are not seen as a tool to influence salary as we cannot cancel premiums for continuity of employment. We may forbid a person from having two

> positions at the facility [. . .] the only way to influence the situation – to challenge a category if he made a mistake in professional work, and if you do not like something that is not comfortable for you – it is impossible to do anything.
>
> (Poltava region, head of department, outpatient facility)

However, personnel mistakes are rarely revealed publicly and are usually discussed at facility meetings. The principle of *krugova poruka* ('cover-up') seems to avoid the practice of informing the broader population about the existing problems. Perhaps this principle is related not only to professional mistakes, but also to the gaps in the system, as we observed a lot of socially desirable answers in our study. Indeed, when general questions were asked (whether there is a job appraisal system, whether it works well), respondents provided an answer which describes the practices in a positive way, but further detailed questions bring less positive insights of the system organisation and practices to light.

Monetary motivation may play an important role in rewarding professional behaviour, but formally, chief doctors have little financial autonomy or available resources. When they are available, financial bonuses are traditionally used to reward long-term work at the facility or an anniversary (for instance, one of the respondents stated that staff in their facility get bonuses at 50-year anniversaries). Despite little opportunity to provide monetary incentives, there are some informal methods to reward the personnel: for instance, opportunity to take a day off, flexibility in choosing vacation periods and issuing letters of recognition are used as informal stimuli by facility management.

In a nutshell, the system of performance appraisal that exists at the time of this study does not seem to be designed with regard to the key goal of stimulating professional development. By contrast, it is focused on punishment for bad performance, rather than a reward for good practices at the hospital. Financial motivation for good performance is almost non-existent, while non-financial motivation (not punishment) is rarely used.

## Discussion and conclusions

By and large, the performance of healthcare providers under the governmental financial and regulatory framework is virtually unconnected with the formal system of incentives (financial as well as other less tangible incentives). Still, healthcare providers – having a salary lower than the industrial average – are expected not only to demonstrate professional behaviour, but also to generate funds for the facility to which they belong.

Our ethnographical explorative study has some limitations. The results should not be taken as representative given the lack of comparativeness between regions as well as between medical specialities, a relatively small sample and convenient sample technique. The extensive mode of data collection and combination of closed- and open-ended questions may have confused some of

the respondents and caused differences in coding their answers. Upon the agreement of respondents, all the interviews are recorded on audio, which possibly could have lowered their willingness to respond to sensitive questions. Despite the limitations mentioned, the study offers a description of the mix of formal–informal practices at state healthcare facilities which have to be overcome for the improvement of the professional behaviour of medical staff.

More power in the healthcare market, or informational asymmetry, coupled with access to patient payments, encourages Ukrainian physicians to act as both fund recipients and brokers, intermediaries between holders of funds (patients) and managers of the funds (healthcare facilities). The study results suggest that informal patient payments given to healthcare service providers are partially passed to department heads or chief doctors and further (Belli *et al.*, 2015).

When the system of bonuses is weak but 'envelope' payments are major incentives for providers (a higher weight for informal rather than formal stimuli), it brings a lot of ambiguity to the system of healthcare service provision. At the moment in Ukraine, patients' feedback (financially or via marketing buzz) on doctors' performance plays a major role in stimulating professionalism. Shishkin and colleagues (2003, p. 29), for example, describe two strategies used by young doctors in terms of professionalism: some 'are trying to compensate the lack of professionalism by actively extorting money from patients (at any price)', while others improve their professional knowledge, skills and experience 'in order to obtain the same unspoken right to charge for services, as more experienced doctors have'. Still, when the informal economy prevails in the sector with an interwoven lack of restraints and disrespect for law, it is also threatened with the loss of morality of medical doctors and, therefore, the loss of professionalism in general (Bazylevych, 2009).

Very similar barriers to the enhancement of professionalism are found in post-Soviet Lithuania: an unexpected link to informal payments related to the topic of professional growth has been discovered where salaries and work conditions have been sheltered and controlled by the state (Riska and Novelskaite, 2011). The authors also conclude that 'in a post-socialist health care system, physicians are often operating in a system guided by four logics: the state, the market, professional culture, and the informal economy of peer referrals, gift giving, and extra payments' (Riska and Novelskaite, 2011, p. 89).

Nevertheless, informal practices are sensitive to politics, as the case of Cambodia also shows: the formalisation of the under-the-counter payments has been designed as the first step toward the growth of professionalism (Dieleman and Harnmeijer, 2006). The country offers an example of a transformation that has displayed positive effects on professionalism in healthcare after new policy implementation. In particular, the introduction of flat fees has brought not only clear patients' and providers' roles and responsibilities, but also financial resources to healthcare facilities obtained via official channels that make possible the introduction of performance-related bonus systems (Barber, Bonnet and Bekedam, 2004; Dieleman and Harnmeijer, 2006). Although a performance-related system might bring controversy to the value system of a

profession where altruism opposes incentivising performance (Buurman and Dur, 2012; Lindkvist, 2013), Cambodia has made a step not only toward a more civilised system of provider payments, but also toward consumerism and the market orientation of healthcare services, which bring new approaches for ensuring professionalism and the role of altruism.

Furthermore, evidence-based practices have become an important push-factor in the development of the medical profession connected with 'software' or processes-related changes in healthcare provision (McKinlay and Marceau, 2008; Timmermanns and Oh, 2010). Indeed, the design and implementation of a system of stimuli, in which additional educational activities are supported by the facility administration, and measures are taken to make the market of vacancies more transparent, does not require large resources but, rather, good managerial skills and knowledge of best practices. Patients' complaints or feedback, for example, are rarely taken into account in decision-making, possibly because of lack of knowledge and applicable tools in the field. Good managerial practice is even more important in the context of limited resources as it does not require additional funds (as in the case of buying new modern equipment).

Moreover, our study reveals that other sources to fund participation in external events are provided by pharmaceutical companies, but one should consider possible bias toward the company products, which might not be the most effective and cost-efficient. There should be clear guidelines and policies which ensure ethics in public sector and pharmaceutical industry collaboration (Relman, 2001).

As has also been mentioned above, professionalism is rated as the fourth most problematic issue in Romanian healthcare after corruption, lack of modern equipment and lack of interest of medical staff. However, all three top-rated dimensions contribute to medical professionalism: attention and good attitude toward patients, the utilisation of safety technologies and modern equipment, and transparency in service provision are integral parts of healthcare professionalism. Moreover, lack of practices which are conducted in line with morality and an ethical code affects trust in state medical and healthcare institutions (Blumenthal, 1994). Lack of professionalism and trust may turn up in the most responsible and unexpected moments. For example, it was especially problematic during the Maidan clashes in 2014 in Ukraine when patients with trauma avoided state emergency service providers and searched for voluntary medical care (Stepurko *et al.*, 2014).

Healthcare systems with very limited resources are expected to find creative and 'soft' decisions when good health outcomes are in the political agenda. Meanwhile, a lack of political will to confront poor performance of service providers, harmful practices and inappropriate care is often observed when an institution's effectiveness is undermined 'by diverting it from its purpose or weakening its ability to achieve its purpose' (so-called 'institutional corruption') (Lessig, 2013, p. 553).

Swick (2000) emphasises the embeddedness of the medical profession in social and family life, as well as the importance of relationships between patient

and physician. In line with this, the context of most post-Soviet societies can be described as lower state control of public services after the collapse of the Soviet Union, changes in the roles of institutions, slow pace of democratic and market-led reforms, as well as 'the self-serving authorities against a poor and defenceless population' (Wanner, 2005; Sanghera and Iliasov, 2008; Riska and Novelskaite, 2011). Following the general trend, not only the medical profession, its ethics and morale, but also the general understanding of professionalism has been constructed under a new reality, values and norms. As Sanghera and Iliasov (2008, p. 3) argue, 'professions in post-socialist societies emphasize the relationship between the state and the professions in terms of control and discipline, suggesting that professionals lack the critical autonomy and integrity necessary to shape their social field'. Therefore, the challenge of finding the balance between economic restraints, cultural context, and work autonomy and identity is faced by many professions in post-Soviet environments, especially those who are salaried and strongly controlled by the state.

To summarise, multiple barriers exist to the enforcement of healthcare professionalism in Ukraine. The importance of personal connections does not contribute to transparency in appointments or the discovery and prevention of bad practices in healthcare and the stimulating of good ones, and, therefore, it threatens the health outcomes and attributes of healthcare services. Human resources, as the most important resource in the healthcare sector, require proper managerial practices framed by relevant and respectful regulations in order to ensure adequate access to and quality of healthcare services.

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## Note

1 According to Transparency International (2014), Ukraine ranked 142 out of 175 countries, and low rates of political stability are observed in the Worldwide Governance Indicators (2013), which rank Ukraine at 21.3 in contrast to Poland at 78.7 or Belarus at 46.4. Health expenditure per capita is currently equal to US$313 and public health expenditure stands at 54.5 per cent of total health expenditure (WHO Global Health Observatory Data Repository, 2013).

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