

Primary Health Care in the NIS: History and Avenues for Reform

By Zoya Shabarova

Since the mid-1970's, the concept of primary care has become a focal point for health care organizations around the world. This trend developed as new countries appeared on the map and were faced with the need to quickly create and develop an economically effective health care system. Two decades ago, the Soviet primary care system could, and did, serve as an example for developing countries.

The primary health care system in the USSR encompassed a vast array of services. According to the definition in the 1982 edition of the Great Medical Encyclopedia, the system "includes ambulatory care at polyclinics, health stations, and medical and sanitary units; ambulance and emergency medical services; obstetrical services; and to some degree hospitals, where patients come or are brought first. Feldsher stations and feldsher-obstetrical stations and catchment-area hospitals in the rural areas also belong to primary health care institutions. Over 80 percent of all the patients start and complete their treatment within this system. The system is also charged with carrying out preventative and anti-epidemiological efforts."

The primary health care system was structured by the catchment-area principle, where residents of a particular geographic area or production zone are served by an assigned physician, who coordinated medical care and education for the patients. This catchment-area physician was the first medical worker to see a patient in the event of illness. If care could not be provided at this level, the physician referred the patient to a secondary health care facility. In this way, the catchment-area physician was also a liaison to medical care on the polyclinic and in-patient level.

But this system had a number of flaws. As Vladimir Zagorodny, MD, first deputy chief of the Kiev City Health Administration, noted last October in a presentation to contractors from the USAID's Mission for Ukraine, Moldova and Belarus, "Preventative medicine in the USSR was a written policy but not actually practiced. The population was cut off from preventative health care, the medical community as a whole did not take part in decision-making, and health care specialists were not prepared to carry out preventative efforts." Only 5 percent of a catchment area physician's work time was dedicated to disease prevention. The main effort went to diagnoses and treatment—which often took place at in-patient facilities.

It also meant that the catchment-area physicians functioned less as primary care doctors treating a variety of problems, but as dispatchers to specialists.

"The tendency in recent decades to overspecialization has led to such a decrease in the level of competence of catchment-area physicians so that they are no longer able to complete simple diagnostic and treatment procedures such as vision and hearing testing and treatment of tonsillitis or inner-ear infections. As a result, only 18-26 percent of those who began treatment with the catchment-area physician actually finished treatment on the same level, compared with an average of 70 to 75 percent in most other areas of the world," Nadezhda Melnik, first deputy chief of the L'viv Oblast Health Administration told the Ukrainian Ministry of Health last May.

Part of the problem was caused by the fact that the main criteria used to gauge the success of the polyclinic was the number of patient visits. Patients waited in crowded hallways and endless lines reading outdated posters on the dangers of smoking and abortions, just to see the narrowly-specialized doctors. The catchment-area physician was turned into a bureaucrat, buried under tons of medical records, reports, and sick lists.

Today, NIS health care leaders recognize the necessity for health care reform. For example, Ukraine, relying on the recommendations of the World Health Organization and experience of other countries, decided to reform primary care using the family medicine model. In 1988, in L'viv and the L'viv Oblast, an experiment was initiated to introduce family medicine. The family medicine concept was developed and the job description of the family doctor were established. Massive educational efforts were undertaken among health care workers, residents and health care reform decision-makers. Special five-month courses for family doctors were started in the L'viv Medical University. In 1995, the L'viv Association of Family Doctors was founded and now has 150 members.

According to the Ukrainian Ministry of Health, introduction of the family doctor model in the L'viv Oblast has achieved the following results: The family doctor now makes 40 percent of the diagnoses that were previously made by specialists, and refers the patients to specialists two-and-a-half to three times less often than catchment-area physicians. The rate of hospitalization among family doctor patients is three times lower than those seeing catchment-area physicians. And the death rate among patients of family doctors is 9 percent versus 12.1 percent at the oblast level.

Last May, the Ukrainian Ministry of Health set transition to primary health care based on the principle of the family doctor as one of its top priorities to improve the current health care system.

Belarus has also made strides in primary health care. In 1996, with aid from the European Union's TACIS project, Belarussian authorities, and contributions from sister cities in Spelle, Germany and Markelo, Holland, the town of Krupitsa (30 km from Minsk) opened a modern primary care medical facility for its residents. Since the center opened, new family health care practices have been introduced such as family doctor consultations, family planning programs, minor surgery, and implementation of health education outreach programs. In 1997, the number of consultations with specialists decreased by 50 percent compared to the previous year, while the number of visits to general practice physicians increased by 20 percent. In a poll, two-thirds of the population said the quality of medical care had improved. The Minsk Oblast Health Administration sees the Krupitsa experiment as a success and plans to open 15 to 20 similar centers in Belarus.

Azerbaijan also has experience in restructuring its primary care. The World Bank a project to develop an economically effective and stable model for health care based on decreasing the number of hospital beds and reorienting treatment from an in-patient to outpatient. The 116 feldsher-obstetrical stations will be replaced with 15 ambulatory facilities designed to serve a population of 10,000 people. In addition to the state medical facilities, private nursing and obstetrical centers are planned for villages. Community participation is sought through an organization of health councils in each village. The council will coordinate health care initiatives, analyze needs and ways to achieve goals, as well as conduct education efforts among the population.

In order to improve pediatric care in Armenia, UNICEF has sponsored a project to develop and integrate preventative medicine on the primary care level with active community participation to support and broaden basic medical care. In particular, training has been planned for primary health care personnel for a multi-disciplinary approach to sick children. Equipment will be provided for treatment of the leading causes of childhood and maternal mortality. Also planned is a national campaign to promote understanding of the need for high-quality pediatric primary care.

Across the NIS, primary care is emerging as a cornerstone of health care reform efforts. In May 1998, for example, the Ukrainian Ministry of Health identified the family practice model as a key component in improving the current health care system; other nations of the former Soviet Union are promoting this model as well. As the concept of primary care evolves, it must also address environmental health, sanitation and hygiene, which are just as important as

accessibility and quality of care for improving health and quality of life. Introduction of the family physician model should include improving all of the component parts of primary care.

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