

**MINISTRY OF HEALTH OF THE RUSSIAN FEDERATION**

**NOVOSIBIRSK STATE MEDICAL INSTITUTE**

**Department of Social Hygiene and Health Administration**

**Methodological recommendations**

**FAMILY DISPENSARY: STRUCTURE AND FUNCTIONS**

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## Introduction

Family dispensaries are known to be the most important structural and functional family health facilities at the pre-hospital (primary) level. It is in the family clinics that patients are observed throughout their life. Unfortunately, dissemination of the family care practices did not start in this country until recently. Our present recommendations are based on the studies of structure, functions, effectiveness and efficiency indicators and social role of specialized wards and multi-profile polyclinics that work as family dispensaries. Since demand for family care services grows constantly, we believe that these recommendations will be useful for physicians of all relevant profiles.

We will be grateful to our readers for their comments and cooperation.

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Novosibirsk Medical Institute.

Authors: A.F. Finchenko, Ph.D., assistant professor, Head of Department of Social  
Hygiene and Health Administration;  
L.N. Tsvetkova, Ph.D., senior trainer;  
A.P. Solomatin, assistant professor;  
E.A. Finchenko, Head of Oblast Statistics Bureau;  
E.D. Zarankin, Chief physician, hospital # 27;  
P.V. Oparin, Chief physician, polyclinic # 24.

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Family dispensary's structure and functions

Family health care has proved effective for preventive measures, continuous monitoring and sanitary care at a primary level. This is why training of family doctors, definition of catchment area for family care facilities and family clinics' structure are so important now. Our research has shown that large multi-profile polyclinics and family dispensaries can and should be involved in the creation of the universal structures uniting gynecologic, pediatric and therapeutic services. There are several opportunities: diagnostic services using expensive imported equipment can be located in municipal and oblast diagnostic centers and specialized centers. Specialists from polyclinics and family practices, including gynecologists, gerontologists, geneticists, sociologists, psychotherapists and experts of other profiles will serve as consultants for family doctors. They will monitor defined categories of patients from all catchment areas. Family doctors can examine patients from their catchment areas in polyclinics or family dispensaries, if proper conditions are created.

Family dispensaries may be organized on the basis of the regional and municipal polyclinics that have children's wards, stomatologic, gynecologic and other specialized departments, and will not be too costly. Existing staff will be sufficient for the reorganization. Separation of the following three wards will be important: tertiary medical ward, diagnostic division and preventive care and monitoring department. The most serious cases will be examined in the municipal and oblast specialized centers, diagnostic center and clinics at research centers and medical institutes.

If it is impossible to locate family physicians within the catchment areas, their rooms may be organized in preventive care wards in polyclinics. The role and place of family dispensaries in the existing health care structure are clearly defined. Family dispensary is an out-patient facility rendering comprehensive medical services. These facilities should replace the existing polyclinics as the most fitting successors. It is very important that a comprehensive approach is used and patients are observed by one family physician from the moment of birth to the moment of death.

In order to ensure a radical breakthrough in health care and to achieve better results in care provision, we need to create a united system of medical and social services and promote an inter-disciplinary continuity in the work of these services. Comprehensive approach to preventive care on the basis of medico-social concepts of the public and individual health should be used. The leading role here belongs to a family and family health care.

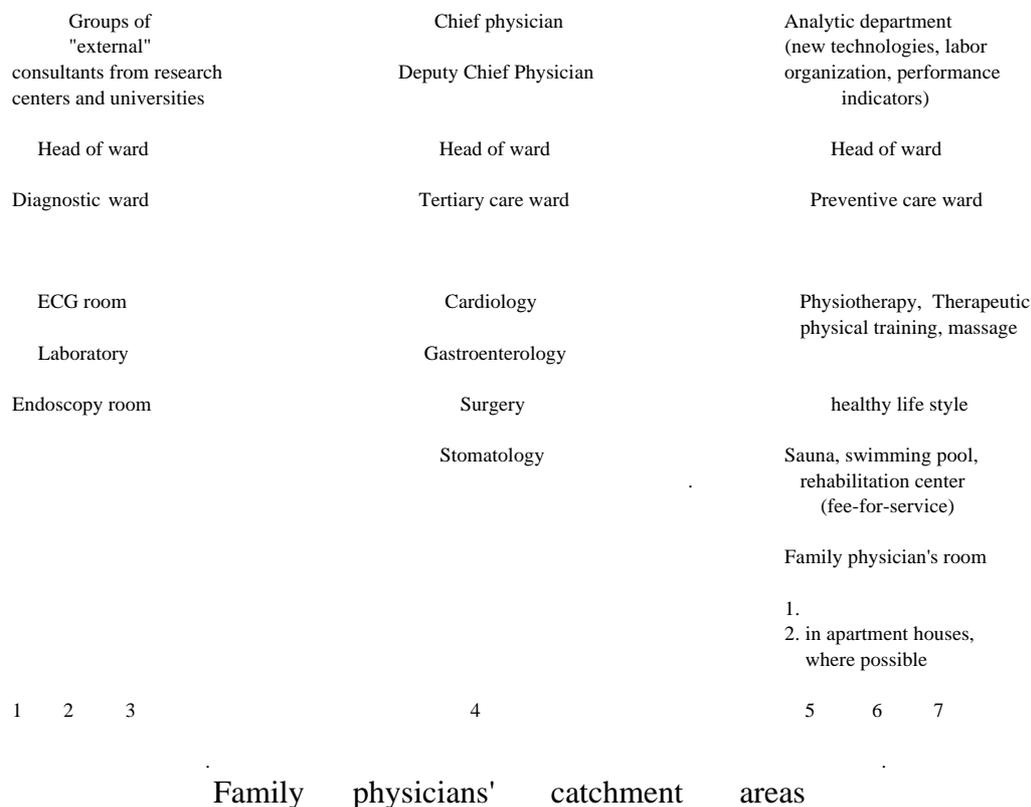
In this connection, mission and functions of regional, municipal and territorial polyclinics should change. These facilities will represent three different types of specialized services. In particular, diagnostic services for children, adults and the pregnant will be rendered in a diagnostic center. Preventive care wards will be responsible for patients' rehabilitation. Treatment will be provided in specialized rooms. The structure of a pilot polyclinic and family dispensary is shown on Figure 1. This structure may cover the whole region and be created on the basis of two or three polyclinics. Separate polyclinics can be easily transferred into specialized wards or a diagnostic center, depending on available equipment and premises. Such polyclinics may serve as inter-regional centers, depending on patient volume, occupancy rates and territory. The major goal of these polyclinics and their administration will be to coordinate and assist family and "uchaskovi" physicians. All systems of training,

licensing and administration should be restructured to accomplish this goal. Creation of new structural and functional units within primary care sector has been necessitated by the following factors: current trends in morbidity; increase in death rate; epidemiologic situation; aggravated environmental situation; a need for unification of tertiary and general health services and social and clinical medicine; realization of life-time preventive activities for children, teenagers, women, workable population and retired people.

Creation of family dispensaries will allow all family members to visit only one out-patient facility instead of several. Moreover, continuity of children's and adult care will be achieved.

Organization of family dispensaries on the basis of modern multi-profile polyclinics will not demand additional staff or premises. It needs new organizational forms of work and administration.

Figure 1. Family dispensary's structure



#### REQUIRED STAFF FOR FAMILY DISPENSARY RENDERING SERVICES TO ABOUT 20,000 FAMILIES

1. Chief physician - 1
2. Deputy chief physician on economic issues - 1
3. Head of ward - 3
4. Medical specialists, physicians - 45

5. Chief nurses - 3
6. Senior nurses - 3
7. Room nurses - 20
8. Family practitioners - 20
9. Visiting nurses - 20
10. Maintenance personnel - 5
11. Drivers - 1

One of the major issues on the agenda is continuity of work of the out-patient facilities. Unfortunately, when they talk about continuity, they often mean documentation, timely transfer of patients from polyclinics to hospitals or from room to room. Meanwhile, this problem has one more important aspect. First, there is no continuity of children's and adult health care facilities networks. If a child is effectively and correctly monitored by his pediatrician, later he "gets lost" and does not receive any preventive care neither when he is registered at an adult health care facility, nor when he enters university or college.

During this period of time that varies from one to five years a child loses health for the rest of his life. It is only when a serious disorder or pathology appears that a child is included in a dispensary register by the therapist he is assigned to.

Continuity, in terms of diagnostic and preventive activities, can be provided only in adequate and feedback-based facilities (laboratories, diagnostic rooms). Then there is no need to repeat and duplicate tests and special examinations.

Inter-disciplinary integration and continuity is of great importance here. For example: nephrology - urology - gastroenterology - surgery. Cooperation and simultaneous work of surgeons and gastroenterologists will ensure a timely operative invasion. Delayed or prematurity surgical invasions often occur in cases of intestinal gastric ulcer, cholelithiasis, pancreatitis, etc.

Usually, hospital surgeons do not observe their patients after discharge and entrust them to "uchastkovi" therapist. This why a prior task now is to transfer the most serious cases to the competence of the specialized wards and departments in polyclinics and to "unload" community (uchzstkovi) doctors for them to concentrate on preventive measures.

There are serious drawbacks in the work of health administrative organizations on women's and children's health protection. The order of the RF Ministry of health of 12.06.85 on "The measures to eliminate the drawbacks in the work of pediatric and obstetric health facilities" is not being fulfilled. Strengthening of material and technical base of pediatric and obstetric facilities, organization of preventive measures and care for prematurely born children are too slow.

Maternity houses and children's hospitals fail to meet sanitary standards and are under equipped. These facilities cannot provide appropriate care for pregnant women and children

of early age. Communication between women's dispensaries and polyclinics of a general network is insufficient. The number of patients who get services within one catchment area exceed all possible norms. Pre-delivery diagnostic examinations, family planning, obstetric and pediatric care, prevention of inherited pathologies should be improved radically. Quality of care for the newly born is too low. Children's and mothers' mortality is extremely high. Ratio of malfunctions in obstetric aid, intensive care for mothers and the newly born is too high. Children ill with pneumonia and infectious diseases do not receive an adequate treatment.

In this connection, it is important: to promote protection of mothers and newly born children; to radically improve the quality of care for women, pregnant women and women in labor. We deem necessary: to ensure a timely registration, examination and treatment of pregnant women; to provide continuity of care provided in maternity houses and polyclinics; to examine pregnant women without waiting lists. It is important to provide all pregnant women with consultations by therapists and specialists in women's dispensaries according to the schedule. All children between 0 and 1 year of age should be examined more often. Over 80% of the population get treatment in out-patient facilities. Polyclinics, women's dispensaries and community practitioners should use the modern concepts, ideas of an integrated disease prevention, up to a mass-scale prophylactic medical examination of the population.

Morbidity rate, hospital performance, chronic disease incidence, recurrences and complications depend on how effective polyclinics and community doctors are.

Unfortunately, there are many drawbacks, unsolved problems and difficulties in the work of out-patient facilities now. Out-patient facilities, once created as preventive care organizations, have been losing their preventive role. It has been replaced with diagnostic mission and treatment of patients. However, due to the lack of material and technical base, the overwhelming majority of polyclinics and women's dispensaries lag behind in-patient facilities, especially large multi-profile hospitals. This is why quality of primary care is so low, and patients are not satisfied with it.

Most of polyclinics suffer from serious drawbacks in staffing policy and personnel utilization. Unevenness of workload among both polyclinic and visiting doctors, loss in time, absence of doctors on their working places and inappropriate job descriptions are usual phenomena. This situation can be explained by an increased patient volume, variation of patient flows during a day, month or year.

During "rush hours" physicians have to see too many patients. This results in huge lines, losses in useful time and decrease in quality of care.

System analysis of personnel utilization in polyclinics conducted by polyclinics ##24 and 27 has revealed considerable unused resources. It is clear that the implementation of new forms of work and administration can decrease the losses in useful time by 65% which will allow the polyclinics to increase the patient volume by some 37 percent.

Our calculations have shown that more effective utilization of the polyclinics' staff will allow the polyclinics to avoid hiring additional physicians and, thus, save considerable resources. The reasons why physicians are often absent at their working places are the following:

regular leave; maternity leave; administrative leave; doctors attend re-training courses; doctors are ill; doctors have to take care of their ill relatives, etc. We should draw your attention to the fact that physicians often do the work that is not in their job description. They have to work in the military registry office, do paper work, participate in conferences, seminars, briefings, meetings, etc. There is no doubt that modern polyclinics have too many serious problems with personnel placement and utilization. There are several reserves to improve the current situation: 1) to increase polyclinic and visiting physicians' workload; 2) to improve administration and management and, thus, to decrease the losses in time; 3) to prevent physicians doing additional work that is not stipulated in the job description.

However, these measures will hardly change the quality of care. This is exactly why we need to create a comprehensive system of care for children, adults, teenagers, women and older people on a primary (out-patient) level.

In this connection, we deem it important to unite women's dispensaries, children's and adult polyclinics into one network. A woman cannot get an appropriate consultation or treatment at a women's dispensary. Consultants invited by the dispensaries do not take part in treatment for extragenital pathologies, sepsis, etc. In these terms, a family dispensary has a great advantage over the existing polyclinics and women's dispensaries. Besides, the problems with the lack of premises, diagnostic rooms, laboratories and equipment will be better solved in family dispensaries.

First, the useful space in children's, adult and stomatological polyclinics and dispensaries can be used for specialized medical and diagnostic services; second, unification of the adult and children's care specialists, diagnostic and medical rooms of the polyclinics and women's dispensaries will provide a more rational utilization of resources; third, some structures and positions will be cut down. Since the patients will be referred to the dispensary by their family physician who defines a precise goal of the referral and keeps all documentation (i.e., medical charts), there will be no need to keep a registry office at the dispensary. All medical charts, reports and certificates will be a family physician's responsibility.

We believe that there will be no need in deputy chief physicians. If a chief physician gets ill, his work may be fulfilled by one of wards' head. The dispensary will need only three senior nurses, "keeper-nurses", etc. There will be no need in the positions of "room heads", lab heads and heads of numerous wards.

The problems of continuity will be solved more easily. Patient volume will fall down. There will be more time to conduct evaluation and analysis. Appropriate conditions will be created for family physicians both in the dispensary and in the catchment area. Training and re-training of personnel will be improved.

This structure of health care facilities' network will ensure continuity of care and an on-going observation of the pregnant, women in birth, feeding mothers, the newly born, children of the first year of life, older children and adults.

Such models fit the current situation in health care sector and allow us to implement the latest achievements of medical science. The implementation of these models has several goals: to improve public health; to improve reproduction; to decrease morbidity and the death rate. Why is it that we cannot leave the primary care sector in its present state? Why must we

reform polyclinics, women's dispensaries and multi-profile polyclinics? Why should we concentrate our efforts on the implementation of new technologies? The matter is that it is impossible to use new comprehensive methods, a system approach and advanced technologies within the old system where all health care facilities are isolated from each other.

Much has been said about bringing order into the work of out-patient facilities and its principles. Polyclinics and women's dispensaries have been set as primary care facilities for the masses rendering preventive medical services. However, most of the polyclinics have to carry out diagnostic functions and provide treatment, rather than disease prevention. If polyclinics continue treating patients, they will have to purchase new diagnostic equipment and medicines. This will mean creation of facilities, identical to hospitals in terms of functions and equipment. Another option is to change the functions and structure of polyclinics and make them deal with disease prevention and patient education only. Lack of integration and continuity of care provided by children's, adult, stomatological polyclinics, pediatric wards and maternity posts impedes solution of the above-mentioned problems. It is practically impossible to create a system of continuous multi-level care when sanitary services, pharmacies, sanatoriums, resorts and social organizations are isolated from health institutions. To put it differently, the current organizational structure makes the implementation of the new concepts of modern diagnostics, treatment and prevention impossible. Unfortunately, these key issues of the Russian health care system are not being considered vigorously.

Now that people realize the potential and possibilities of medical science and out-patient facilities, incompetence of the polyclinics has become so obvious. This is why it is so important to discuss the polyclinics' future and their role within primary care sector. It is immoral and professionally incorrect to conceal drawbacks and discrepancies in the work of polyclinics since it affects life and health of the millions.

It is not difficult to notice some obvious paradoxes. Polyclinics are considered to be the leading echelon of our health care system. Meanwhile, polyclinics receive only 25 percent of all budgetary allocations for health care. This explains why material and technical base of the polyclinics is so poor. Polyclinics are the "front line" of health care. However, high-qualified physicians and scientists do not work there. Polyclinics should carry out only preventive functions. However, only from 20 to 30 percent of their time is spent for disease prevention. All the rest of the time is spent for the same diagnostic work and treatment as in hospitals and research centers. Obviously, the quality of this work in polyclinics is much lower than in hospitals because of the lack of resources and equipment.

It is common knowledge that it is easier to prevent diseases than to treat them. It often happens that the patient who's condition has aggravated has to go to his polyclinic, get a low-quality treatment there and only after that get to a specialist. Polyclinic doctors must prevent diseases. However, they are not competent in this field. Questions of disease prevention are missing in the university training programs.

Polyclinics are regarded by some authors (A.F. Serenko) as highly-specialized health care institutions which they are not, especially in the rural areas. They fail to carry out preventive functions they are entrusted with. The current trend is to turn all out-patient facilities into

tertiary diagnostic and curative institutions similar to tertiary and multi-profile hospitals. This is not only irrational, but demands too much time as well.

We believe that a family dispensary as a model of an integrated primary care will eliminate many serious problems and become a good alternative to the current primary care system. Our research has shown that the creation of family dispensaries will not demand additional allocations or personnel. Family dispensaries will simplify the scheme of primary stage of care (family community doctor - family dispensary - multi-profile hospital) and make it more economical and manageable.

## CONCLUSIONS

Our experience based on the study of several pilot family dispensaries allows us to create a whole new structure of primary care without additional expenditures and quickly. This makes family dispensaries so important for physicians of all profiles, especially for social-hygienists and health administrators.

## REFERENCES

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