

***ZdravReform* Technical Report 0955**

**Strengthening Primary Health Care in the  
New Independent States:  
An Introduction to Five Case Studies**

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## TABLE OF CONTENTS

<b>1 SUMMARY</b>	<b>3</b>
<b>2 THE PURPOSE OF PRIMARY HEALTH CARE REFORM</b>	<b>4</b>
<b>3 FIVE CASE STUDIES</b>	<b>5</b>
3 1 FAMILY GROUP PRACTICES IN ISSYK-KUL OBLAST	6
3 2 FAMILY MEDICINE IN L'VIV, UKRAINE	6
3 3 "FAMILY MEDICINE POLYCLINIC," DNEPRODZERZHINSK, UKRAINE	7
3 4 PUBLIC-PRIVATE COMPETITION IN ST PETERSBURG, RUSSIA	7
3 5 TRAINING FAMILY PHYSICIANS IN KYRGYZSTAN	8
<b>4 LESSONS LEARNED FROM PRIMARY HEALTH CARE REFORM</b>	<b>8</b>
4 1 FINANCING REFORM IS ESSENTIAL	8
4 2 PRIMARY CARE PHYSICIANS MUST BE RECOGNIZED	10
4 3 PATIENTS MUST BE GIVEN MORE INFORMATION	12
<b>5 LEADERSHIP AND ENTREPRENEURSHIP ARE CRITICAL</b>	<b>.13</b>

## 1 0 SUMMARY

The five “case studies” that follow this overview describe recent attempts to strengthen primary health care in several of the New Independent States of the former Soviet Union. Increasingly severe health problems and significantly diminished budgetary resources—each a consequence of the painful socioeconomic transition occurring in these countries—have combined to place enormous pressure on every health care system in the region *to improve the quality of care* and, at the same time, *to reduce the cost of that care*. Strengthening primary care has become a popular strategy for achieving both of these objectives. This introductory chapter (1) describes the purpose of primary health care reform in the New Independent States, (2) introduces briefly the five case studies that follow, and (3) discusses several “lessons” of reform that can be distilled from the case studies and from other attempts at reform in this part of the world.

These lessons are as follows:

- First and most important because of the severe shortages of budgetary funds, successful primary care reform requires simultaneous changes in the *financing of health care*, in order (i) to stimulate the reallocation of funds from specialist and hospital care to primary care, (ii) to reward primary care physicians for the increase in the intensity and responsibility of their work, and (iii) to ensure the availability of the additional resources that are needed to cover the expenditures which are required at the beginning of reform, well before any economic savings have been generated.
- Second, a strong primary health care system requires both a major broadening of the skills of physicians and other health personnel, and a fundamental change in the attitudes of health care workers. This is to permit more care to be provided at the time of a patient’s first contact with the health system, and to place greater emphasis on the prevention of illness and the promotion of wellness. But health care workers are unlikely to develop new skills and attitudes unless they are rewarded for doing so, both economically and professionally.
- Third, effective primary care also depends on the active involvement of patients, in particular, a willingness by patients to share responsibility for treatment and for the maintenance of one’s health. Evidence suggests that ordinary citizens *will* become more active and responsible, *if* they are given the *necessary information* and a *genuine opportunity* to participate in the organization of their care.
- Fourth, as is true of any effort to reform as large and deeply entrenched an institution as medicine, no significant progress is possible without strong individual leadership and entrepreneurship. However logical or desirable reforms may be, and however much public and professional support they may enjoy, energetic and creative “champions” of change are needed to articulate the need for reform, to craft innovative solutions to otherwise intransigent problems, and to mobilize and sustain the large numbers of people who must embrace and implement the reforms before anything can change in

practice Government officials at all levels must learn to identify and support these individual champions of reform and, in particular, to provide them with real authority, flexibility, and freedom from out-dated rules and regulations, which they, the champions, need in order to be able to realize their vision of change

## **2 0 THE PURPOSE OF PRIMARY HEALTH CARE REFORM**

In each of the New Independent States, a difficult and painful transition is underway from communism to a market-based economy, and from communist party dictatorship to political democracy The path to reform has been chosen willingly and enthusiastically by millions of people, eventually, this path will lead to substantial gains in the material well-being of the vast majority of the populations of the new states and in their economic and political freedoms Yet, the journey is a harsh one Throughout the region, the collapse of production and other economic dislocations have contributed to a worsening of the population's health, while, at the same time, a diminishing of the resources available to governments to deal with mounting health problems Ministries of health and entire health care systems have come under enormous pressure to improve the quality and effectiveness of their services, at a time when their ability to do so—within the constraints imposed by prevailing institutions and methods—is being significantly reduced Increasingly, health professionals and government officials in these countries have come to understand that the only way to resolve the contradiction between increasing demands and diminishing resources is to escape the constraints of existing institutions, by adopting a fundamentally different approach to the practice of medicine and the promotion of public health

The new approach, which emphasizes the strengthening of primary health care, often is viewed as an effort to “reinvert the pyramid” The image of an inverted pyramid often is used to describe the health care system that came to predominate in the former Soviet Union, when medicine was oriented primarily to specialist care and to in-patient health care facilities which received the most prestige and professional status and the overwhelming share of available human and economic resources The level of primary health care was, by comparison, fragmented and severely underfunded Primary care physicians and other staff were narrowly trained, poorly equipped, and underpaid Faced with daily quotas of patients to see and burdened by administrative regulations that often required them to refer patients to specialists, even in cases of minor ailments, primary care physicians in the Soviet Union played an unusually small role in the provision of medical care Yet, even higher levels of care, such as polyclinics, also lacked equipment, drugs, and funding, and so many patients, having visited a primary care physician, and then having consulted with a specialist, still ended up in a hospital where diagnostic equipment and needed drugs were most plentiful Such a system inevitably required large numbers of physicians and facilities, while patients were required to make numerous visits and often ended up in the most expensive facilities, usually at a cost far out of proportion to the severity of their condition

This was, obviously, not a very efficient or economical health care system, although these shortcomings never seemed to matter when resources were, or at least appeared, abundant But neither was it a particularly effective health system After a relatively brief period of

rapid gains in the period immediately following World War II, health indices tended to improve very slowly, and even in the best years of the Soviet economy in the early 1970s, morbidity and mortality levels were, by international standards, closer to those of middle-income developing countries than to those of countries in the West, the standard by which Soviet health professionals and politicians both preferred to measure their accomplishments. Not least important, it was also a very expensive system to maintain, so that when resources suddenly grew short, the system quickly began to deteriorate.

There is no question that a country's public health is determined by many factors other than the quality and effectiveness of its public health services. Probably more important in an overall sense are the state of the economy, which provides people with income and, thus, the ability to house, feed, and clothe themselves, as well as to buy care when necessary, and the state of public infrastructure—e.g., the availability and quality of water, sanitation, communications—as well as the overall quality of the environment. These factors, too, have all deteriorated during the post-communist transition and have contributed to the worsening of health statistics. Economic conditions and public infrastructure are as important to the health of the population as the health care system.

Nevertheless, as experience in other middle-income countries has shown, improvements in the quality of health care services and, more particularly, in the overall structure and configuration of health care can have dramatic effects on a population's health and sense of well-being. Inexpensive preventive medicine and public health education can reduce the incidence of illness and promote wellness. And a system capable of identifying and treating ailments and conditions early in their development can reduce the subsequent need for more expensive care, as well as the incidence of more serious illness and premature death. That is the rationale for strong primary care and for the efforts to "reinvert the pyramid" left over from the Soviet period. By strengthening primary care—that is, (1) by raising the quality of primary care facilities, (2) by broadening the skills and capabilities of primary care physicians and other health care workers, and (3) by eliminating the considerable waste in the present system—the entire health care systems of the New Independent States will become more efficient economically and more effective in terms of their impact on public health. The population's health will improve, but at no greater cost, and possibly at lower cost, in public resources.

### 3 0 FIVE CASE STUDIES

Four of the following case studies describe efforts to strengthen the *organizational basis* of primary health care in the New Independent States. The fifth case study is a memoir by an American family physician that focuses on efforts to strengthen the *training* of primary care physicians. Taken together, the five cases present a wide variety of approaches to primary health care reform and suggest that there probably is not one single "best method" of reform in conditions of the former Soviet Union. One of the goals in presenting these studies is to emphasize to readers the variety of approaches to reform that may be possible, and perhaps to help readers solve some of their own problems by illustrating what others have tried. There are some *common problems* associated with primary care reforms and a

few *common lessons* that can be distilled from various experiences with reform, which will be discussed below. First, however, it may be useful to summarize briefly each of the five cases.

### **3 1 Family Group Practices in Issyk-Kul Oblast**

Probably the most comprehensive and ambitious attempt to introduce primary health care reform in any of the New Independent States has been mounted in Issyk-Kul Oblast, Kyrgyzstan. The centerpiece of the Issyk-Kul reforms is the “family group practice,” or FGP, which is an independent “juridical entity” with its own bank account. Composed of two to three physicians, plus several nurses and other staff, FGPs are responsible for providing primary health care services to families which have chosen, *individually and voluntarily*, to receive their services. Since 1994, a total of 81 FGPs have been formed, and more than 85 percent of the region’s 400,000 residents have enrolled with one or another FGP.

Although FGPs still are financed out of the state budget, a new funding mechanism is being developed and tested—called “fundholding”—which will make the FGPs responsible for financing *all* non-hospital care, including all outpatient services provided by polyclinics and hospitals. The new funding mechanism will give FGP physicians a powerful material incentive to provide as much, high-quality care as possible and to avoid medically unnecessary referrals to specialists and hospitalizations. The Issyk-Kul reforms are in their early stages and have not yet demonstrated fully their effectiveness. However, the reforms have been strongly endorsed by the government of Kyrgyzstan which, with financial assistance from the World Bank, presently is implementing similar reforms in the capital, Bishkek, and its surrounding oblast.

### **3 2 Family Medicine in L’viv, Ukraine**

Attempts to strengthen primary health care in L’viv, Ukraine, date from 1988, when a four-month course providing supplemental training in “family medicine” was begun at L’viv Medical School (LMS). The purpose of the course is to broaden the skills of already practicing primary care physicians and to promote a conception of primary care in which a single physician if possible (or small group of physicians if necessary) is responsible for treating all members of a family on a continuous basis. In 1991, a family medicine department was established at L’viv City Polyclinic No. 2, in an attempt to expand professional support for family medicine and to provide a site for clinical training for family medicine trainees from LMS. In 1995-96, L’viv City Hospital No. 1 organized two satellite family medicine clinics, each situated in the middle of a district included in the hospital’s catchment area. Each satellite clinic has six family physicians and is responsible for providing all necessary primary care to approximately 10,000 persons.

Surveys of family medicine patients indicate that the improved primary care provided by the satellite clinics and polyclinic department have had a measurable positive impact, both clinically and economically, and that family medicine patients are more satisfied with their

care and more trusting of their family physicians, compared to patients who continue to obtain care in traditional fashion. However, the movement to strengthen primary care in L'viv has been limited, primarily by a lack of funds (financing reform has been discussed frequently but not yet acted upon) and because local health officials have been unwilling to allow patients freedom of choice with respect to their health care providers.

### **3 3 The “Family Medicine Polyclinic” of Dneprodzerzhinsk, Ukraine**

Although very limited in its scope and impact, one of the most successful and noteworthy efforts to strengthen primary care is the privately-owned and operated “Family Medicine Polyclinic” in Dneprodzerzhinsk, Ukraine. The clinic serves 11,000 persons, most of whom work at enterprises that have contracted with the clinic to provide supplementary care, that is, in addition to the care received from the city’s public health facilities. There also are a significant number of individual, private patients who pay out of pocket for services. Roughly half of the clinic’s revenue comes from the city government, in payment of services that otherwise would have been supplied by city health care facilities, the remaining revenue is a mix of pre-paid, capitated fees negotiated separately with each client-enterprise, plus fees for services actually delivered.

Survey evidence suggests that the clinic’s patients receive higher quality care than do the patients of city health care providers and that the cost of the clinic’s care is less than that provided by the city. Yet, despite these results, no effort has been made to replicate this “experiment” elsewhere in the city, or even to generalize the experience and apply its lessons at the city’s health care facilities.

### **3 4 Public-Private Competition in St Petersburg, Russia**

One of the most unusual attempts to strengthen primary health care has involved a private medical insurance company in St Petersburg, Russia, which is one of the “payers” certified by the local government to receive and spend a portion of the city’s mandatory territorial health insurance fund. The insurance company, *MedExpress Ltd*, contracts with health care facilities such as city polyclinics to provide services to the city residents it is responsible for under its contract with the territorial insurance fund. In an effort both to improve the quality of primary care and to increase efficiency, *MedExpress* required one of its polyclinics to organize within the clinic a separate “general medicine practice” that competes with the clinic’s own primary care physicians for patients who, in turn, are free to choose between the general practitioner (GP) and regular clinic personnel, when seeking care. The GP currently is responsible for providing care to approximately 3,700 persons. And although available evidence is far from definitive, the GP physicians appear to provide higher quality care than the regular clinic physicians, and at lower cost, which parallels the experience of the similar experiment in private medicine in Dneprodzerzhinsk.

### **3 5 Training Family Physicians in Kyrgyzstan**

The fifth and final case study is very different from the other four studies. First, it is a personal memoir by an American family physician, Dr. Idar Rommen, who spent a year in Karakol, Kyrgyzstan, participating in the *ZdravReform* assistance program financed by the U.S. Agency for International Development (USAID). Second, it focuses not on organizational reforms aimed at strengthening primary care, but, rather, on parallel efforts to strengthen the training of primary care physicians, so that these physicians become capable of delivering the increased range and quality of services that are required by a strong primary care system. Dr. Rommen's memoir describes the many practical problems that complicated and delayed development of an effective training program in general and family medicine, in conditions that probably are typical of most of the New Independent States. Even more important, perhaps, are his observations about the current quality of primary health care in Kyrgyzstan and his insights into the barriers obstructing reform, for in these respects, too, the situation in Karakol is similar to that prevailing elsewhere in the former Soviet Union.

For example, because of their previous narrow training, even three different specialists operating in a group (internist, pediatrician, obstetrician) are not able to provide the range of skills and services that a typical GP or family physician in Britain or the United States can offer. Meanwhile, according to Dr. Rommen, local physicians are continuing to employ therapies that have not been proven to be effective and that may even be dangerous, thereby exhausting scarce resources without improving patients' health. Nearly all of the local physicians he worked with are hard-working, dedicated, compassionate, serious professionals. However, the reason why the quality of services tends to be well below that offered in the West is due only partly to Western physicians' access to better technology and greater amounts of equipment. Strengthening primary care is thus only partly a matter of receiving and investing more funds; strong primary care also requires a more disciplined approach to medicine, in which only practices whose effectiveness can be shown are supported, and in which effectiveness is measured in terms of clinical performance and patients' satisfaction, not by one or another expert's opinion.

### **4 0 LESSONS LEARNED FROM PRIMARY HEALTH CARE REFORM**

Although the five case studies are very different from one another, together they reveal a number of common problems and obstacles that reformers everywhere have encountered and must overcome, as well as lessons that probably need to be considered by future reformers.

#### **4 1 Financing Reform is Essential**

By far the most important lesson that has been learned so far is that efforts to strengthen primary health care probably are doomed to failure unless accompanied by significant, simultaneous reform of the financing of health care. Financing reform is needed in order to achieve three, inter-related objectives: (1) to provide the additional funds that are required

in the early stages of reform, (2) to enforce the reallocation of funds away from specialist and hospital-based care in favor of primary care, which, is a more appropriate allocation of scarce resources and, at the same time, is the most practical means of raising the additional funds required for primary care, and (3) to motivate and reward primary care physicians and other primary health care workers, who must work more intensively than they do presently and exercise increased responsibility

This importance of financing reform sometimes is not sufficiently understood, possibly because the effort to strengthen primary care frequently has been motivated by budgetary pressure and by the hope that improved primary care will generate badly needed financial savings that can be used to ease the relentless decline in budgetary financing of health. It is clear that over *the long run*, a health system based on strong primary care *will* be more efficient economically and *will* make it possible to ensure a healthier population at the same or lower cost. But in order to strengthen primary care, investment in infrastructure is required, and usually the only available source of funds is the existing health care budget.

The necessary expenditures are of two sorts. Significant *investments* are needed (1) to refurbish existing facilities and to build new ones (in rural areas, most FAPs and SVAs are in such poor condition that they cannot provide good quality primary care, while many city polyclinics are much too large and/or distant from their service population), (2) to provide primary care facilities with the diagnostic and other equipment needed in order to deliver the broader range and improved quality of care that are required, and (3) to provide additional training to physicians and other personnel in order to enable them to care for a much broader range of problems, patients, and conditions. At the same time, additional *operating funds* are needed (1) to pay the salaries of the greater number of more highly skilled primary health care physicians and other personnel, (2) to maintain the refurbished and/or newly built facilities and to replace equipment, as these wear out, and, especially (3) to ensure adequate supplies of the essential drugs and other “consumable” goods that are required for effective ambulatory treatment of many illnesses and conditions. The financing of operating expenses for primary care can be offset by reductions in spending on the maintenance of unneeded hospital capacity. For example, in Uzbekistan, where the government is finalizing an ambitious primary health care reform package of investments in three experimental oblasts, which are to be financed by the World Bank, the *additional* (i.e., incremental) operating expenses of the new primary care system—the added annual expenditures required in order to maintain the new program and to realize the full benefits of the investments—may be equal to as much as 15 to 20 percent of current oblast health care budgets.

These costs can be an unwelcome surprise to health and finance officials who are struggling mightily simply to maintain current levels of health-related expenditures. Indeed, in all of the New Independent States, beds and even whole facilities have been closed, staff have been reduced, and a much larger share of the cost of health care has been shifted to patients themselves. Many officials have viewed correctly the strengthening of primary health care as a means of saving money, thereby alleviating these budgetary pressures. However, the attainment of financial savings cannot be realized immediately, and in order for these

savings to be realized over the long run, the fundamental capabilities of the health system at all levels need to be strengthened and modernized, for which resources are necessary. And when it is understood that primary care reforms thus require *additional* expenditures at first, and will yield economic savings only later on, some officials may become discouraged. For this reason, it is vital that good estimates of both the investments required and the additional operating costs are prepared at the time that primary health reforms are being designed and, further, that these estimates are widely distributed and discussed. At pilot sites in the USAID *ZdravReform* Program in Central Asia, local officials aided by international experts currently are determining the level of the additional expenditures that may be required.

Of course, it is not enough simply to calculate the resources needed, it is even more important to identify realistic sources of funds and to develop practical mechanisms that will ensure these funds are made available. This is particularly important in regard to operating funds. Means must be designed and created that will stimulate individual physicians and entire health care facilities to deliver health care in new, more cost effective ways, and specific mechanisms must be established to reward economically those physicians and facilities that increase their efficiency and effectiveness and to ensure that funds are reallocated from facilities providing specialized, inpatient care to facilities providing primary care.

The importance of financing reform is plainly evident in the case studies. In both Karakol, Kyrgyzstan, and L'viv, Ukraine, ambitious efforts to strengthen primary care have been hampered severely by the lack of resources and constant budgetary pressures, which have narrowed the oblast health departments' room for maneuver. In neither case have officials understood clearly the financial costs of primary care reform, although many officials do understand, at least in principle, that financing reform is essential if primary care reform is to succeed. Still, despite considerable progress in strengthening many aspects of primary care, the inability so far to implement financing reform threatens to undermine what has been achieved and to doom primary care reform to failure.

By comparison, smaller, more limited attempts at reform in Dneprodzerzhinsk, Ukraine, and St. Petersburg, Russia, have been more successful, mainly because the financing obstacles largely have been overcome. The introduction of strong economic incentives and new financing mechanisms in these two cases has resulted in improved operational efficiency and, even more important, has ensured that providers of primary care receive a portion of the economic savings that are realized elsewhere in the system on account of improved primary care.

#### **4.2 Primary Care Physicians Must Be Recognized and Rewarded**

A second important lesson is that the practice of primary care medicine must be recognized as a separate, prestigious medical specialty, and the physicians and other personnel responsible for providing primary care must be adequately rewarded, both economically and professionally. The key ingredient in a system of high-quality primary health care—a well-

trained family medicine specialist—is still rare in the New Independent States. Although internists (*terapevty*), pediatricians, and many obstetrician-gynecologists currently provide primary care services, these physicians' skills and experience usually are so narrow that they are compelled to refer the majority of their patients to specialists, even in cases of very minor complaints and conditions. Therefore, efforts to strengthen primary care often have focused on reform of the training of physicians and other health care workers. Considerable attention has been paid to the reform of medical education, with the aim of producing eventually Western-style "family practitioners" or, in some cases, "general practitioners"<sup>1</sup>. However, because it will take years for changes in medical school training and curricula to transform the medical profession, significant resources also have been devoted to the organization and provision of supplemental training to already certified physicians who may have 20 or more years of professional practice ahead of them.

As shown by the studies of Karakol and L'viv, attempts to reform medical school education and to provide good quality, supplemental training have encountered a number of obstacles. There are severe shortages of good training materials and qualified training personnel. Nor are there adequate funds to cover expenses of the physicians being trained, let alone money to replace the earnings these physicians must give up during their training. At a more conceptual level, there has been significant disagreement over the range of services that primary care physicians should be expected to offer and the types of patients they should treat, and this lack of consensus among professional physicians has made it difficult to design training programs that command wide professional support. The case studies suggest that most primary care physicians would welcome an opportunity to discuss with specialists the question of where the dividing line between primary and specialist care should be drawn. Such discussions should focus on practical issues, e.g., which conditions can be safely treated at the primary level and which indications should be used as the basis for a referral. Such discussions, if held regularly, also could improve the coordination of care—both of particular patients and within and among specific facilities—which should raise the quality and efficiency of care. In the long run, such discussions should help to increase the prestige and self-confidence of all primary care physicians.

A more serious problem has been the lack of rewards. One might reasonably ask why already certified physicians should devote significant time, energy, and out of pocket expenses in order to be trained or retrained as a family medicine specialist, when afterwards they still will rank well below nearly all specialists (e.g. surgeons, urologists) in terms of their salary and professional prestige? In fact, many physicians *are* making such sacrifices, despite the lack of rewards, which is evidence of the powerful appeal associated with many aspects of a strong primary care system: e.g., the opportunity to treat a wider variety of conditions and patients, the more extensive and gratifying interaction with patients, the opportunity to educate patients and change behavior, the greater personnel freedom and

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<sup>1</sup> In the United States "general practitioners," or GPs, simply have broader skills than typical specialists, whereas "family practitioners" have their own, separate, professionally recognized specialty. In order to become certified as a family practitioner, a physician normally must complete a three-year, post-graduate residency and then pass a set of grueling examinations. In the United Kingdom, the GP is similar to an American-style family practitioner.

responsibility, etc. Nevertheless, opportunities for professional growth cannot long suffice as an incentive to draw talented, ambitious people into the practice of primary care medicine. As the case studies suggest, there must be other rewards, especially higher pay, as well as enough power to be able to act as “gate-keeper” to the rest of the health care system—i.e., to refer patients to specialist and hospital care. Such authority will enhance the role and prestige of the primary health care physician, and it will send a strong message to specialists and hospital physicians that primary health care medicine must be regarded as an important, indeed vital, specialty in its own right.

### **4.3 Patients Must Be Given More Information**

It is generally understood that effective primary health care requires not only differently trained physicians, but also a different kind of patient—one who is both willing and able to play a larger role in treatment, when required, and to assume greater responsibility for preventing illness and maintaining wellness than is typically the case. Some health care workers frankly doubt that many ordinary people can, or will want to, play this role, and they use such doubts as a pretext for resisting efforts to strengthen primary care, in particular, efforts to reallocate resources away from specialists and in-patient facilities to primary health care providers.

To a certain extent, the case studies lend support to the skeptics. In Karakol, for example, many patients continue to seek care even for minor ailments from specialists, rather than from the new FGPs, and this has slowed the pace of reform. In general, it is clear that the *passivity and inertia* of ordinary people are one of the principal barriers to change.

However, the case studies also suggest that if people are given the tools they need to play their role effectively, in particular, more and better health information, and if they are given a *genuine* opportunity to exercise responsibility, such as free choice among physicians and health care facilities, many will respond as desired. In Issyk-Kul Oblast, an unprecedented public campaign aimed at persuading families to choose voluntarily one or another FGP revealed in passing a huge, pent-up demand among the public for more information about medicine, about the causes of illness, and about means of staying healthy. In L'viv, patients who received primary care from the City Hospital's family medicine “satellite” clinics said they received more information and more respectful, less patronizing treatment, compared to patients who continued to receive primary care from large city polyclinics. Overall, patients of the satellite clinics expressed higher levels of satisfaction with their care than patients of the polyclinics, and this greater satisfaction was returned in the form of higher levels of trust, manifested in a striking decline in the number of unnecessary (and expensive) emergency ambulance calls by these patients who (1) were better able to reach their family physicians at nights and on weekends when they had a problem and (2) were more willing to accept their physicians' advice, even when delivered over the telephone.

## 5 0 LEADERSHIP AND ENTREPRENEURSHIP ARE CRITICAL

There is, lastly, a final lesson about primary health care reform that can be seen in the case studies, as well as in other experiences with reform elsewhere in the world, namely the importance of individual leadership and entrepreneurship. Medicine is not engineering. Although based on science, the practice of medicine, like any profession, consists mainly of relations between real people and between the myriad interests that motivate each individual. Any significant reform, involving any aspect of life, always upsets the *status quo*, altering the material rewards and psychological mood of everyone involved—sometimes for the better, sometimes for the worse. The net effects of reform are always uncertain, for no one can know with 100-percent confidence what actually will happen and how life will change as a result. Such uncertainty tends to bolster the resistance of those who seem likely to “lose” as a result of change, even as it weakens the resolve of those who seem likely to “win.” As a result, reform always is more of a “political” than a technical challenge, insofar as real people must be inspired to work for change over an extended period of time, if reform is to have any chance of success.

In each of the case studies, one element stands out: whenever there was progress, much of the credit could be attributed to a single individual or small group of “champions” who, with extraordinary energy, commitment, and resourcefulness, led the fight for change. On its face, this should not be surprising. No system changes spontaneously, of its own accord, however logical or sensible the changes may be, and however much generalized, but otherwise passive, support there may be in favor of change. Change requires vision and leadership that is capable of motivating people to surpass the limitations imposed by their personal and institutional interests, and it requires creativity, in order to find or craft solutions to seemingly intractable problems. One of the striking features of the case studies is how much was due to a special few.

The implication of this conclusion for health officials who wish to reform their health systems, by strengthening the primary level of health care, is plain. Such officials should always be on the lookout for “champions” of change—and then be prepared to stand aside and provide these champions with the necessary authority, resources, and room to maneuver. Particularly important in this connection is relief from legal and regulatory barriers that, in many instances, give special advantages to specialist and hospital care or make it difficult for primary care physicians and facilities to expand their role and responsibilities. Experience throughout the New Independent States suggests strongly that procedures need to be worked out and adopted, which would enable a ministry of health *by itself* to authorize the temporary suspension of certain rules and regulations, at a given facility or in a given district, and in response to a specific, documented application, in order to allow local “experiments” that are designed to demonstrate the benefits of primary health care reforms. Such “waiver” authority, as it is called in the United States, is needed so that local and national health officials can encourage the “champions” of health care reform. For if the “champions” are not given sufficient latitude to promote their vision and convictions, the passivity and inertia of the majority of people who stand to gain from reform are

unlikely to be overcome, while the relatively fewer people who are threatened by reform will prevail