

**TECHNICAL REPORT NO. UKR-16**

**Strengthening the Primary Care  
Delivery System in  
Kodyma Rayon, Ukraine**

**April 1997**

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**STRENGTHENING THE PRIMARY CARE DELIVERY SYSTEM  
IN KODYMA RAYON, UKRAINE**

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The health workers of Kodyma Rayon, from the Chief Doctor in Central Rayon Hospital to the doctors, feldshers and nurses in the district hospitals, polyclinics and feldsher clinics, all were cooperative, generous, and open. That spirit is what keeps the health system alive, and will allow it to change and improve.

A special thanks to my work companions and housemates for the nine days and nights in Kodyma. We share a friendship that no one else can know.

Dr. Robert Drickey is Associate Professor of Family Medicine at the University of Colorado Health Sciences Center and a member of the NADIYA group for Colorado-Ukraine medical collaboration. Dr. Drickey has extensive medical and management experience in Latin America and the United States.



## EXECUTIVE SUMMARY

The *ZdravReform* Program (ZRP) selected Kodyma Rayon as a pilot rural project in 1995. ZRP consultants conducted an assessment of the health care system in Kodyma in December 1995 and found substantial inefficiency and excess capacity. In the last year some of the consultants' recommended reforms have been accomplished. Abt Associates Inc. requested consultation from the NADIYA group of the University of Colorado Health Sciences Center, Department of Family Medicine, to evaluate the reforms accomplished in Kodyma, and make recommendations for further reform.

The consultant reviewed all relevant studies by ZRP consultants and employees of health care systems in various parts of Ukraine. Observations made by consultants in L'viv in the past year have only partial relevance for the situation in Odessa and Kodyma. The consultant, accompanied by a team from the Odessa ZRP office, spent nine days in Kodyma Rayon. The team visited Central Rayon Hospital and Polyclinic, three of the seven district hospitals and polyclinics, five of 17 feldsher points, and the medical school in Kotovsk. They spoke with as many people as possible, including patients, to determine the current state of the health care system. The consultant presented his findings and recommendations in Kodyma and Odessa to receive feedback from health care workers and officials.

The system was found to be too complex, too specialty-oriented, overly-regulated, not meeting patients' needs, and most of all, too expensive. The system is almost entirely bankrupt. Excess bed capacity and inappropriate hospitalization continue.

The basis for a primary health care system already exists in Kodyma. A majority of true primary care in rural Kodyma takes place in the feldsher points and polyclinics.

Budgetary reality is now forcing further reforms. The 12 inpatient departments of Central Rayon Hospital will be integrated into four units. The seven district hospitals will be closed. Beds for long-term patients will be located in local "mercy homes." Many workers will be laid off. At least one group of doctors will begin to practice privately in Kodyma. Mobile brigades will follow a regular route to health centers, schools, and other centers.

Recommendations for future primary care in this rural area revolve around feldsher points and polyclinics.

1. Feldsher training and status should be enhanced.
2. Family doctors should be utilized at the polyclinic level.
3. With further training, specialist doctors should increase the breadth of their practices.
4. With guided training in Odessa and L'viv, advocates and teachers for primary care should be created.
5. Teaching methods for the education of feldshers and physicians should be modernized.
6. Ministry of Health and Oblast regulations should be changed to enhance primary care.
7. Financial incentives should be developed to encourage primary care.

8. Mandated user fees should be introduced.

9. Future consultants should concentrate on management and change.

## 1.0 Introduction

The purpose of this consultation was to evaluate primary care delivery in Kodyma Rayon in Odessa Oblast, Ukraine, and to make recommendations for strengthening primary care. The *ZdravReform* Program (ZRP) selected Kodyma Rayon as a pilot rural project in 1995. ZRP consultants conducted an assessment of the health care system in Kodyma in December 1995 and found substantial inefficiency and excess capacity.<sup>1</sup> The consultants recommended closing all seven district hospitals, consolidation of several departments in the Central Rayon Hospital, and substantial reduction of staff and beds. In the last year some of the recommended reforms have taken place. Authorities have reduced the number of hospital beds from 575 to 365 throughout the central and district hospitals, and reduced staff. They consolidated some surgical services at Central Rayon Hospital. Three district hospitals were closed briefly in 1996, but were re-opened following pressure from citizens and local officials. Further reforms are planned.

Abt Associates Inc., which coordinates ZRP, requested consultation from the NADIYA group of the University of Colorado Health Sciences Center, Department of Family Medicine, to evaluate the reforms accomplished in Kodyma, and make recommendations for further reform.

The reality of the situation encountered in Kodyma added urgency to the task at hand. The health care system is almost entirely bankrupt, similar to most other service sectors—similar indeed to the entire economy except for some new, private enterprises. Dr. Vitaly Borsch, the hardworking and creative Chief Doctor of the Kodyma system, is in a very difficult position. He must make extensive and drastic changes in a system that for many years had provided free, complete care based on a hospital and specialty-physician model, and that provides extensive employment in the Rayon.

Within the week prior to this consultation, budgetary reality for the year began forcing some of the changes discussed for the last year. To maintain even the current dysfunctional system would require 3.2 million Hryvnias (U.S. \$1.8 million), and Odessa Oblast will provide only 1.1 million Hryvnias (U.S. \$610,000). Thus, the timing of this consultation is particularly appropriate.

Another reality adding to a sense of urgency is that, although US Agency for International Development will extend the ZRP contract for another year, most Abt resident expatriate advisors will remain only until May 1997, followed by frequent short-term consultations. Ukrainian personnel will inherit principal responsibility for making the necessary changes to establish a primary health care system.

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<sup>1</sup>Clark, J., Christianson, C., Yazbeck, A., "Assessment and Implementation Plan Design for the Development and Testing of Market-oriented Methods of Management, Odessa Oblast, Ukraine." Abt Associates Inc. 1996

Observations made by consultants in L'viv in the past year have only partial relevance for the situation in Odessa and Kodyma.<sup>2,3</sup> Odessa considers itself somewhat of a "free port." That is, Odessa is neither Ukrainian nor Russian, but Odessa, with even a separate language that is a combination of Russian and Ukrainian. However, Russian is the main language. Kodyma does not identify strongly with Odessa; it is geographically closer to Vinnitsya. Sections of Kodyma Rayon were part of the Vinnitsya Oblast in the past. Western Ukraine, where L'viv is located, is more European, and identifies more with the West. The concept of family medicine has a history in L'viv since the late 1980's, while in the Odessa region family medicine has no history except in the last year with ZRP. Finally, Kodyma is essentially rural as opposed to the principally urban context of L'viv. Kodyma is about as far away from a large city as is possible in the Ukraine.

## 2.0 Definition of Primary Care

Over the past two years, ZRP has recommended the re-orientation of the health care system in Ukraine toward primary care.

**Primary care is defined as the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.<sup>4</sup>**

"Integrated" refers to the breadth of services offered by a single provider or team of providers. For example, a well-trained provider at the primary care level is able to provide preventive, curative and psychosocial care (counseling), care of chronic diseases, referral to the next level of care in some cases, and interpretation and follow-up of specialty recommendations. A single provider is able to offer services to all age groups and both genders, and therefore is able to appreciate the relationships in families, the effects of those relationships on disease, and the effects of disease on the family. Family interactions are extremely important in the etiology, prevention and treatment of disease.

With a team of primary care providers from different disciplines (e.g., internal medicine and pediatrics), care may be less well integrated. Various family members require separate visits to different providers. Unless excellent communication exists among the various providers, relevant information for the prevention and treatment of disease may be lost.

"Accessible" refers to geographic and cultural accessibility. Care should be convenient to where patients live. Given the current lack of public transportation in rural Ukraine, geographic accessibility is especially important.

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<sup>2</sup>Reeves, J. and Wouters, A., "Strengthening Clinical and Economic Aspect of Family Medicine in the L'viv Oblast," Abt Associates Inc., October 21, 1996.

<sup>3</sup>Stevens, J., *Zdrav/Reform/Program "L'viv Intensive Demonstration Site, Final Report, May 1995 through December 1996,"* Abt Associates Inc., December 23, 1996.

<sup>4</sup>Institute of Medicine, 1996

Cultural accessibility refers to the fact that class differences and disparity in levels of education often exist between doctors and patients. Often patients are better able to communicate with someone from their local area, particularly someone such as a mid-level provider (feldsher), nurse or community health worker.

It is important to keep these concepts in mind and to refer back to them as one considers the changes that must be made to the Ukrainian health care system to allow it to survive and improve.

### **3.0 The Kodyma Health Care Delivery System**

Kodyma is the city center of Kodyma Rayon, an agricultural region located in the northwest corner of Odessa Oblast. This region relies almost entirely on agriculture and agriculture-related business. The population of Kodyma Rayon, approximately 37,000, decreased by 10.3 percent in 1994, and 12.1 percent in 1995. The population growth rate was +7.8 per 1,000 in 1989, and -10.1 per 1,000 in 1996. The birth rate decreased from 13.4 per 1,000 in 1989, to 12.4 per 1,000 in 1996, and the crude death rate increased from 17.2 per 1,000 in 1989, to 22.5 per 1,000 in 1996.<sup>5</sup>

The Kodyma health care system is based on the Central Rayon Hospital in Kodyma, and seven district hospitals located around the Rayon. In addition, 17 feldsher points (clinics) are located in smaller towns, 100-2000 in population, around the Rayon. Sixty-seven physicians, and 253 nurses and feldshers are employed in the system. Hospital beds in the past totaled 575, for a population of 37,000. In 1995, only 85.7 percent of the bed capacity was used, despite an average length of stay of 15.9 days. Many of the beds were occupied by patients who could be treated as outpatients, or by "social patients" who would be unable to care for themselves at home, but who would not require hospital care if some nursing home-type facility were available.

The health care system has been severely underfinanced for the past several years, due to the collapse of the economy since the dissolution of the Soviet Union in the early 1990s. None of the health care workers has been paid for eight months. Except for some emergency medicines, patients must purchase their own medications and x-ray film for out-patient and in-patient care. The system is in debt for 450,000 Hryvnias (US \$250,000) in back wages, and 20,000 Hryvnias (US \$11,200) for medications.

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<sup>5</sup>Omelchenko, L., "Study of PHC Reform in the Kodyma Rayon of the Odessa Oblast: Planning of Mobile Brigade Introduction" (Draft), Abt Associates Inc., March 1, 1997.

### 3.1 Central Rayon Hospital

The Central Rayon Hospital consists of 250 beds in 12 departments. It is staffed by 60 specialist physicians and 152 nurses and feldshers. The hospital provides a range of services including internal medicine and its subspecialties, with a separate infectious disease building, surgery and its subspecialties and anesthesia, pediatrics, obstetrics and gynecology, radiology, psychiatry, and physical therapy.

The hospital has undergone some organizational restructuring in the past year, including a reduction in beds and staff, and consolidation of some surgical services.

The hospital is the site of a large polyclinic that includes clinics in all of the specialties, including dental, and is staffed by specialist doctors from the hospital. The polyclinic is organized into smaller centers, each of which receives patients from separate districts of Kodyma city. Patients referred for admission from district hospitals, polyclinics, or feldsher clinics are evaluated first in the polyclinic.

### 3.2 District Hospitals

Three of the seven district hospitals around Kodyma Rayon were closed in mid-1996. They were all reopened after a month because of pressure from citizens and local officials. All of the district hospitals have decreased in size in the last year from 30-50 beds each, to 15 beds each. Each district hospital is staffed by at least one physician, and several nurses and feldshers. A number of vacant positions currently exist.

### 3.3 Polyclinics

Each district hospital serves as its own polyclinic for outpatient care, staffed by physician, feldshers and nurses. Patients self-refer or are referred by feldsher points for outpatient evaluation and treatment. The polyclinic of the Labushnoe District Hospital is located in a separate building in the village.

### 3.4 Feldshers

A feldsher is very similar to a mid-level provider in the United States. Feldshers work at the primary care level in the villages, or in a hospital or clinic. They provide many basic services including preventive and acute care. Many doctors were former feldshers, and a level of trust appears to exist between most doctors and feldshers.

Feldsher training takes place in medical schools, while physician training takes place in medical institutes or medical universities. Feldsher training requires 2.5 years if the student enters after 11 years of prior education and 3.5 to 4 years if they enter after nine years of prior education. Feldshers are trained by doctors and other feldshers. Feldsher training is very complete, including lectures in basic and clinical sciences, and practical experience in hospitals and outpatient settings.

Each feldsher point or feldsher clinic consists of several rooms in which patients are seen. Most feldsher points are staffed by a feldsher, an obstetrical feldsher, a nurse or assistant, a public health nurse, and a physical therapist.

Currently feldshers respond any time, day or night, to calls from patients to see them in their homes.

### 3.5 Referrals

Required referrals increase the complexity and cost of the health care system. For example, a newborn infant in the hospital, *by regulation* must be examined by a pediatrician, a surgeon, a neurologist, and an ENT doctor. A well-trained pediatrician, family doctor, or feldsher could provide excellent newborn exams, and refer the infant to a specialist only if a specific problem is found. A pediatrician, *by regulation* must refer a child with an ear infection to an ENT specialist. A well-trained pediatrician, family doctor, or feldsher can treat ear infections and refer patients to an ENT specialist only if the initial treatment is not successful, or for special problems related to the ears.

Currently, some providers use mandatory referrals as an excuse to take no responsibility for treating the patient.

Patients have the right to self-refer to a specialist. In a managed care system, patients do not have that right, but must first see their primary care provider who may refer them to a specialist. In Kodyma Rayon, at the present time, patients should probably retain the right to self-refer to a specialist. However, if quality care is provided at the primary care level (feldsher points and polyclinics), patients will be less likely to self-refer.

### 3.6 Pharmacy System

The state-owned pharmacy system is under a different administration than the rest of the health care system, under a different ministry, and is well supplied. The pharmacy system has entered into some joint ventures with non-Ukrainian enterprises and has achieved some degree of privatization. The hospitals, polyclinics, and feldsher points have no money for medicines, except for some emergency medications. Patients are required to buy medications at state-owned pharmacies in various villages and in Kodyma. X-ray film is purchased in the pharmacy system also, and is plentiful.

## 4.0 Primary Care Delivery in Kodyma Rayon

A majority of true primary care in rural Kodyma takes place in the feldsher points. Feldshers may be the unsung heroes of primary care. Feldshers are clinicians who provide accessible (if not entirely integrated) health care services and could be accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

Primary care takes place also in the polyclinics, but is less well integrated and accessible there. Very little provider-patient continuity is evident in the polyclinic setting. Specialist doctors are able to provide primary care, but various specialists are required in a single clinical setting because specialists' skills are limited to certain age groups, genders, or biological systems (e.g., pediatrics, gynecology, or cardiology). Often patients must travel outside of their villages to reach a polyclinic.

Some specialist doctors stated that they are already doing family medicine and that specialist doctors can "easily" do general practice. They made statements such as, "The physiology is all the same." "Children are just little adults." "Prenatal care is easy." These concepts are incorrect for several reasons:

1. Specialist doctors have forgotten much of what they learned in general medical university training that is not applicable within their own specialty.

2. Approaches to patients in different age groups and to diseases within different age groups are distinct. To be able to see and treat patients in different age groups, and in different disease categories requires additional knowledge and training.

3. Primary care is more than merely a combination of specialties. Primary care requires knowledge and skill in psychology, family dynamics, behavior change techniques, and prevention, to name but a few areas.

#### 4.1 Staffing

Staffing in the polyclinics and feldsher points appears more than adequate to provide primary care. With broadened skills (See Section 7.0 Recommendations for Future Reforms), fewer personnel should be required. *At the primary care level*, a well-trained family doctor or feldsher could provide a broad range of services, and thus obviate the need for several separate specialists in a polyclinic. Experience in the United States suggests that a family physician can manage the primary care of 1,600 to 2,000 people effectively. A lesser number of specialists could provide care for the more difficult problems referred to them.

Currently, in the polyclinics, specialty doctors work in three or four hour shifts. Efficiency could be improved by having primary care providers (family doctors and feldshers) work six or eight hour shifts. Experience in the United States suggests that a family physician or mid-level practitioner can efficiently provide complete care (preventive and curative) for two to four patients per hour.

## 4.2 Logistical Support

a) Equipment currently in the feldsher points is not adequate to provide primary care. As seen in the L'viv study last year,<sup>6</sup> the addition of some fundamental diagnostic tools such as otoscopes, ophthalmoscopes and EKGs could greatly increase the primary care capabilities of the system. With proper training, feldshers could provide initial readings on EKG tracings and then send them on for official readings by a cardiologist.

Some in Kodyma suggested that x-ray machines be available in the feldsher points. Given the expense of buying and maintaining x-ray equipment and the number of times an x-ray is really necessary, x-ray units in the feldsher points would not be an efficient use of resources. X-ray equipment at the level of the polyclinic would be more practical.

As seen in the L'viv study last year,<sup>7</sup> in the polyclinics and feldsher points the addition of some simple laboratory equipment such as elementary glucometers to measure blood sugar, hemoglobinometers to detect anemia, and urine dip stick tests to detect infections would greatly increase the primary care capabilities of the system.

b) Office space is adequate to provide primary care at most facilities visited.

c) The patient record system was described well in the L'viv study,<sup>8</sup> and does not differ greatly in Kodyma. Currently patients' medical records reside in several different places—preventive care records in one location, ambulatory clinical records in a different location, and acute hospitalization records in a third location. Modifications to unify the patients' medical records will be necessary and will evolve as primary care develops. At the very least a patient's preventive care, ambulatory care and summaries of hospital care should be in a patient's primary chart in the feldsher point or polyclinic, to provide a more complete record of the patient's health history.

d) Administrative and management systems are centralized, with all or most decisions made by upper level administration. At the feldsher clinic level, minimal administrative support is necessary, and could be managed at the feldsher level by current personnel. As new procedures such as user fees are implemented the administrative burden will increase.

## 4.3 Patient-Provider Relationships

Patients at the feldsher clinic level generally spoke highly of their feldsher providers (See Appendix D). Usually the feldsher is someone from the town where the feldsher clinic is located, or has practiced there for a number of years (6 months-22 years).

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<sup>6</sup>Reeves, J. and Wouters, A., "Strengthening Clinical and Economic Aspect of Family Medicine in the L'viv Oblast," Abt Associates Inc., October 21, 1996.

<sup>7</sup>ibid.

<sup>8</sup>ibid.

<sup>10</sup>Hrubiy, S., "Family Medicine Patient Satisfaction Survey," Ukraine Marketing Group, L'viv 1996.

Health care appears to be very provider—as opposed to patient—centered. That is, the patient comes to the provider, the provider makes an assessment and prescribes treatment, and the patient accepts the treatment. There is little education of the patient about their condition, or involvement of the patient in decision-making about their own health.

Some prevention and screening activities seem excellent. Immunizations and pap smears are practically required for all appropriate patients, and outreach takes place if a patient fails to come in for these preventive activities. Prevention education in other areas is not pursued vigorously. For example, smoking and alcohol abuse are rampant. However, apart from a few signs advising of the ill-effects of tobacco and alcohol, no active patient education takes place.

Patient privacy is almost non-existent in most of the sites surveyed. Health workers and other patients enter exam rooms without knocking, often while the patient in the room is undressed. Patient gowns are not used. Patients themselves seem unfazed by this lack of privacy.

In a discussion about AIDS with the Chief of Infectious Diseases, clearly the concept of confidentiality exists, at least with regard to AIDS. The extent to which confidentiality is maintained could not be determined.

## **5.0 Reforms in Kodyma during the last year**

During the last year Dr. Borsch, the Chief Doctor for Kodyma Rayon, met with local administrators and community leaders on numerous occasions to recommend reforms in the health care system. His task was made more difficult by the fact that the Rayon administration changed at least two times. Consensus on necessary reforms could not be reached. In rejecting some reforms, Rayon administrators considered the broader social implications of adopting the reforms, such as resulting unemployment and lodging and care for the elderly and indigent. Nevertheless, Dr. Borsch was able to achieve some reforms.

### **5.1 Hospital Downsizing**

In the past year the number of hospital beds in Kodyma Rayon was decreased from 575 to 365, mostly by reducing beds in the district hospitals.

### **5.2 Reduction in Staff**

Concomitantly, staff was reduced in the hospitals. Other staff reduced their hours to remain employed.

### 5.3 User Fees

Currently, the constitution of Ukraine guarantees free health care. However, user fees were attempted in the last year, but were not successful. People do not have sufficient money, or would prefer to pay with goods. The people have been accustomed to free and plentiful services for many years, so it is difficult for them to understand that now they must pay for some services.

The patient satisfaction survey accomplished during this consultation indicates that patients are willing to pay for some services (See Appendix D).

See also ZRP “Health Care Issues Brief: User Fees.”

## 6.0 Current Plans for Future Reforms

As mentioned, budgetary realities for the next budget period are forcing some changes that were recommended last year.

### 6.1 Reorganization of Central Rayon Hospital

Plans are being made for further reorganization of the Central Rayon Hospital. The 12 inpatient departments will be integrated into four units: polyclinic, internal medicine, surgery, and obstetrics/gynecology.

### 6.2 Closure of District Hospitals

The seven district hospitals are slated for closure. Many more workers will be laid off.

### 6.3 Formation of Groups of Doctors for Private Practice

Dr. Borsch is planning to encourage the formation of at least one group of doctors to practice privately in Kodyma. The group of doctors would include doctors who have been laid off from the Kodyma Health System, or who have had their positions reduced to part time. The plan calls for the private group to lease space in which to practice in closed sections of the Central Rayon Hospital. Detailed plans have not been developed.

### 6.4 Mobile Brigades

Dr. Borsch hopes to implement a plan for “mobile brigades.” A doctor, feldsher or nurse and driver will work in an ambulance, following a regular route to health centers, schools, and other centers where patients will come to see them. They will also respond to emergency calls from patients at home. The physician staff in the mobile brigades will be former specialists from the district hospitals. They will receive prior additional training, but no current plan, nor funds exist for training. No detailed planning has been done at this time for implementation of mobile brigades.



## 6.5 Mercy Homes

When the district hospitals are closed and when beds are further reduced in Central Rayon Hospital, patients who require nursing home-type care will require places to stay. These patients include mentally retarded or severely mentally ill, non-violent patients, and the very old and infirm who have no family to care for them. The current plan advanced by Dr. Borsch is to establish “mercy homes” in many of the towns, to house these types of patients. Mercy homes existed in the past, but were discontinued with the proliferation of hospitals that began to care for all patients. Dr. Borsch hopes that village councils and/or communal farms will sponsor and manage the mercy homes. No further specific or detailed planning has been done to establish mercy homes.

## 7.0 Recommendations for Future Reforms

### 7.1 *Emphasize Primary Care in the Feldsher Points and Polyclinics*

a) The majority of new or converted resources for training and equipment should be directed toward feldsher points and polyclinics, with emphasis on the feldsher points.

b) The Central Rayon Hospital, after restructuring, should receive resources only for maintenance of basic secondary level services such as surgery, childbirth, and minimal hospitalizations. For illness, the hospital should be considered as a place of last resort.

### 7.2 *Enhance Feldsher Training and Status*

a) Immediate efforts should be made to provide on-going increased training for feldshers to broaden their skills. Current monthly educational activities should be directed toward broadening skills. Examples of enhanced training include developing diagnostic, treatment and referral skills to manage patients who present with the 20 most common complaints (e.g., backache, upper respiratory infection, gastrointestinal disturbances, ear aches, mild hypertension, chest pain, etc.).

b) Feldsher basic training in medical school should be reviewed and enhanced to broaden skills as described in 7.2.a.

c) Appropriate portions of curriculum developed in L’viv family medicine training should be integrated into basic and on-going feldsher training.

d) With increased training and skills feldsher status will be enhanced. Their status should be further enhanced by publicly honoring them, stating that they are the basis of the primary health care system.

### 7.3 *The Place of Family Medicine Doctors*

a) The family medicine doctor program developed in L'viv should be continued and expanded to other Oblasts in Ukraine, including Odessa Oblast.

b) The family medicine movement should be supplemented by enhanced feldsher training and status.

c) In rural areas such as Kodyma Rayon, family medicine doctors would be best placed in free-standing ambulatories, as supervisors of feldshers and as the next step in the referral ladder from the feldsher points. Feldshers are the appropriate health care providers for small villages. The appropriate size used to determine whether a village should have a family doctor or a feldsher will depend on the local context, including finances.

### 7.4 *The Place of Specialist Doctors*

a) In order to increase efficiency in the Kodyma Rayon health system, specialist doctors must increase the breadth of their practice. Specialist doctors can become primary care doctors, but the transition will require additional training. They must learn new skills to broaden their practice, to see a greater variety of people and problems.

b) Specialist doctors should be used to train each other in small multispecialty groups in the polyclinics.

c) Specialist doctors should receive guided additional training in the feldsher points.

### 7.5 *Create True Advocates and Teachers for Primary Care*

a) Select one or two physicians and one or two feldshers who are bright and motivated to change and learn, and who would be good teachers. Send them to the four-month Family Medicine Course in L'viv to bring back the material and organize family medicine education in classes and apprenticeships in Odessa Oblast and Kodyma Rayon. If the four-month course is not possible, the future advocates should spend at least one month in L'viv to see the breadth of practice that is possible. Perhaps the training could be spread over several periods of time, to minimize time away from job responsibilities and family in Odessa or Kodyma.

b) Alternatively, send only one physician or feldsher, who would be a good teacher, to the four-month Family Medicine Course or several shorter periods of time in L'viv, to return to organize family medicine education in Odessa Oblast and Kodyma Rayon.

c) Abt Associates Inc. should consider the possibility that the cost of a single short term consultant from the United States is probably equivalent to the cost to support at least one Ukrainian from Kodyma or Odessa in the four-month course in L'viv.

d) Alternatively or additionally, provide a physician or physician assistant from the United States for six months to a year to set up a family medicine education program in Odessa Oblast and Kodyma Rayon. Possibilities include a Peace Corps Volunteer or other volunteer, or a series of senior medical students and/or family medicine residents and/or faculty. The University of Colorado Department of Family Medicine is applying for a grant to establish an exchange family medicine training program with Ukraine.

e) Abt Associates, Inc. plans future consultations to teach modern primary health care education and training techniques to be instituted in L'viv and elsewhere. Most current education and training are based on didactic lecture methods. Modern techniques would include problem-based learning (PBL) in which small groups of students are presented with clinical problems and, with the help of a facilitator-teacher, the students themselves determine what needs to be learned, and how to go about finding the information. The students then gather the information and teach it to each other. PBL develops life-long learning techniques. The emphasis is on learning, not on teaching.

Other modern techniques pay increased attention to teaching-learning styles in practicum, or apprenticeship learning environments.

f) Concentrate most effort on this recommendation (7.5). Many of the recommendations made following the consultation in L'viv last year can be applied later in time in the Odessa/Kodyma area. If efforts at change are too broad at this point in time, human energy will be defused and the efforts may fail.

#### 7.6 *Mobile Brigades*

a) Because the doctors who will work on the mobile brigades are specialists, they should receive additional training as described above *before* they begin work in the mobile brigade. In that way they will be able to handle more effectively a broader range of problems without referral.

b) One rapid method of training would be to place a doctor with a feldsher at a feldsher point for some period of time before initiating mobile brigades. The doctor could then see the breadth of problems and age groups that present to a primary care practice. Doctor and feldsher can work as a team, learning from each other.

c) Separate the 24-hour emergency response function of the mobile brigades, which can be handled by well-trained feldshers, from the regular daily clinical function of doctors working at various sites. Feldshers can transport the true emergency patients to the location where the doctor is working in the day or directly to the hospital at night.

d) Patients must be charged user fees for ambulance calls, or they will abuse that service.

### 7.7 *Effect Regulatory Change to Optimize Primary Care*

a) Change Ministry of Health and Oblast regulations to allow more individual discretion by doctors and feldshers regarding what they are able to treat and what they should refer.

b) Some *practice protocols* already exist in the system and are used variably. Practice protocols should be reviewed and revised by feldshers and their supervising physicians to guide treatment and referral for the majority of common presenting complaints. Model practice protocols are available from the United States to be used as starting points for feldshers and physicians to develop their own, locally relevant protocols.

c) Oblast regulations should be developed to allow charging patients user fees (See 7.8 *Institution of Regular User Fees*).

### 7.8 *Institution of Regular User Fees*

a) A schedule of mandated user fees should be instituted. Over time, the amount and extent of user fees should be gradually increased. A proposed Oblast decree will direct health facilities to charge patients a fixed fee for each visit to a polyclinic and a fixed fee for each day spent in the hospital. The proposed fees will be small and will help cover the costs of utilities and overhead.

b) Fees for primary care should be minimal or non-existent. Fees should be concentrated on specialist and non-essential services. This policy will help to drive use of the system toward primary care.

### 7.9 *Develop financial enhancements for effective, efficient primary care*

a) Using models and data that exist currently in Ukraine and elsewhere, develop a system of financial incentives that reward effective, efficient, good quality primary care.

b) Financial incentives should:

1. Encourage additional training for doctors and feldshers.
2. Encourage effective treatment at the primary point of contact of the patient with the health care system, and discourage referrals, except when appropriate.
3. Encourage out-patient treatment whenever possible, and discourage hospitalization.
4. Encourage rapid discharge of the patient from the hospital, and discourage long lengths-of-stay.

c) Financial incentives can be applied to both providers (doctors and feldshers) and patients (See 7.8 *Institution of Regular User Fees*).

#### 7.10 *The Science of Management and Behavioral Change*

a) Numerous consultants have made numerous recommendations for change in the Odessa/Kodyma health care system over the last two years. While progress has been made, some essential changes have not yet taken place. Change is probably one of the most difficult human endeavors. Yet change is inevitable. The task of good managers is to guide change so that those whom the changes will most affect truly participate in planning for change and understand why change is necessary.

b) An entire science of transcultural management and behavior change has developed in the last 20 years to deal with the tremendous growth in international commerce and exchange. Future consultants for ZRP should be selected for expertise in transcultural management and behavior change. We know the kinds of changes that must take place. Now we must discover how to achieve them.

### 8.0 **Obstacles to Future Reform**

#### 8.1 *Resistance from the Doctors and Feldshers*

Physicians tend to be independent by nature. Like most people, they are conservative and tend to resist change. Therefore, expect to encounter some brisk resistance from physicians.

Resistance from some of the feldshers themselves might be anticipated. Some may fear taking on more responsibility. Some may be comfortable in the roles they now occupy and not wish to expand or grow.

Active participation by doctors and feldshers, indeed by all workers in the system, in planning and development is essential. As in any system involving human behavior, clear initial expectations, evaluation of performance, and expectations for improvement will be key in encouraging active participation of doctors and feldshers in development of proposed changes.

Additional training may alleviate some fears regarding adequacy for expanded practice among providers. Financial incentives and movement of the entire system toward primary care may encourage some of the reluctant ones.

#### 8.2 *Resistance from the People*

The people who receive care from the health care system had been accustomed to free complete care for many years under the Soviet system. However, the Soviet system has been gone now for several years, and the people have lived with the reality of decreased funding and services for several years. While the people may be nostalgic for the health system of the

past, if an efficient, friendly health system, accessible close to home is developed, the people will accept it. Patient satisfaction studies done in L'viv and in Kodyma indicate that this is true (See Appendix D).

Active participation by the people at the village level in planning and development of changes is essential. The people are accustomed to top-down management, but the health system can use this opportunity to develop participation and planning skills among the people.

### *8.3 Broader Social Considerations*

As mentioned in 5.0 (Reforms in Kodyma during the last year), Rayon administrators have resisted change for the last year, due to their concern about the broader social implications of adopting reforms, such as the resulting unemployment and lodging and care for the elderly and indigent. However, worsening financial, social, and health conditions are creating increased pressure for change. Dr. Borsch must build consensus for change among physicians, staff, the medical worker's union, the Oblast Health Administration, cooperatives, community leaders, Rayon administrators, the mayor, and the general Rayon population.

### *8.4 Lack of Funding*

Lack of central or outside funding will remain a reality for some lengthy period of time. Therefore, a move toward user fees and self-funding is absolutely necessary. Many of the recommendations for primary care can be accomplished without additional funding, but with a re-setting of priorities. If less money is spent on specialty care and on hospitalization, more money will be available for primary care in an outpatient setting.

### *8.5 Partial Withdrawal of Abt Associates*

It is unfortunate that with changing priorities in foreign policy in the United States, and with decreased funding for foreign assistance, work that is in its infancy in Ukraine must be cut short. Some of the proffered recommendations have taken these changes into account. Recommendation 7.5, to create true advocates for primary care in Odessa/Kodyma, who are able to teach, is made for that reason.

## **9.0 Ability to Replicate Kodyma Reforms**

When reforms proposed for Kodyma Rayon are instituted, data gathering within the health care system is currently adequate to demonstrate beneficial effects. Beneficial effects might include decreased referral rates, decreased hospitalizations, shorter lengths of stay, decreased costs for the system, increased patient satisfaction and, over a long period of time, decreased mortality rates.

In the short term, because of the numerous consultative resources already utilized in Kodyma Rayon, and because Kodyma Rayon has a health system leader who seems willing to attempt innovations, concentrated efforts should continue in Kodyma before trying to export

reforms to other areas. To the extent Kodyma reforms are successful, they ought to be replicable in other similar rural areas of Ukraine. After the reforms in Kodyma are solidified, health personnel from other rural areas of Ukraine might be invited to come, observe, learn, and take back to their practices aspects of the reforms that are applicable to their own situations.

## CONCLUSION

A model primary health care system in Kodyma Rayon would be based in feldsher points and polyclinics. Feldshers with enhanced skills would provide preventive and curative treatment for up to 70 percent of people who present to their practices. Family doctors and specialist doctors with enhanced skills would provide primary care in polyclinics, and supervise and receive referrals from feldshers. Well-trained physicians in polyclinics would provide preventive and curative care for up to 85 percent of people who present to those practices. Specialists without enhanced skills would remain in the Central Rayon Hospital to provide consultation in their specialties and care for hospitalized patients.

All three levels—feldsher points, polyclinics, and Central Rayon Hospital—care for the same patients. More severe cases and more complicated diseases requiring consultation or hospitalization are referred along the referral ladder, from feldsher point to polyclinic, to hospital. But the majority of care can take place at primary care levels (i.e., feldsher points and polyclinics).

Out of any population of 1,000 people, 750 of them may have a medical illness in any one year. Of those, about half will consult the health care system. Of those, perhaps 10 to 15 require hospitalization. Most health care can be provided on an outpatient basis by well trained generalists. Generalists usually have a broader view of the patient and the patient's context. Generalists appropriately order fewer tests and thus cost the system less. Certainly, outpatient treatment is less expensive than hospital treatment.

One of the key words in this model of primary care is training. All health care providers in systems all over the world require on-going training to stay current. Feldshers, family doctors, and specialists desiring to practice medicine more broadly, that is with both genders, in all age groups, and many disease categories, will require further training. In L'viv a generalist curriculum has been developed to teach family doctors. That curriculum could be adapted to teach feldshers and specialty doctors. That enhanced training does not need to take place all at once, but could take place over a period of time. But the time to begin is now.

## **Appendix A Scope of Work (Revised January 24, 1997)**

### **Objectives:**

- (a) To assess the existing primary care network in Kodyma Rayon and assist ongoing reform efforts aimed at strengthening primary health care delivery system.
- (b) To further the development of a model for providing rural primary care that could be replicated in other parts of Ukraine.

### **Background:**

Kodyma Rayon is located in the northern-western corner of Odessa Oblast and relies almost entirely on agriculture and agriculture-related business for its economic base. The economy of Kodyma, as with most of Ukraine, is severely depressed and as a result, local taxes available for health care have fallen drastically. Budgetary funds are not sufficient to support the existing structure of the health care system. Local authorities have been unable to pay health workers for more than four months. Medical supplies are critically low. Medicine is available for critical patients only; non-critical patients must purchase their own medicine.

ZRP consultants conducted an assessment of the health care system in Kodyma in December 1995 and found substantial inefficiency and excess capacity. Only 85.7 percent of bed capacity is used, despite an average hospital length of stay of 15.9 days. ZRP consultants suggested that local administrators close all seven of the 30-bed district hospitals, consolidate several departments in the Central Rayon Hospital and reduce staff and beds substantially. It is also worth noting that the population of Kodyma (approximately 37 thousand residents) continues to decrease. The population fell by 10.3 percent in 1994 and another 12.1 percent in 1995.

Since the original assessment, the chief doctor has taken several steps to restructure the health care delivery system in Kodyma to reduce the excess capacity, bring expenditure in line with available funds and to improve quality of care. In 1996, the Chief Doctor consolidated several departments, eliminated 145 beds and reduced the number of doctors by about 40 percent in the Central Rayon Hospital. He also temporarily converted five of the seven 30-bed district hospitals into outpatient clinics and developed plans to provide home care through a mobile brigade. Paid services were also introduced in 1996 to augment budgetary funding and local agricultural cooperatives agreed to provide nearly all of the food needs of the hospital free of charge.

### **Statement of Work:**

1) *Conduct an extensive site visit of Kodyma Rayon:* Assess ongoing efforts to strengthen the primary care delivery system and recommend changes where appropriate. The assessment should include the following components:

a) *System organization*: Describe and assess the organizational structure of the primary health care delivery system in Kodyma Rayon (e.g., polyclinics, free-standing ambulatories, mobile brigades, feldsher points, etc.) and recommend changes where appropriate.

b) *Primary Care delivery*: Assess the range of services provided by primary care delivery points and, conversely, the range of services that are referred to other facilities. Examine actual referral rates where available.

c) *Staffing*: Assess the staffing arrangements of the primary health care delivery points and the functions, roles and qualifications/training of primary health care providers. Assess whether functions are delegated among staff members most effectively. Assess whether staff members are appropriately trained. Provide recommendations where appropriate.

d) *Logistical support*: Describe and assess whether equipment, office space, patient record systems, administrative systems, and available lab services sufficiently support development of an effective primary health care delivery system.

e) *Incentive systems*: Provide input so that an economist can assess which economic incentives exist that promote use/provision of primary health care instead of more expensive specialty and inpatient care when appropriate (e.g., salary incentives, decentralized budgets, user fees, etc.).

f) *Patient-provider relationships*: Assess whether patient-provider relationships adequately foster improved patient health and satisfaction (e.g., providers educate patients, patients are encouraged to take responsibility for health, preventive care is provided, providers are patient-oriented, organization encourages long-term patient-provider partnership, basic tenets of patient privacy are preserved).

g) *Results of recent reforms*: Describe reforms to strengthen the primary care delivery system over last year and assess whether these reforms have been successful. If information does not exist with which one can measure success, recommend how to monitor success over next six to nine months.

h) *Critical obstacles to further reform*: Identify obstacles to further development of the primary health care system in Kodyma and recommend steps for overcoming the obstacles where possible.

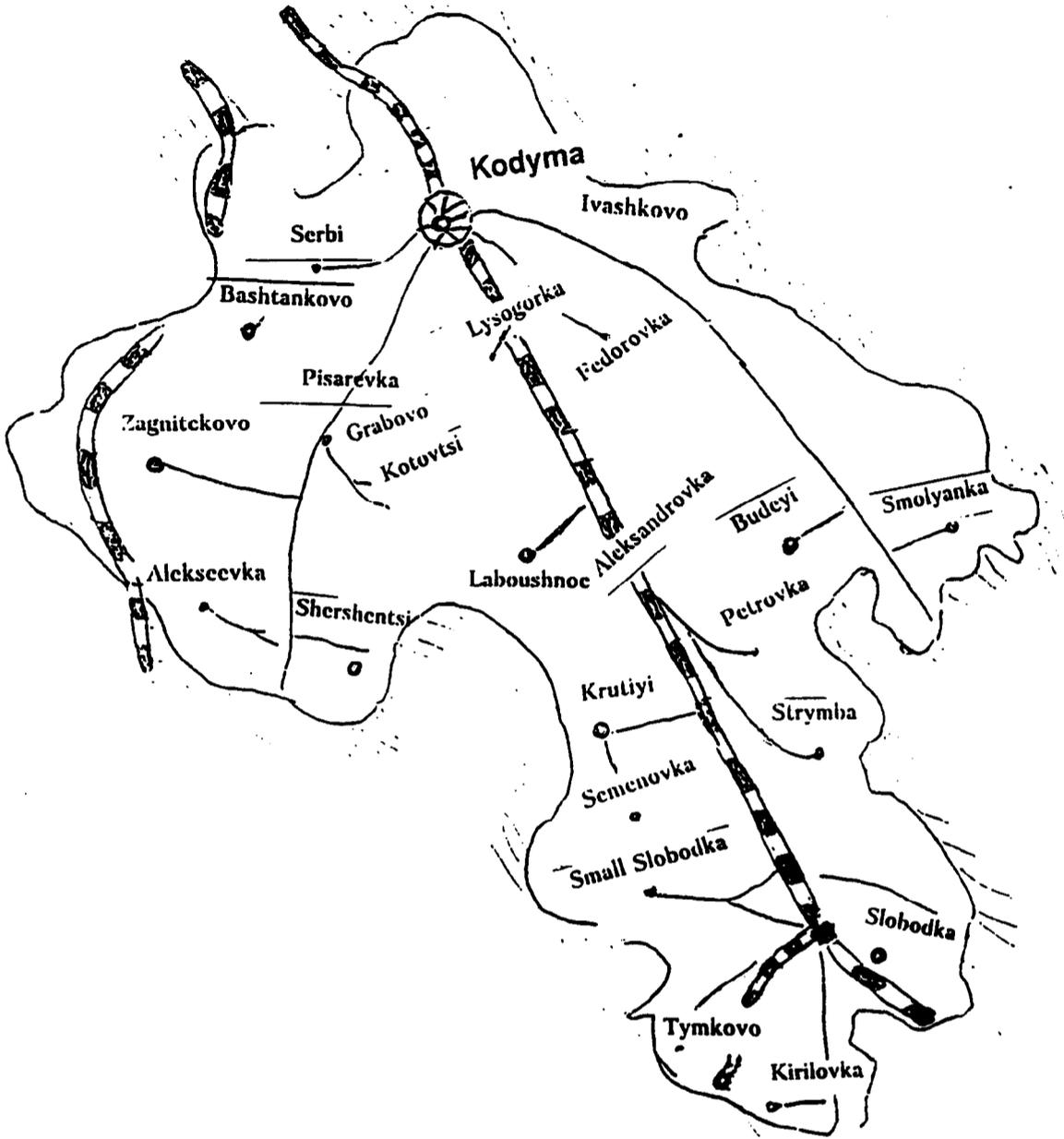
i) *Other Miscellaneous Recommendations or concerns*.

2) *Assess ability to replicate Kodyma reforms*: Based on findings in Kodyma, any discussions with health authorities, and on existing documents regarding L'viv primary health care experience, assess whether efforts to strengthen primary health care provision in Kodyma maybe and/or should be replicated in other rural areas.

Key Outputs:

1. Trip report in standard ZRP format.
2. Technical Report documenting assessment findings and recommendations.
3. Debriefing of preliminary findings for Kodyma counterparts.
4. Seminar in Odessa presenting preliminary findings and recommendations to local health administrators and other interested individuals.

**Appendix B Map of Kodyma Rayon**



Appendix C Statistical Data from Kodyma Rayon Health System

Localities in Kodyma Rayon without District Hospitals

	<b>Locality</b>	<b>Population</b>
<b>1</b>	<b>Pisarevka</b>	1555
<b>2</b>	<b>Smolyanka</b>	463
<b>3</b>	<b>Alekseevka</b>	1028
<b>4</b>	<b>Semenovka</b>	195
<b>5</b>	<b>Petrovka</b>	448
<b>6</b>	<b>Alexandrovka</b>	218
<b>7</b>	<b>Strymba</b>	339
<b>8</b>	<b>Fedorovka</b>	176
<b>9</b>	<b>Lysogorka</b>	1008
<b>10</b>	<b>Grabovo</b>	1344
<b>11</b>	<b>Kotovtsi</b>	282
<b>12</b>	<b>Small Slobodka</b>	630
<b>13</b>	<b>Tymkovo</b>	831
<b>14</b>	<b>Kirilovka</b>	91
<b>15</b>	<b>Ivashkovo</b>	1409
<b>16</b>	<b>Pirizhnya</b>	1503
<b>17</b>	<b>Serbi</b>	1971

Localities in Kodyma Rayon with District Hospitals

<b>Slobodka</b>	4294
<b>Laboushnoe</b>	2584
<b>Krutiyi</b>	2071
<b>Shershentsi</b>	3267
<b>Bashtankovo</b>	3086
<b>Zagnitckovo</b>	4528
<b>Budeyi</b>	1933

### Feldsher Facilities in Kodyma Rayon

#	Locality	Population	Remoteness from District Hospital in Kms.
1	Pisarevka	1555	6
2	Smolyanka	463	6
3	Alekseevka	1028	5
4	Semenovka	195	3
5	Petrovka	448	8
6	Aleksandrovka	218	4
7	Strymba	339	12
8	Fedorovka	176	14
9	Lysogorka	1008	10
10	Grabovo	1344	11
11	Kotovtsi	282	6
12	Small Slobodka	630	3
13	Tymkovo	831	5
14	Kirilovka	91	10
15	Ivashkovo	1409	10
16	Pirizhnya	1503	9
17	Serbi	1971	9

### Visits to Feldsher Facilities in Kodyma Rayon

Locality	Population	Visits				# of visits per day		
		Clinic visit		Home visit				
		1995	1996	1995	1996	1995	1996	change
<b>Pisarevka</b>	1555	1358	3300	848	400	7.9	13	5.3
<b>Smolyanka</b>	463	1900	2200	1301	891	11	11	-0.4
<b>Alekseevka</b>	1028	2517	1807	2696	3044	19	17	-1.3
<b>Semenovka</b>	195	1696	2064	308	527	7.2	9.3	2.1
<b>Petrovka</b>	448	2900	2877	2100	1569	18	16	-2
<b>Aleksandrovka</b>	218	798	1020	106	135	3.2	4.1	0.9
<b>Strymba</b>	339	2526	2264	641	684	11	11	-0.8
<b>Fedorovka</b>	176	439	1260	141	571	2.1	6.5	4.5
<b>Lysogorka</b>	1008	2352	1537	1560	1097	14	9.4	-4.6
<b>Grabovo</b>	1344	####	8222	3823	3774	55	43	-12
<b>Kotovtsi</b>	282	683	696	134	374	2.9	3.8	0.9
<b>Small Slobodka</b>	630	3743	3443	1861	1212	20	17	-3.4
<b>Tymkovo</b>	831	4642	3435	2887	1617	27	18	-8.8
<b>Kirilovka</b>	91	11	108	29	366	0.1	1.7	1.6
<b>Ivashkovo</b>	1409	5600	4880	2300	2480	28	26	-1.9
<b>Pirizhnya</b>	1503	4498	7823	573	526	18	30	12
<b>Serbi</b>	1971	####	11027	2926	3239	58	51	-7.3

**Diseases and Patients' Visits to District Hospitals of Kodyma Rayon**

	Diseases	Budeyi		Zagnitckovo		Krutiye		Labushnoe	
		1995	1996	1995	1996	1995	1996	1995	1996
1	Infectious diseases							11	4
2	Oncologic diseases		39		99		51		50
3	Endocrine diseases		37		132		63		60
4	Leukemia	13	12	21	21	9	10	9	9
5	Psychological diseases		1						
6	Neurological diseases	46	31	52	28	33	31	43	66
7	Cardiac and Vascular	438	506	914	1041	440	626	500	611
8	Pulmonary diseases	185	313	386	318	196	194	309	236
9	Gastroenterological	145	123	239	275	244	183	236	235
10	Urogenital diseases	20	22	44	61	17	32	29	36
11	Musculoskeletal	69	81	127	176	83	141	195	240
12	Traumas	27	41	90	81	21	32	56	72
13	<b>Total</b>	<b>973</b>	<b>1250</b>	<b>1933</b>	<b>2281</b>	<b>1043</b>	<b>1369</b>	<b>1427</b>	<b>1674</b>
14	# of residents		3086		4528		2071		2584
#	Diseases	Slobodka		Bashtankovo		Shershentsi		Centrl Ryn Hosp	
		1995	1996	1995	1996	1995	1996	1995	1996
1	Infectious Diseases		1						1240
2	Oncologic		117		85		93		421
3	Endocrine		65		82		78		547
4	Leukemia	9	11	25	25	20	19	170	179
5	Psychological	1	1	5	1			1519	1494
6	Neurologic	28	42	119	142	40	57	3566	3364
7	Cardiac and Vascular	761	1245	769	780	599	852	3394	3253
8	Pulmonary	183	215	572	184	111	112	2282	2287
9	Gastroenterological	114	124	196	263	193	221	1272	2330
10	Urogenital	12	17	52	33	40	44	1530	1025
11	Musculoskeletal	95	130	103	85	133	151	1288	1180
12	Traumas	30	33	79	42	17	26	1264	1181
13	<b>Total</b>	<b>1232</b>	<b>2012</b>	<b>1915</b>	<b>1695</b>	<b>1164</b>	<b>1682</b>	<b>20949</b>	<b>20124</b>
14	# of residents		4291		3086		3267		

**OPERATIONAL DATA COLLECTED AT AMBULANCES AND DISTRICT  
HOSPITALS OF KODYMA RAYON THROUGH 1995-1996.**

District Hospital	Population	Mortality		Morbidity		# of visits			
		1995	1996	1995	1996	at polyclinic		home visits	
Ambulatory						1995	1996	1995	1996
<b>Slobodka</b>	4294	85	121	35	40				
therapist						1946	2811	1179	919
dentist							5306		
<b>Laboushnoe</b>	2584	65	73	30	25				
therapist						3643	3778	554	1048
pediatrician						1308	4433	653	2024
dentist							4064		
<b>Krutiya</b>	2071	66	48	26	30	2907	1818	653	2024
therapist							1840		
<b>Shershentsi</b>	3267	83	94	39	33				
therapist						2268	2093	615	804
<b>Bashtankovo</b>	3086	81	85	29	42				
therapist						4905	4221	747	1064
<b>Zagnitckovo</b>	4528	132	111	47	44				
therapist						3031	3021	553	552
pediatrician						2577	1035	1196	489
<b>Budeyi</b>	1933	61	59	19	22				
therapist						2431	2322	353	475
dentist							888		



## Appendix D Report of Patient Satisfaction Survey

The patient satisfaction survey developed by Ukraine Marketing Group<sup>10</sup> was used by Dr. Natasha Antanasova to interview 25 random patients in a variety of settings during the field work in Kodyma. Although the survey cannot be considered scientific, it does give some indication of patient sentiment.

The patients interviewed ranged from 25 to 72 years of age. All had received secondary or professional level education.

- 60 percent came to the health facility with cardiac or vascular problems,
- 10 percent came to the health facility with diabetes or its complications.
- 20 percent came to the health facility with respiratory problems.
- 10 percent came to the health facility with trauma and its complications.

80 percent stated that their health facility is located within easy reach and is accessible.

All patients considered that their health providers had a high level of professional skill.

85 percent based their evaluation of professional skill on:

1. Friendly relationships
2. Kindness
3. Diagnostic skills

90 percent said they would prefer to choose their own provider.

10 percent said they would prefer to go to a provider at the district level.

25 percent of patients are referred to specialists for diagnosis and treatment. All others receive diagnosis and treatment at the point of primary contact.

If hospitalization is needed, 70 percent stated they would prefer to be treated at home or in a day treatment facility. 30 percent would agree to be sent to Central Rayon Hospital.

85 percent expressed a willingness to pay for some services such as urgent laboratory tests, extra injections, functional diagnostics (?), and massage.

## Appendix E Notes for March 5 and 11 talks

### I. Introduction

Who I am and why I am here.

### II. What we have done over the last nine days.

-Visited 3 of the 7 district hospitals.

-Visited 5 of 17 feldsher points.

-Visited Central Rayon Hospital and Polyclinic.

-Visited the medical school in Kotovsk

-Talked with as many personnel as possible to find out how the health care system functions here.

-We were treated wonderfully everywhere we went.

### III. My observations.

-You are all very aware what is happening in the current economic crisis; therefore I won't go into those details. Needless to say, the health system, as many other systems in the former Soviet Union, is very dysfunctional, almost to the point of stopping all together.

-But, even though you may not have been aware of it, the health care system had difficulties even before the current financial crisis, just as the system in the United States has difficulties. Both systems were too complex, too specialty oriented, not meeting the needs of patients, and most of all, too expensive. In the U.S. right now the health care system is undergoing great change. Here in Ukraine you have the opportunity, during this crisis, to restructure your health system to make it much more efficient and much more productive. That is exactly the same thing we are trying to do with our health system in the U.S. It is a painful process, because change is difficult. It means we have to think differently than we have thought in the past. It means that we have to act differently than we have acted in the past. But if we don't change, if we continue in our old ways of doing things, the entire health system will collapse, leaving our patients to fend for themselves.

So I encourage you to try to understand the recommendations that I am going to make, to take the recommendations into your hearts, into your souls, into your thinking. And to work together to achieve the changes that must take place.

### IV. Primary health care.

The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

V. Observation of system in Kodyma. Very specialty based. Tell Borsch's story, and others. No one taking responsibility.

VI. Recommendation: The system can be based on primary health care. All of you health care providers—doctors, feldshers, nurses—have the basic knowledge. With some additional training you will have the knowledge and skills to provide all the basic services that patients in your communities require. It has been shown that a well-trained primary care provider can handle 85 to 95 percent of the problems that present themselves to a primary care practice. A well-trained primary care provider should have to refer only 5 to 15 percent of the patients they see. They can handle all of the other problems. But you must be willing to take responsibility to do it. And you must be given the responsibility by the system, by the authorities. And you must be provided the assistance, both in training, and in support. So that if you call for help with a diagnosis or with a problem, the doctor will not say, “what an incompetent feldsher; he or she does not know enough.” We must all work together for the good of the patient. The guiding principle must be the good of the patient.

I will be making written recommendations on specifics.

Question for groups:

You have heard the definition of PHC. How does Primary Health Care differ from what you do currently in your practice?

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