

General practitioners and family doctors in the Russian Federation

MICHAEL RYAN

JOHN STEPHEN

SUMMARY

This paper looks at the emergence in Russia of a strategy for delivering primary health care which differs radically from the specialist-based system of the former Soviet Union. Drawing on Russian language sources, the paper outlines previous training arrangements, the limited role of 'sector' doctors and the reasons for official endorsement of general practice during the years of perestroika. It reports that the Health Ministry asked all the country's regions to make a gradual transition to general practice in 1992, and that legislation made the choice of family doctor a universal right in 1993. The conclusion refers to factors which are likely to determine whether that right will become a reality.

Keywords: *general practice; specialization; health service reforms; Russian Federation.*

Introduction

One of the most interesting policy initiatives in contemporary health care has recently started to bear fruit. During 1994, post-communist Russia acquired a group of doctors who had completed a 2-year post-graduate training course which qualified them as specialists in family medicine.

In the exact Russian terminology, these people are now formally qualified to work as 'doctors of general practice (family doctors)'. It is essential to cite that entire phrase because it recognizes an important distinction, one which was explained succinctly and unambiguously by a senior official of the Russian Health Ministry in 1992: 'What we call a doctor of general practice is a specialist in curative medicine who is providing initial multi-profile medical care at a pre-hospital stage to adult patients. And a family doctor provides the same care, only to child patients as well, and moreover is concerned with medico-social problems of families.'¹

Levels of specialization

The term 'specialist in curative medicine' needs to be set in context, which is that all qualified doctors are in effect 'specialists' of a sort. The crucial fact is that post-graduate training in family medicine has now started in a country where differentiated courses are the norm, even at the level of basic medical education, an arrangement which dates back to an early period of communist rule.

That such differentiation at the initial level continues today is evident from an order on the training of health care personnel which was issued by the Russian Health Ministry at the end of 1994. It made clear that separate courses lead to qualifications in:

curative medicine (6 years); paediatrics (6 years); community medicine (6 years); and stomatology (5 years). In addition to those four categories, it also identifies as doctors people who have trained to be medical biochemists or biophysicists in 'medico-biological' faculties.²

Therefore, whatever overlap there may be in the content of their courses, newly qualified doctors in Russia do not have a broad generic education in common. After obtaining their first qualification (a diploma not a degree), they normally advance up the specialist ladder by enrolling on advanced courses, many of which are related to the demands of specific posts in hospital or primary health care units.

Table 1, which relates to 1993, shows the distribution of doctors by what are termed basic specialties. The total includes all doctors who were employed in curative and public health units, social welfare institutions, research institutes, medical training establishments and administrative agencies. As for the residual category, it almost certainly includes a range of other specialists such as the medical biochemists and biophysicists referred to above.

Sector doctors

Many of the staff identified as specialists in Table 1 provide primary care in urban polyclinics and are more appropriately termed sub-specialists. This particularly applies to those in general medicine and paediatrics who have responsibilities for adult and child populations in sectors (microdistricts) of urban communities or at the place of work. A key limitation on their role — and a reason for overstaffing — is the patients' freedom to refer themselves to other sub-specialists (e.g. ophthalmologists), who are also based in the polyclinics. Self-referral and the absence of a single type of doctor-of-first-contact were key features of the Soviet health service (at least in urban areas).

Before the years of glasnost, newspaper articles which reported the work of sector doctors often painted an unduly rosy picture, but it can be accepted that there were indeed individuals who continued to practise in the same sector for many years, demonstrating exemplary appreciation of their patients' family and socio-occupational circumstances. Occasionally, this ideal-type was encapsulated in the terms 'home doctor', and even 'family doctor'.

The new orthodoxy

As is well known, various comparative studies have shown that the provision of primary care by specialists is the accepted norm in many developed countries.^{3,4} However, during the period of perestroika, the Soviet Health Ministry came to approve an alternative approach in line with the general trend for the regime to admit systemic failures and consider radical alternatives which often originated in capitalist countries. That twofold thrust can be identified in the following words of Yevgeni Chazov, the then Health Minister of the USSR: 'It is no secret that today the sector doctor — the key figure of our health service — has largely lost a sense of responsibility for the health of patients.' Increasingly, that figure saw himself mainly as a 'despatcher', someone who hastily referred patients on to colleagues with the appropriate specialist remit.⁵ A year later, the possibility of a new departure

T M Ryan, MA, PhD, honorary research fellow, Department of Politics, University of Wales, Swansea; and W J Stephen, MB, ChB, DObst, RCOG, retired general practitioner, Wells, Somerset.
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Table 1. Doctors by basic specialty at the end of 1993.¹

Specialty	Number in thousands	Per thousand population
General medicine ²	167.3	11.3
Surgery	79.1	5.3
Obstetrics and gynaecology	40.0	5.1*
Paediatrics	78.2	24.2**
Ophthalmology	14.7	1.0
Otolaryngology	12.3	0.8
Neuropathology	19.4	1.3
Psychiatry ³	18.8	1.3
Phthisiology	9.9	0.7
Dermato-venereology	8.7	0.6
Roentgenology and radiology	19.7	1.3
Physical culture	3.8	0.3
Public health and epidemiology	30.4	2.1
Stomatology and dentistry ⁴	77.4	5.2
Residual ⁵	88.8	
Total	668.5	45.2

*Per thousand women. **Per thousand children aged 0–14 years.
¹Source: *Rossiski Statisticheski Ezhegodnik 1994*; 173. ²Translates *terapevty*. ³Includes psychiatrists specializing in drug addiction.
⁴Dentists (*zubnie vrachi*) are included, despite having specialized secondary education, not higher education. ⁵Not given in source.

opened up when Chazov stated: 'We will study very carefully the experience of undertaking the sector doctor's work on the family doctor principle.' He went on to announce that an experiment along those lines had commenced in a number of Russia's regions.⁶

In fact, family doctoring was not completely unknown within the former Soviet Union; it had been embodied in the separate and semi-secret health service for the party and government elite. After the fall of communism, another ex-minister, Igor Denisov, made that very point, only to be reminded that the arrangement had operated in exceptionally favourable circumstances. The doctors in question had a small list of families, were given transport for house-calls, and furthermore, were backed up by a polyclinic which had highly qualified consultants and could provide excellent specialist care.⁷

Denisov also disclosed interesting evidence about the consequences for policy-making of opening a window on the West. Along with others, the former Health Minister had studied the experience of a number of countries which trained family doctors, and he implied that Canada, where 40% of physicians are family doctors, was judged to be the most appropriate model. Canada's transition to family medicine, he said, had helped to ensure that, while spending only 6–8% of gross national product on health care, the country performed better regarding many health indicators than the USA, which was expected to spend over 12% of gross national product on health care in 1993.⁷

Here one can observe that, although the former Soviet Union spent far less than either country on health care, it still had an urgent need to employ resources more efficiently and cost-effectively. The point is corroborated by data which reveal an exceptionally heavy reliance on the most expensive component of health care, namely hospitals. In 1989, Russia had a vast supply of hospital beds (138.7 per 10 000 persons) and as much as one-quarter (24.9%) of the total population were admitted to hospital that year. Once there, patients stayed for an average of 16.2 days — a very long period by international standards.⁸

Improved qualifications

The course in family medicine referred to earlier commenced after the first postgraduate training for general practitioners which had started in Leningrad in January 1989. The latter did not entail continuous full-time study and 3 years passed before the successful participants graduated as specialists in 'general medical practice'. But what could they do that sector doctors could not?

'In the first place,' states *Meditsinskaya gazeta*, they possessed, 'a sufficiently sound knowledge base and practical skills in the related specialties of surgery, gynaecology, ophthalmology, otolaryngology and neurology.' Giving two examples of clinical activity that such a background made possible, the article reported that the graduates take minor surgery clinics and 'can diagnose and treat neuroses'. Furthermore, 'they can now give advice to patients on urgent questions regarding family relationships, sexology and geriatrics'. After appraising the course, the Health Ministry recommended it for consideration throughout Russia.⁹

A government commitment

If the Health Ministry had previously favoured experimentation on a voluntary, local basis, it took a firmly pro-active stance next and indicated that all regions (there are nearly 80) should move to adopt the principle of family doctoring. That turning point occurred in August 1992, being marked by the publication of an order with the self-explanatory title: 'Concerning the gradual transition to the organisation of primary medical care on the principle of a doctor of general practice (family doctor).' The Ministry also issued a model curriculum, created a legal status for the new specialism, its practitioners and the post in question, and settled various related matters.¹⁰

That was not all. In 1993, the government enacted the law 'Concerning the fundamentals of the Russian Federation's legislation on health care', and under article 22, it conferred on all families the right to choose a family doctor who provides a service based on their place of residence. By implication, the entire population was promised the opportunity to benefit from what was once a privilege reserved for members of the communist elite.

Conclusion

An obvious question to address is: Can the government manage to honour their commitment? A pessimistic appraisal would take into account the general tendency towards regional self-determination which affects health care organization along with other things. Presumably, that would tend to strengthen resistance to change which may well exist in some of the 50 or so training institutions. Furthermore, the partial commercialization of medicine which is now occurring could give financial encouragement to specialization.

However, cautious optimism could be justified on the ground that implementing the government's commitment represents a top priority for the new Health Minister, Professor Aleksandr Dimitrievich Tsaregorodstev. Appointed in December 1995, he soon declared that: 'The most important element in the work to reform health care is the introduction of the general medical practitioner system.'¹¹ In this, he is likely to have broad public support, since the new system will be seen as more in sympathy with the old Russian saying that a doctor should give part of his heart to every patient.

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Address for correspondence

Dr T M Ryan, Department of Politics, University of Wales, Swansea, Singleton Park, Swansea SA2 8PP.

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